Original Articles.

A REVIEW OF THE MIDWIFE SITUATION.*

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THE midwife situation abroad and in our own country has impressed us so strongly that, when the question of licensing the midwife was agitated, we felt that the subject merited a thorough study in order to form an opinion which might command the consideration and respect of the best medical thought of this country. We hope for your co-operation in this study, and, therefore, do not hesitate to go into considerable detail on what seem to us points of great importance.

Let us begin by reviewing the methods of supervision employed in foreign countries and our own. Then let us carefully consider whether or not we have the moral right, in view of our present knowledge, to offer to the community two standards of obstetrical skill: one for those who can afford it, — the product of four years of medical training; the other for the impecunious, — the midwife, unskilled in general medicine and surgical technic. Or let us see if it is not possible to have our present laws in Massachusetts enforced and one grade of obstetrical knowledge required for all who practice the art.

To realize that this is not an idle theoretical discussion, but the presentation of an actual problem directly concerning the welfare of our community, we only have to consult the proceedings of two committees [1, 2] interested in social service here in Massachusetts to find that proposed legislation for the immediate regulation and licensing of midwives has been actually agitated during this present year.

We hope to convince you that the practice of the midwife, when licensed, has never been successfully or satisfactorily regulated and controlled in any country or state; moreover, that we in Massachusetts are most favorably situated in this regard both as to the number of midwives actually in practice now and in the existing laws concerning them. Also we hope to show that these laws can be so modified as to greatly facilitate the prosecutions not only of the midwives, who practice now in open violation of the law, but also the class of practitioners that shield these women. We also hope to show that the community should be aroused to demand and expect much better obstetric service than it would be possible for the people to receive under the midwife, no matter how well trained for her vocation.

Historical. — The midwife problem in its broad sense is a sociological problem. To understand clearly our present position, a brief glimpse at the past, tracing the midwife in her development and course, may give us perspective and a broader view of the present situation. In Great Britain and throughout Europe the midwife has been an established institution in all historic time.

Bacteriology, antiseptic and aseptic surgery have put obstetrics on an entirely different basis, raising it to the position, sociologically at least, of the most important branch of surgery. Therefore it is right that society demand the most intelligent obstetric care. These conditions have developed the efficient trained nurse of to-day, acting in harmony with the doctor, who carries the responsibility. What position, then, does the midwife hold in this modern scheme?

We shall attempt to answer this question by showing what has been done in the older countries, where the best efforts for her development have been made, and also the provisions for her training in this country, and with what results.

A glance at the most recent history in Europe and at home shows a series of attempts to license, educate and control the midwife. The writers have recently had the opportunity personally to observe the conditions in England, Austria, France and Germany, and to ascertain the laws of Italy in regard to the midwife. We find that the question of reducing to a fair minimum the injuries to her patients is a more or less urgent question in every country, including many of our states to-day.

ITALY.

A joint committee of the Chicago Medical Society and the Hull House,[3] after an investigation of the midwife situation throughout the world, gave it as their opinion that the best schools of midwives were those of Rome and Naples, with Paris third and Berlin fourth.

In 1886 the Italian government [4] took control of the midwife situation. Since that time reliable statistics as to puerperal fever and other diseases related to the parturient woman have been collected. Before this took place the mortality was admittedly very high.

A new law was put in force Feb. 23, 1890, and has remained substantially the same since that date. Under this law the education of the midwife was placed under the supervision of the government. Midwife schools could be established in any city or town where a university existed. The funds were to be supplied by the Minister of Instruction in conjunction with the local authorities. The direction and teaching were to be under the professor of obstetrics.

The requirements for admission to such a school were as follows: The candidate must be healthy, not disfigured, between the ages of eighteen and thirty-six. She must present a certificate of good conduct and have been successfully vaccinated or have had smallpox. The total fees were $38. The course was from one and one-third to two years. The examinations were both written and oral, with graded marks. One of the requirements was the histories and clinical courses of two complete cases observed by the candidate and signed by the professor. If "eminence" was attained, the matriculation fee and one year's tuition was returned to the candidate.

Regulations of practice. — The midwife must notify a physician if the patient's temperature reaches 100.4°. If a physician is not available, and the temperature rises to 101.3°, the municipal

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authorities must be notified. She is prohibited from using instruments or drugs or doing intra-uterine operations, except in urgent cases, where she assumes the responsibility of her actions. If puerperal fever develops, she is suspended for five days or disinfected by the authorities. She must keep a case book.

Instructions. — Her instructions are minute and in general good, describing a fair technic and the ordinary care of a labor case, which if carefully and conscientiously carried out by intelligent women should maintain a fairly satisfactory mortality rate. Let us glance for a moment at the results of this system.

Statistics collected in 1894 for the previous fifteen years show the conditions from the time the government took control, three years before the present law went into effect, and the twelve years following. Briefly, these figures show that in 1887 there were 85 deaths per million population from puerperal fever. A drop to 56 took place after the law of 1890 came into effect, and a gradual falling continued from that time till in 1902 there were 32 deaths from puerperal fever per million inhabitants. Similarly in other diseases connected with pregnancy, parturition and the puerperium the deaths fell between 1887 and 1902 from 150 to 53 per million population.

As the midwife does the bulk of obstetrics in Italy, the improvement in her training and equipment must constitute a large factor in this better showing.

The total death-rate, however, for 1902 was 1,037 from puerperal fever, and from other diseases connected with pregnancy was 1,746, giving a combined death toll from the practice of the midwives for that year of 2,783, with an estimated population of about 33,000,000, or 85 per million, and this rate of preventable deaths after the law has been in force twelve years and may be said to be in good working order.

FRANCE.[5]

Since 1803 the midwife has been controlled in France. The French laws of 1893 require a theoretical and practical course of two years in order to obtain a midwife's diploma issued by the government.

AUSTRIA.[6, 7]

In 1891, Austria lengthened the midwife course from six months to two years in the clinic, six months' preliminary theoretical and eighteen months' practical work.

GERMANY.

