THE REGISTERED MIDWIFE: A NECESSITY.*

BY EDMOND P. CODY, NEW BEDFORD, MASS.

WE are agreed that the expectant mother should be safeguarded through her pregnancy by all that scientific medicine can guarantee; that her delivery and convalescence should be under the strictest surgical aseptic precautions, aided by skilled nursing; and at all times she should receive the fullest measure of sympathy. We further wish that this could be the lot of every parturient woman. This is the obstetric ideal. But we are to consider a condition, not a theory.

The women at the opposite social extremes receive these; those with the money to purchase can have all the necessities and refinements of obstetric science and the very poor, through the increase of charitable and philanthropic societies, co-operating with visiting nursing associations and other agencies of relief, including in Boston the work of advanced medical students, can receive equally efficient service.

So it is the middle group or stratum of our people we are to study in approaching the midwife problem, the foreign born who can pay a small fee for the service. For the midwife is not the accoucher of the pauper. She is not a philanthropist, but a wage earner.

Until the end of the 16th century, the midwife was almost absolute in the field of obstetrics and conditions akin to it. In 1588 Louise Bourgeois, midwife at the court of Henry XIV, published a collection of observations on sterility, fecundity, abortion, accouchement, and diseases of women and children generally. The Chamberlaines, midwives also, furnished the first rude instrument, which later modified by Palfyn of Ghent and re-modified by almost every professor of obstetrics since, has developed into our forceps of the present day.

It was Paul Portal of France who first proposed version by the foot, and to Justine Siegemund, daughter of a minister and Court midwife of Germany, belongs the distinction for the first published suggestion of bimanual version and for puncture of the membranes for induction of artificial labor.

With the extension of medical education and medical literature at the beginning of the 17th century, obstetrics began to occupy the attention of physicians and students, the midwife began to lose her place in the higher ranks of life and man midwives being fashionable in France, the influence extending gradually, forced her lower to the level of her services today. Her past had been honorable, and as shown by these examples, often of distinct contributive value.

Dr. S. Josephine Baker publishes a table from Prinzing and other sources which gives the number of midwives and their incomes in 9 of the principal European countries.

In England, registered in 1909, there were 27,238 midwives, or 7.3 to every 10,000 inhabitants, these averaging 38 births per year. Switzerland in 1903 had the largest proportion of midwives, 10.1. Average births, 29. Russia, with 14,000 midwives, or 9 to every 10,000, averaged 550 births each. Their incomes also vary considerably. The English midwife averages $1 to $4 per case; the Austrian, $2; annual income, $60 to $75; and the German $.50 to $4; annual income, $75 to $100. Switzerland averages $6 per case, annual income of $80; while in Russia no average fee is given, but annual income is given as $80.

Training schools for midwives exist in most European countries. The length of training varies from six to nine months in England and Prussia, to one or two years in France, one in Switzerland; Italy, two or three; Netherlands, two; Russia, three; Belgium, two; Scandinavia and Japan, one year.

Germany has 43 institutions for training midwives, 27 in Prussia, four in Bavaria, three in Baden, two in Saxony, and one in each of the remaining provinces.

The requirements for admission differ in different countries, but the general requirements prevail, such as age limit, health, character and general education. The teaching is practical and didactic. In Prussia, all graduate midwives are expected to be examined once in three years. Inspectors are assigned to supervise midwives in Germany, Austria and England, a definite number to each.

So we find that the midwife has been an integral unit of European life for centuries, a functionary, trained, licensed and supervised by the governments. Her income shows that she is an important economic factor.

On accepting the invitation of the Society to read on the midwife, my first intention was to study the records of the city clerk's office and the hospital records of New Bedford for suitable material. Later, it seemed better to extend the inquiry to include the other large cotton cities of the state, Fall River, Lowell, and Lawrence. In these four cities we find by the last census, 408,433 people. Most of these people are foreign born and work in the mills.

Our foreign population may be grouped essentially as follows: Most numerous, the French Canadian, estimated about 100,000 in the four cities. They have been with us for at least forty years. They marry young, have large families, are distinctly racial in language, and customs; are thrifty and send much of their earnings to Canada.

The Lancashire English, next in number, the whole number difficult to determine; perhaps

* Read before The Obstetrical Society of Boston, Jan. 28, 1913.

50,000 or 75,000. Portuguese, more properly called Azoreans, have come in the past fifty years. Their largest colonies are in New Bedford, 18,000, and Fall River, while the later and lesser additions are the German, the Russian, the Greek, the Pole, the Italian, and of recent years and in smallest numbers, the Turk.

A list of nine questions was sent to each city clerk, and the questions with the answers follow:—

Question 1. Whole number of births reported in 1912? and,

Question 2. Number of births reported by midwives? Can be answered as follows:—

	Total Births.	Midwife Births.	Midwife Births.
Fall River	4900	1259	25
New Bedford ...	3736	819	25
Lawrence	3000	952	31
Lowell	2700	400	16
	14,336	3430	24¼%

One-quarter of the mothers delivered last year in these cities employed midwives. A difference of 15% between Lawrence, the highest, 31, and Lowell, the lowest, 16.

The high rate in Lawrence might be explained by the poverty consequent on the labor disturbances of last year.

Question 3. Still births reported by midwives?

But one city, Lawrence, had received such reports, 26. Many still births must have occurred in the practice of midwives in the other cities, but the reports did not get on the records.

Question 4. Number of cases of ophthalmia neonatorum reported by midwives?

Fall River ..... 3 cases

Question 5. Greatest number of births reported by one midwife?

Lawrence	259	
Lowell	175	A Polish Austrian.
New Bedford ...	154	Portugese.
Fall River	145	

Question 6. Whole number of midwives?

Fall River	50
New Bedford	34
Lawrence	15
Lowell	13

Question 7. Nationalities of midwives, judged by their names and the number of each?

The number was not given in one return, Fall River.

New Bedford, Eng., 10; Polish, 3; Port., 19; Jew, 1; Afr., 1.
Lawrence, Eng., 2; Polish, 2; Ital., 6; Ger., 2; Unknown, 3.
Lowell, Polish, 3; Jew, 1; Irish, 7; Greek, 2.
Fall River, Eng. Polish. Irish.

Poland is given as the nationality in all four cities, the most distinctly separate in customs and language; England in 3; Portugal, the Jew, and Ireland in 2. The absence of the French Canadian is significant. They alone are adequately served by a sufficient number of physicians of their own race. I understand that they do obstetric work for little remuneration.

Question 8. Number of deaths from puerperal septicemia?

Lawrence	19
Fall River	7