In Germany we find essentially the same condition as in Austria, and as we have had opportunity to observe the entire training of the midwife, and the results of her practice, we propose to discuss at length the details of the situation of the German midwife, feeling that a study of her position will reveal not only the amount of knowledge required before she is entrusted with responsibility, but also the complicated and complete supervision regarded as essential by that enlightened nation. Such a study will enable us to see what preparations we must be ready to make should we decide to adopt a system with the midwife as the solution of our present condition, and what results we are entitled to expect under practically ideal supervision.

We have been unable to learn exactly how much obstetrics in Germany is in the hands of the midwife. Certainly nearly all normal cases and most operative cases in the early part of labor are conducted by the midwife alone, save in the families of wealth and position, where education has opened their eyes to the necessity for the physician's exclusive help during this critical period. We were constantly surprised to see how even in many of the families of the well-to-do the midwife was depended upon to assume the full responsibility. In the type of women entering the schools of midwifery, nearly all classes were represented, from the professor's daughter to the simplest peasant girl.

We must realize that Germany has been training the midwife for generations to understand the firmness of her hold upon the general public. The trained midwife followed as naturally in the course of development as the trained physician, and we find with the knowledge of the necessity for clean obstetrics, stringent laws were passed for her education and regulation.

The midwife in Germany to-day is trained in the government *kliniks* by university professors who are salaried by the state — the same professors, for the most part, who are responsible for the education of the medical students. The midwife course is in most cases six months; always as much as that is required. Her textbook, issued by the government, she is required to know almost by heart from cover to cover. It takes up anatomy, including the entire skeleton; the nervous, alimentary and circulatory systems, as well as the genito-urinary tract. There is also considerable physiology, bacteriology, normal and pathological obstetrics, and a full description of her legal status. This book is supplemented by lectures and explained by recitations occupying in all about twelve hours a week throughout the course.

She also has thorough drills in the principles of diagnosis by means of abdominal palpation, auscultation, pelvimetry and vaginal examination, this work being carried on in the pregnancy wards. She has almost daily drill in the " vaginal touch " by means of the manniken and the fetal cadaver. She is required to make vaginal examinations and to deliver a certain number of cases in the confinement ward under the direction of the resident physician and graduate midwives. Here also she is taught as far as is possible in the limited time of her instruction the principles of aseptic technic. This is further supplemented by the observation of surgical operations, both gynecological and obstetrical, in the amphitheater.

At the conclusion of her course she is subjected to a rigid examination, both oral and written, before a board of examiners. Besides answering questions for some fifteen minutes, the candidate

must demonstrate her knowledge of making a diagnosis of presentation and position in the manniken, and outlining her methods of procedure in the given case. As we were present at such an examination we can definitely state that it is a rigid test and one that the average third-year student of the Harvard Medical School would find some difficulty in passing with distinction.

Now let us turn to the midwife in practice and see what her position is; in other words, how she is regulated. She is constantly under the supervision of a government physician, who is coroner, medical examiner and local board of health officer combined. She must report to him before she begins her practice, and so long as she is in his jurisdiction her work is constantly subjected to his supervision. To him she must report immediately all stillbirths and deaths, all cases of puerperal fever and ophthalmia neonatorum. Her home, her equipment, her clothing and her person must always be ready for his inspection. She may lose her right to practice if her home is dirty or if she is caring for obstetrical cases under her own roof. The contents of her bag and her case book are outlined by law. She is required to wear clean and washable gowns when in attendance on cases. Her hands must be clean and the skin in good condition at all times. She must report to this officer any septic lesion or ulcer on any part of her body. Violations of these rules will lead to fine, or imprisonment, or both.

The midwife must report to some local physician any symptoms suggesting eclampsia or miscarriage. She must notify him in any case of antepartum hemorrhage, contracted pelvis or abnormal presentation, and this includes a breech presentation. Should the second stage last more than two hours, without progress; should the pulse or temperature rise above the limit considered not abnormal in obstetrics; the fetal heart rise above 180 or fall below 110; the placenta remain in the uterus too long after the delivery of the child; the uterus fail to contract and continue to bleed; or the perineum rupture during delivery, the midwife must notify a physician in writing, or over the telephone, of the condition, and unless actually employed on some case requiring his time it shall be the duty of this physician to respond immediately to the midwife's summons or he is subject to punishment.

In case an emergency arises out of her jurisdiction as laid down by law, after notifying the physician (or even before if the danger is imminent), it shall be her duty to do whatever seems necessary for her to perform, save only forceps and version, but in each and every instance she must communicate as soon as possible with the health officer by a detailed account of exactly what she has done and her reasons for so doing.

This gives an idea of the duties and responsibilities laid down by law for the regulation of the midwife. Added to all these requirements she must also return at stated intervals, in Bavaria every two years, for re-examination, after a few days' residence in the *klinik*, thus obliging her to keep constantly up to date.

But let us see how, in spite of all this, the midwife actually appears in practice in Germany. In the first place, one observing the work of the midwife in the confinement wards is struck by her lack of what is known as the aseptic conscience; that is, the knowledge that she is or is not surgically clean. After faithfully scrubbing her hands for the allotted fifteen minutes, she will unconsciously touch something outside of the sterile field and continue as if surgically clean. This, the writers have often observed. Of course there are exceptional pupil midwives who do not fall into this error, and they are usually ones who have previously received a nurse's training. But if the midwife makes these breaks in the hospital under the eyes of her instructor, and in ideal surroundings for surgical cleanliness, how much more likely will she be to fall into careless ways when out alone in a peasant's house? This is very marked in those midwives who return for their required period of training and re-examination. As one German house officer in the Frauenklinik in Munich remarked, "It is utterly impossible to teach these older midwives the first principles of asepsis."

At the time of the examination of the midwives in Professor Stökel's *klinik* in Marburg, one of the writers was present at dinner with the board of examiners, and after the dinner joined in the perfectly free discussion of the midwife problem, for these gentlemen openly admitted that it was a distinct problem to-day in Germany. When informed in answer to a question that it was against the law to practice as a midwife in Massachusetts, two members of the board instantly agreed that we were to be congratulated on our position, and that it was as it should be.

Others felt that while it might be true in America that the midwife could be dispensed with, that it was a mistake to hope for such a thing in Germany. Professor Stökel held this view and felt that the solution of this problem was in raising the standard of the German midwife by requiring a previous training, such as that of a nurse, before undertaking the midwife course. But he admitted that the community as a whole would have to be educated and said that it was a curious fact that even among people of refinement, the older and dirtier the midwife, the greater seemed the confidence placed in her ability and judgment.

Obstetricians as a whole lament the condition in Germany; many admitted frankly that of course the midwife was not qualified to attend cases in labor, but that the system was so firmly established in the community at large that it was doubtful if there ever could be a complete change made. Professor Bumm, in his recent book on obstetrics,[8] admits that the number of deaths from puerperal fever in Germany is far too high, — out of 2,000,000 births, 5,000 deaths from puerperal fever were reported in one year, — and he states that of course many cases were unreported.

A Berlin physician prominent in gynecology has recently written [9] to a committee of the

American Medical Association asking for information in regard to the number of deaths from puerperal fever throughout America, as he understood that we had no midwives in this country. The answer was made that, not only were we without vital statistics of any value, but that we were in many states overrun by midwives. The Department of Medical Economies of the *Journal of the American Medical Association*, referring to this correspondence, adds, "Midwifery is not so well regulated in this country as in Europe, and yet the harm done is probably less, since midwives are not so numerous."

The midwife is responsible for the extreme conservatism in the German point of view in regard to labor. Cases are allowed by the midwife to go along in labor practically indefinitely unless fever or other reportable complication arises. These cases regularly come late to operation, and the trend of obstetrical research has been distinctly how to care for these late emergencies. As a matter of fact, fever is the commonest cause for which the German midwife sends for help. In not a few of these cases, through inability to recognize a contracted pelvis, the only operation to be widely recommended in general practice is craniotomy on the living child, while in the *kliniks* this condition is met by hebeostomy and extraperitoneal Cæsarean section.[10]

Thus we have in Germany a system of training and regulation of the midwife so complete as to be almost ideal — a system of perfect harmony between the midwife and the physician. And yet the system is not a success in so far as it fails to meet with the approval of those medical scientists most deeply interested in the progress of German obstetrics.

ENGLAND.

To us in New England the situation in Great Britain is of special interest because we are largely of English stock and are influenced by English tradition. In England from earliest times midwives have flourished and have been an integral factor in the social fabric. The legal correspondent of the *Lancet* gives the following historical sketch:[11]

"Four centuries ago bishops in England licensed the physicians, surgeons and midwives. They continued this practice down to the middle of the eighteenth century. About that time the College of Physicians of London took over the duties from the bishops of examining and admitting midwives to practice, a charge which they in turn renounced some ninety years ago. Since that time any person who chose might undertake the important duties of midwife. No test of competency was imposed by any responsible authority, and so the public was left to such protection as the common law afforded against the malpractice of uninstructed practitioners." For many years prior to the active agitation of the Midwife Law, which culminated in 1902, there were trained midwives acting in conjunction with some of the hospitals and institutions in London.

Since the passage of the Medical Acts, bills have been brought forward every few years in Parliament for licensing and regulating midwives. These bills were usually crushed by medical advice, but while the medical profession never took a definite and organized stand against the idea, the promoters of the bills were gaining in organization and influence with every defeat. In 1900 a measure brought forward by them was nearly made a law and in spite of defeat they continued these activities without pause with the opening of the succeeding session of Parliament.

Let us see who the contending parties were. Mr. Egerton, in a speech in the House of Commons, is our authority [12] for the following forces in favor of the bill for the licensing and regulation of midwives: the Obstetrical Medical Men, Women's National Liberal Association, Women's Industrial Council, Women's Liberal Federation, the Incorporated Midwives Institute and representatives of the Body of Coroners. Whether the reference to the Obstetrical Medical Men means a definite action on the part of the British Obstetrical Society or not, we have been unable to ascertain, but English obstetricians frankly admit that they as a whole were in favor of the act, as they were in constant touch with the evils of the then existing conditions and felt that any change would be welcome. It is interesting to note that many of the other organizations in favor of this measure, and most active in bringing it about, were societies interested in enlarging the sphere of the professional woman. This was an important factor — to give a new field of useful (?) activity to the women of England.

Against the bill we find the majority of the medical profession of England ununited and lacking definite policy. The General Council of Medical Education and Registration considered the bill thoroughly bad. The leading medical journals opposed it. In Parliament one of the opposition stated that 95% of the medical men of England were against the bill. In 1900 the *Lancet* made an extensive canvass [13] of English medical men and found that, out of 7,250, 5,000 opposed the bill, 640 were indifferent and 1,547 were in favor of the measure. Some physicians wrote against the bill in broad, sound terms; others attacked it bitterly on narrow and private grounds, and we actually find a body of medical men urging that all medical practitioners unite in a declination ever to respond to an obstetric case of difficulty or danger when it is known that a midwife has been in attendance.

Fenwick,[14] writing in 1902, emphasizes the fact that midwives are dying out naturally; therefore there is no need of legislation which would lead, he considers, to the following situation: A new order of independent practitioners; the midwife after some three months of work and the expenditure of some $75 would be created by Parliament the equal of the medical practitioner, who has spent five years or more in preparation and roughly, $5,000. He goes on to say: "It is, then, mere futile foolishness to pretend that a thing will not enter at once into competition with a candidate

general practitioner, or to imagine that she will carefully confine her attention to the poorer classes, or to expect that she will refrain from practicing medicine as well as midwifery. It is submitted that the first and greatest effect of this legislation will be to flood the country with more or less well-educated women only too eager to avail themselves of the opportunity of becoming licensed quacks." Let us note later how nearly his prophecy has come true.

Another objection was made to the Midwife Law.[15] As drafted, it applied only to England and Wales. One member of Parliament proposed that the new law should conform with the provision in Ireland, where an almost perfect midwife system was in force. In 1902, that country was divided into well-arranged dispensary districts, and in each district a medical man with a midwife under him. The midwife cannot act herself, but was sent by the physician and kept him informed of the progress of the case, and of any complications. This proposal, however, met with no response.

This futile and diversified opposition by the ununited medical profession of England met with the expected defeat, and the bill was made a law July 30, 1902. Briefly condensed,[16] it prohibited any woman after a lapse of a few years from using the name of midwife or its equivalent, or to habitually and for gain attend women in childbirth unless certified to do so by the Central Midwives' Board, violation of this to be punished by fine. It placed all authority in the hands of a Central Midwives' Board composed of seven persons, four to be medical practitioners appointed by medical bodies of recognized standing. Of the other three, one at least must be a woman. This board was to act under the approval of the Privy Council and after consultation with the General Medical Council. It defines[17] the most essential requirements for the midwife as: The obstetrical examination, external and vaginal; the delivery of 20 lying-in women under competent supervision, and the following of an equal number of women during the ten days after labor; the candidate must have attended a sufficient course of instruction of not less than three months' duration, and passed a satisfactory examination.

We now see the legal status of the midwife in England to-day. She has a short course of training in any one of the leading lying-in hospitals in England instructed by members of the staff, who are also the professors in the medical schools. This is more or less at the expense of the medical students, who formerly enjoyed more of the professors' time than now.

Let us see how the law has worked out. There are at the present time[18] 29,000 midwives on the roll of the Central Midwives' Board, nearly as many as there are physicians in Great Britain. Thus we find that practically all of the prophetic statements of our authority Fenwick have been fulfilled. We have the statements of two prominent obstetricians in London to the effect that the midwives to-day are doing the bulk of the middle-class obstetrics in England, and not only that, but they are taking care of the children during the first year as practicing physicians. There is also a general complaint among the practitioners that humanity compels them to respond to the summons of the midwife when in trouble, but there is no provision for any compensation for the physician.[19]

So we have in England two standards of obstetrics side by side, but not in harmony. We have a midwife scantily trained assuming the rôle of physician not only within but outside her legal province. That such a profession is remunerative must be admitted when we see the tremendous size to which it has grown, and when we realize that it is increasing much faster than is the medical profession. With such inadequate training and such meager provision made for supervision, working utterly out of harmony with a growing proportion of the medical profession, we can feel certain that the results must be inferior to what we have seen in Italy and Germany.

UNITED STATES.

In the United States we have at the start one distinct advantage over the older European countries. Although the midwife custom or tradition came over with the early settlers, it was soon shaken off. Let us quote one physician in this Commonwealth, who writes anonymously in 1820,[20] presupposing evidently an agitation of the midwife situation: "The attention of the public having been lately turned to the subject of the employment of female accoucheurs, has led to some discussion among the faculty and others with regard to the safety and expediency of introducing them into the practice of midwifery instead of physicians. There is, perhaps, no place of equal size in which this branch of medical practice has been so entirely confined to male practitioners as in this town [Boston]. In no place perhaps in the world is this standard higher, in no place is the female character more pure and elevated than in this; yet in no place probably is the practice of midwifery more safe."

"No one can thoroughly understand the nature and treatment of labor who does not understand thoroughly the profession of medicine as a whole. He must look upon it with the eye of a physiologist and a physician before he can comprehend its nature, its relations, or its objects."

Again I quote our physician of 1820, long before the days of asepsis and modern surgical obstetrics. He continues: "As medical science has improved, it seems at last to have been settled that physicians regularly educated could alone be adequate to the exigences of obstetric practice. This is the opinion held, taught and defended by the most eminent lecturers on midwifery in Europe.

"The opinion in Great Britain of the profession at large has been expressed in the most unqualified manner. Among ourselves, it is scarcely more than half a century since females were almost the only accoucheurs. It was one of the first and happiest fruits of improved medical

education in America that they were excluded from the practice; and it was only by the united and persevering exertions of some of the most distinguished individuals of which our profession has been able to boast, that this was effected."

After enumerating various emergencies which might arise with or without the midwife's knowledge, and for which the physician is hastily summoned, for the physician in all countries is the last resort, our writer of nearly a century ago says: "No man called in on an emergency like those I have mentioned can be made sufficiently master of the circumstances to be able at once to do justice to himself or to the patient. Much depends always upon the previous history of the case, the course which the labor has taken, the symptoms which have occurred in the course of it. A moment of hurry and of danger like this, when the fear of a fatal issue is the only object before the eyes of the patient, her friends or her attendant, is no time for the communication of a long series of facts, no time to enter into the whole details of the labor. And besides this, none but the accoucheur herself is a competent judge when the assistance of a consultation is required, and she will very naturally be desirous to put off as long as possible the moment when she is to acknowledge herself incompetent to the further management of the case."

In conclusion, our far-seeing friend of 1820 writes: "It is now to be determined whether, when the most rapid advances are making in learning and knowledge, when new opportunities are opening for the improvement and cultivation of medical science, when the members of the profession are becoming better educated and better fitted for its duties, society will choose to go back for half a century and adopt a practice which experience has shown to be unsafe and pernicious."

After ninety years we of the medical profession whose especial duty it is to protect the welfare of the hopeful mother and her unborn child are brought to face the same problem. Shall we who enjoy the many improvements in medical science, who are "better educated and fitted for its duties," who enjoy "the advances in learning and knowledge," and who realize much more fully than our wise and loyal medical predecessor of nearly a century ago possibly could realize the responsibilities of the more intricate, the more complex and the more difficult methods required by modern obstetrics, and who look forward to far greater advances in preventive obstetrics, whereby the skill and judgment of the obstetrician shall be trained to foresee and forestall the many dangers to the coming mother; shall we, I say, let down the bars, shall we take the weaker course and compromise the birthright bequeathed to us by such worthies?

But to return to our history. What influences in society have again raised this question, and what new arguments do they bring?

With the stream, or, better, the mighty river of emigration which has swept into this country within the last half century, has come very naturally the midwife-habit and the midwife. In all the large cities or centers of foreign population these midwives have quietly plied their trade, commonly unrestricted, unsupervised and unmolested.

Not till the present wave of prophylactic medicine with its searchings for the causes of disease, be they pathological, social or criminal, did the midwife come strongly into official light. The investigation of infant mortality, ophthalmia neonatorum, of puerperal fever and finally of abortion, have pointed a finger at the midwife as a large factor in the etiology of all these misfortunes. I hasten to add that the midwife is not the only offender. A certain percentage of registered, though ill-equipped, physicians undoubtedly plays a large part in these generally preventable misfortunes, and we feel that any measures undertaken for the improvement of obstetrics in this state should take into consideration both classes of offenders.

The forces now at work uprooting this ancient question are those of the modern efficient charity organization demanding the uplift of the poor, demanding the care for the mother and child; they are the irresistable forces of humanity and right, and we welcome them as friends. We believe it is through such forces, in co-operation with the medical profession, that our best hopes for improved obstetrics lie. But we feel sure that when the situation is clear, intelligent treatment will be sought by other means than the midwife. We agree with the committees of these organizations, who are wisely allied with experienced men of our profession, that the first step, as in any sociological problem, is to obtain full information as to the present abuses and dangers to which the poor lying-in patient may be subjected. Investigation and discussion must precede intelligent action.

Let us first see what our sister states have done in this regard, and with what results. It seems worth while to go into considerable detail in one state so that we may have a standard to which we may compare other states.

Illinois.

We have selected Illinois as a favorable example of the attempts in America to license, control and regulate the midwife.

Before 1899 there was no official recognition of the midwife, a situation by no means uncommon in the United States to-day.

The Act of 1899 licensed midwives in Illinois, and required registration, but made no provisions for supervision, education or control. After a few years under this law a Committee on Criminal Abortion was appointed by the Council of the Chicago Medical Society. This worked with partial success, aiding the police in prosecutions, procuring the removal of advertisements from the press by moral suasion and with the co-operation of the postal authorities.

They soon found that abortion by midwives was very common and that the midwives as a class were deficient in knowledge and ability.

Inquests showed that they practiced medicine and that they cared for abortions and miscarriages, while the law limited their powers to the care of full-term normal labor. As a result of the information obtained by this abortion committee, a joint committee on midwives was formed of members from the Chicago Medical Society and the Hull House, and an investigation instituted, with the result that in 1908 the careful report of a paid investigator was published.[21]

This report states "that the laws governing the practice of midwifery are utterly absurd and inadequate, as is evident when compared with the requirements for obstetric practice by doctors of medicine." A striking contrast is drawn between the training of the medical student with the requirements of a midwife. The report shows careful, thorough and accurate work as far as such an investigation could well go. A trained nurse interviewed 223 midwives, and a woman detective saw as many of these as possible. Card blanks were filled out for each midwife. It was estimated that between 500 and 600 midwives were practicing in Chicago. Of the 223 midwives visited, only 9% were properly registered; 47% of all births in Chicago were reported by midwives.

Only 81 of the midwives were able to read and write English, while 103 could read and write their native language only. One could not read or write her own language; 168 could speak English, while 29 could not; 74 were dependent upon their practice for a livelihood, while 107 were not; 138 lived in good homes and were neatly dressed; 36 were only fair in this regard and 19 were distinctly bad. Of these 223 midwives, 10% were willing to conduct abnormal cases, dilating on their ability to perform version, to deliver a breech or transverse presentation, to remove an adherent placenta or stop a postpartum hemorrhage. The detectives found that 49 agreed to do abortions; 19 received patients into their homes contrary to law, and these homes were practically abortion shops. One, with a policeman husband, leading a dissolute life, showed proudly her license to practice from the State Board; another midwife, while she refused to do an abortion herself, introduced the detective to her physician husband, who agreed to sell her a drug for $3.00 which was guaranteed to bring on an abortion.

Sixty-seven of these midwives held diplomas from foreign schools for midwifery; 111 from schools in America, while 6 held no diplomas. Seven of these American schools in Chicago were investigated. They were veritable diploma mills. The time required for the course was six months, and the fee from $100 to $175. There were three or four hours of instruction weekly. In two of the schools no textbook was used. Thus without being able to read or write, a diploma could be obtained. No practical experience was required by the law in Illinois, although some of these schools furnished it when possible. These 111 American diplomas merely show, then, that these midwives had the money to pay.

One physician in charge of a popular school in Chicago from which many diplomas were seen, offered for an additional fee to instruct the supposed candidate privately in the *modus operandi* of successful abortion work, telling her that it would bring her in large returns, that it was a perfectly safe venture and that the midwives who were caught were fools. Collusion between midwives and physicians for abortions were found, the responsibility and the spoils being divided. An Italian midwife on a labor case informed the ignorant, unsuspecting patient that complications had arisen and called a certain physician who was her accomplice. He operated on a normal case, charged the maximum fee and divided with the midwife.

The investigator closed her report by saying that the most important duty of the state, after examining and licensing the midwife, was to regulate and uplift her, and thus protect the ignorant, credulous community.

The conclusions of the committee of the Chicago Medical Society were that the Illinois law gives no power to inspect and control midwives. They suggest as remediable measures:

1. A short-term license to be issued, thus requiring relicensing at frequent intervals.
2. That a representative of the State Board of Health with the necessary assistants and inspectors be charged with the condition of the midwife practice.
3. That the State Board of Health should make the necessary rules to govern the practice.
4. That the State Board of Health must have control of the education of the midwife, recognizing only the midwife schools of proper standing. Repetition courses every two to four years, with sessions of two to four weeks, should be required.

Thus we have in Illinois a condition of affairs perhaps worse, save only in numbers, than England before the Law of 1902. Can Illinois by these proposed laws hope to approach the situation in Germany?

Michigan.[22]

In Michigan, over 12% of all births for the first three months in 1908 were conducted by midwives. In Detroit many had signs in front of their houses, and all claimed without exception to take complete charge of normal obstetrical cases without a physician. All were foreigners in Detroit: Bohemians, Poles, Germans and Russians, some unable to speak English. Thus we see a condition, without going into further details, closely resembling the situation in Chicago. However, the law in Michigan does not recognize the midwives, and there is no system for their licensing and regulation.

Ohio, Indiana and Wisconsin all have laws for examination and licensing the midwives.

New York.

Coming nearer home, let us glance briefly at the situation in New York state. For many years there has been special legislation regulating the practice of midwives in five of the western

counties. These laws, however, have not been enforced and the situation there has been quite as bad as what we have found in the states of the Middle West.

In 1907 the New York branch of the Health Defense League made an extensive investigation of the situation of the midwife in New York.[23] This investigation revealed the fact that in New York City there were over five hundred midwives practicing in a way similar to what we have reported in Chicago. There were also four midwife schools in New York City. These schools were as thoroughly bad as the ones we have already described.

As a result of this investigation, a midwife law was passed in June, 1907, investing the Department of Health of the City of New York with power and authority to adopt rules and regulations governing the practice of midwifery in New York City. As a result of this law the Department of Health has adopted and published a book of rules governing the practice of the midwife.[24]

Under these rules no person other than a duly authorized physician shall engage in the practice of midwifery without a permit from the Board of Health. To obtain such a permit, an application must be made, certified to by two regularly licensed and registered physicians, and by one reputable and responsible layman. The applicant must be twenty-one years of age, or over, and of moral character; she must be able to read and write; she must have attended, under the instruction of a physician, at least twenty cases of labor, and have had the care of at least twenty mothers and newborn infants during the lying-in period (ten days). This permit to practice is good for one year only, and must be renewed at the end of that time. The Board of Health has the power at any time to revoke this permit. Before a permit is given, the applicant must appear in person at the Department of Health and register her name and address.

In the regulations which she must follow, it is distinctly stated that she is allowed only to attend normal, uncomplicated cases; in all others she must call a physician.

The home of the midwife, her equipment, record of cases and registry of births shall be at all times open to inspection by the authorized officers and agents of the Department of Health. Explicit directions are given for the conduct of normal cases during pregnancy, labor and the puerperium. She is also required to take the temperature morning and night for five days following labor. During this time, or at any later period, should the temperature reach or exceed 101° and continue at this for twenty-four hours, the case must be reported to the Department of Health.

Thus we see some slight provision made for the training of the midwife, no provision made for examination, but excellent rules for her regulation. Exactly how well these laws have been carried out, and with what results, we have been unable to ascertain.

Maryland.

Let us briefly trace her history. Before 1894 no restriction or legalization of the midwife is found. Since 1894 there has been a law in Maryland requiring midwives and nurses to report at once to the health officer, or a legally qualified physician, any "mattering or inflammation" about an infant's eyes occurring within two weeks after birth. The midwife was forbidden to use any treatment on her own initiative. From this law five or six convictions have resulted in Baltimore in fourteen years. However, ophthalmia neonatorum was found to be the chief cause of blindness, and 77% of these blind children were born under midwife care and 23% under physicians. With the exception of this law for the control of blindness, the midwife was in no way restricted in Maryland before the present year, 1910.

In 1906 the committee of the Evening Dispensary for working women and girls, in cooperation with the Mothers' Relief Society,[25] found, early in their service, that the conditions of the practice of the midwives in Baltimore city were, in the light of twentieth century medicine, well nigh intolerable. They, therefore, in 1908 employed a trained social worker, who interviewed 150 midwives, with the following resulting report:

First, 40.7% of the births reported at the Board of Health in Baltimore were by midwives.

Second, registration was inadequate.

Third, no qualifications were required for registration of the midwife; 42 had foreign diplomas; 9, American diplomas; 66% gave no evidence of training of any kind; 24.7% could neither read nor write; 16.7% could not speak English.

Fourth, no supervision was provided. There was only the 1894 law providing a penalty for neglect of the infant's eyes. But only 3% of the 150 midwives used a weak solution of nitrate of silver. The remainder used anything from breast milk to bichloride of mercury of unknown strength. Sixty per cent cared for abnormal cases, did versions, removed, manually, delayed placentas. Inspection of their bags showed 41 clean, 51 dirty, 44 had none, a few used antiseptics for the hands and sterilized the tie. The report adds that "on account of lack of supervision, even well-trained midwives take no precautions to insure asepsis." One foreign midwife showed a sterilizing apparatus, required in her native country, the use of which in her adopted country, she said, would expose her to ridicule.

The Medical and Chirurgical Faculty of Maryland,[26] stirred by this report, proposed and backed a bill which was passed by the General Assembly and went into effect July 1, 1910. The Faculty recommended the passage in the following dubious terms, in part: "Midwifery is in many respects the most important branch of the practice of medicine, and hence it seems strangely inconsistent that its legal regulation is far less stringent than that of medical practice in general."

Let us pause a moment to say that it seems to us "strangely inconsistent" that the Medical Faculty of Maryland should make such a statement in furthering a bill to provide legal recognition for a class of practitioners, proved by the report, on which the plea is based, to be far from satisfactory, and often untrustworthy and even criminal. These practitioners are to be allowed to practice midwifery, which the Faculty themselves say "in many respects is the most important branch of the practice of medicine."

The Faculty continue, "There is scarcely a physician in active practice who has not been impressed with the penalties which the women of the state pay for the negligence of the state in throwing proper restrictions about the practice of midwifery; the deaths, the unnecessary invalidism, the preventable blindness." They give the following example: "Some years ago Dr. C. Hampton Jones, Assistant Commissioner of Health in Baltimore city, reported a series of 32 cases of tetanus neonatorum which occurred in Baltimore during one year. Of these, 28 occurred in children less than twenty-one days old, and 12 occurred in the practice of one midwife alone."

Apparently the dread of injuring the few midwives and the fear of failure to secure any legislation outweighed in the minds of the Faculty the dangers of the "penalties which the women and children of the state pay — in deaths, unnecessary invalidism and preventable blindness." They state their attitude thus:

"It must not be assumed that the *medical profession* is bent upon the complete extermination of the race of midwives. Such an assumption would be both unfair and untrue. The profession is convinced that for the present the midwife is to be regarded as *more or less inevitable*, and it also realizes that not all midwives are equally culpable. But, like all other laws, the midwifery act is intended to regulate the midwives who need regulation, rather than those who, in their own limited sphere, may be efficient and conscientious. Of the latter class, it is safe to say that none will have any difficulty in fulfilling the requirements outlined in the bill. Furthermore, it is to be remembered that the law, if enacted, will not affect those midwives now in practice, except to necessitate their re-registration."

Turning now to the law itself, we find provision for the licensing without examination all midwives practicing at the time the law goes into effect. Others registering after that date must undergo an examination by the State Board of Health, requiring at least the ability to read, write and make out correctly a birth certificate. Further, the applicant must present a certificate from a legal practitioner or a maternity hospital that five cases of childbirth have been attended, and that he or she is competent to attend ordinary cases of labor. Such applicant shall also be required to present certificates from three reputable citizens, stating that the applicant is of good moral character.

Perhaps the most interesting clause in this act follows: "It shall be unlawful for any midwife to make a vaginal examination, to attempt to deliver a retained placenta, to attempt to use forceps, to attempt version or any forcible delivery, but such midwife shall, in all cases of labor that are not normal, notify a licensed practitioner of medicine."

No provision is made for the training of the midwife, yet she is required to diagnose the abnormalities of obstetrics, and that without a vaginal examination.

The only redeeming feature which we can find in the law is that the Board of Health can make the examinations of whatever standard they think desirable, and thus can require the same training and knowledge as is required of medical practitioners for similar work. Let us see how the Board of Health uses this power of examination: In November just past, the first test was held. This examination was, however, a test of whether she could read and write English, and little else.

We believe that the Faculty of Medicine of Maryland intended to protect "the women and children of the state from paying" for neglect by deaths, unnecessary invalidism and preventable blindness. How have they succeeded? They have sanctioned and legalized without any test of fitness, or any requirement or means for their education or improvement, all those very women under whom the "well-nigh intolerable" conditions existed, and in our opinion they have provided for and encouraged many more such women for the future, who should make these conditions completely "intolerable." They have perpetuated a system well calculated to *protect the midwife*, who extorts from the women and children of the state the deaths, invalidism and preventable blindness.

Massachusetts.

Let us now turn lastly to the situation, past and present, in Massachusetts. From our cited authority of 1820,[20] as well as from colonial documents, we know that the midwife flourished in the early history of the colonies. Special provisions were made at toll bridges and ferries for the midwife, as well as for the physician, but evidently about 1770 she ceased to play such an important part, at least in the region about Boston. Thus in contra-distinction to the popular supposition, we are here, as in many of the states in the Middle West, dealing, not with a survival, but with an importation, which is the direct result of immigration.

In 1894, in the laws passed for the registration of physicians, there is no mention made of the midwife. Whether intentionally or not, she was thus excluded from the legal practice of her profession. That this law is valid we have ample proof, for she has been prosecuted and convicted of practicing medicine without a license. But, with curious inconsistency, in the law for registration of births, her existence is admitted, and she is allowed to sign these blanks.

The midwife not only exists, but flourishes in

Massachusetts at the present time, in opposition to the law, which we find has been rarely enforced. The Commission for the Blind in a recent investigation has found this to be true. They consider that at the present time about 150 women are practicing midwifery in the state of Massachusetts. They are scattered widely throughout the state, probably some 25 are practicing right here in Boston, although we find that in the past year only 9 have signed birth certificates. They exist also in Lawrence, Lowell, Fall River, Gardner, Ware and New Bedford. Some of these women are apparently doing good obstetrical work; on the other hand, many are quite similar to those we have described in New York and Chicago.

The results of this investigation have led the Commission for the Blind to feel that the situation in Massachusetts is a serious one, and demands alteration. The Women's Municipal League also has encountered the midwife problem in the pioneer work it has been carrying on of caring for its pregnancy clinic. It was through the activities of these two organizations that we became interested in methods for the solution of the existing evil, and through the co-operation of a member of the Commission for the Blind that we were invited to read this paper to-night.

LEGAL SITUATION.

Before taking up possible means of improving the situation in Massachusetts in solving our present difficulty, let us take a look at the more strictly legal aspect of the situation. Of the other states in the Union, fourteen recognize the midwife by expressly exempting her from the provision of the medical act. Most of the states ignore the situation entirely; probably in many of these the midwife plays a very unimportant rôle, if any at all.

In the few states that have attempted to license and regulate this class of practitioners, their attempts in the light of what we have seen in other parts of the world are pitifully futile. No state has successfully solved the problem. Those that have passed laws for their regulation throughout the state have, in our opinion, made the solution of the problem more difficult.

We in Massachusetts are in a most fortunate and enviable position. In the first place, the number of midwives existing is small and without influence. They are practicing in open defiance of the law. In excluding these women from practice by enforcing the law, we would not be depriving a large class from earning their livelihood. Neither would we be depriving any considerable portion of society of proper care. We are particularly fortunate in having a definition of the practice of medicine handed down by the Supreme Court of our Commonwealth, directly applying to the practice of the midwife. The following is a quotation from the opinion handed down by Mr. Justice Rugg. He writes:[27]

"Revised Laws, Chapter 76, Section 7, mentions obstetrics as one of the subjects of examination for the purpose of testing an applicant's fitness to practice medicine. This goes far towards showing that obstetrics is a branch of the practice of medicine. It requires no discussion to demonstrate that when, in addition to ordinary assistance in the normal cases of childbirth, there is the occasional use of obstetrical instruments, and a habit of prescribing for the conditions described in the printed formulas which the defendant carried, such a course of conduct constitutes the practice of medicine in one of its branches.

"Although childbirth is not a disease, but a normal function of women, yet the practice of medicine does not appertain exclusively to disease, and obstetrics, as a matter of common knowledge, has long been treated as a highly important branch of the science of medicine."

There have been at least two convictions in the state under the present law.[28] But while this shows that prosecutions are possible, it is admittedly a fact that such a process is by no means easy.

Complications in the legal machinery, not to say defects, make it difficult to bring the midwife before the bar of justice. In the first place, there is no easy method of lodging a complaint. The Board of Registration of Physicians is not empowered to discover violations of the law relating to the registration of physicians. That law distinctly states[29] that the board shall investigate all complaints of the violation of the law and report the same to the proper prosecuting officers. Thus the board does not act until a complaint is brought to them that an individual is practicing medicine without being properly licensed. Then, and not till then, it has the power to act, but persons are not anxious to go out of their way to stir up trouble unless some flagrant case arises. Should the physicians at large know that they can bring in a complaint to the Board of Registration, and yet conceal their identity, possibly more complaints would be made and more cases prosecuted.

But it is also difficult to secure sufficient data to bring about a successful prosecution. The present law for the registration of births allows so much time to elapse before the certificate must be handed in that it is often difficult to trace the case.

But more important than all is the fact that public sentiment is not sufficiently aroused to make convictions popular. In many localities officers of the law are unwilling to prosecute cases even when the law and its violations are directly brought to their attention. In one city in Massachusetts when the city marshal was informed of the law and the fact that a midwife was openly violating it, and that by a decision of the Supreme Court the midwife was liable, he replied that in his opinion the judge who would make such a decision merely gave evidence of intoxication. When such is the popular feeling, we cannot expect much result from the laws as they now exist, or in mere modification of the law. What we must first do is to arouse public sentiment, and first of all we must have the

enthusiastic support and united action of the medical fraternity.

That the situation in Massachusetts is in need of improvement, we admit most frankly. We also feel that minor changes in the present laws cannot be made too quickly, and we urge strongly that side by side with the education of the community to combat this evil should go changes in legislation which will make the laws consistent and easier of enforcement.

We feel that the most important change should be in the laws governing the registration of births. The word "midwife" as it occurs, should be at once erased from the statute books. The certificates of birth should be returned by the physician promptly; the form of the certificate could also be improved by providing a means of identification of the person actually responsible for the delivery of the patient. We also feel that theoretically better results would be obtained should the birth certificate be inspected by the board of health within three days of the birth of the child. Under the present law death certificates have to pass through this channel, and suspicious cases are referred by this board to the medical examiner. Would not inspection of birth returns by the board of health assist in furnishing evidence useful in the prosecution of questionable practitioners?

Another law which we feel could easily be amended and which would give better results is one to strengthen the Board of Registration in Medicine. This might read something as follows:

"An Amendment to the Revised Laws, Chapter 76, Section 6.

"It shall be the duty of the board furthermore to keep itself informed of the condition of the practice of medicine throughout the Commonwealth, to the end that illegal practice of medicine, as defined in this law, may be prevented. In order to secure the information required by this act there may be expended a sum not exceeding $2,000 annually."

Above all, we must make the physicians of Massachusetts thoroughly aware not only of the existing conditions of midwifery in Massachusetts, but of how they can aid by doing their duty in the enforcement of the law to the benefit of the community. In those cities and towns where the problem is greatest, the physicians should see to it that provisions are made for an out-patient, lying-in department as an accessory to the local hospital.

A brief study of such institutions in Boston would show how easily such a department can be carried out, and how easy it would be to make it practically self-supporting, and what a benefit such an institution would be to their community. The professors of obstetrics in the medical schools of Massachusetts should impress upon their students not only the importance of post-graduate work in a lying-in hospital, but also where in the state such appointments can be had. Thus by co-operation between the local practitioners in the communities where the midwife now flourishes, and the professors and students of our medical schools, not only could the present midwife situation be greatly improved, but also the medical student would have a better opportunity to obtain training in this important branch of medicine.

CONCLUSION.

In reviewing the midwife situation abroad and in our own country, much has been said, but far more might be said of the unsatisfactory condition of obstetric practice wherever the midwife exists. Two standards of skill and a divided responsibility inevitably are found. The midwife must either be a competent, trained obstetrician, or she must become a subordinate, co-operating with the obstetrician, as does our excellent trained obstetrical nurse, relying on his judgment and resting with him the responsibility of the two lives, before a system harmonious and satisfactory can result.

The history of temporizing with the ignorant, half-trained, often malicious midwife in our sister states to-day reads like many another misguided "freedom" which is virtually a license by the state to practice quackery on an ignorant, unspecting public. The women and infants pay for this "freedom" in deaths, unnecessary invalidism and blindness.

Who are to blame? Is it the ignorant public? Shall we blame the legislators? We believe it to be the duty and privilege of the medical profession of America to safeguard the health of the people; we believe it to be the duty and privilege of the obstetricians of our country to safeguard the mother and child in the dangers of childbirth. The obstetricians are the final authority to set the standard and lead the way to safety. They alone can properly educate the medical profession, the legislators and the public.

A resolution of the Women's Municipal League awaits only a formal endorsement to urge the importance of legislation, not for the licensing and regulating of the midwife, but for such minor changes in the laws as will make the present statutes effective in dealing with the midwife in Massachusetts.

It has remained for this and other active charitable organizations to point out the necessity for bettering obstetric conditions in the state. Let the medical profession, we urge, not only co-operate with these forces for good, but let us obstetricians consider well the situation in obstetrics throughout the state to-day; let us look into the future and consider means for furnishing efficient trained service to rich and poor alike.

Our worthy predecessors of this town,[20] a century and a half ago, retired the midwife to oblivion as having passed her age of usefulness. Oliver Wendell Holmes [30] over seventy years ago, by his monograph on the "Contagiousness of Puerperal Fever," led the world to the safeguarding of the mother during childbirth.

Two recent papers, "When to Interfere in Pregnancy and Labor," [31] and "The Fundamental Conceptions which should Govern Modern Obstetric Practice," [32] read by two members of this society, are convincing proof that the best knowl-

edge of practical obstetrics to-day is here available, and, moreover, the lines for advance are being laid out for the future.

A golden opportunity awaits the obstetricians of Massachusetts to-day to carry on this high standard. Our already fairly satisfactory system should be maintained and advanced along the lines of the most progressive sociologic, economic and obstetric knowledge of the day.

Thus Massachusetts may be kept in her position of leader, guide and example of the best, safest and most efficient system of obstetric practice in this country and throughout the world.

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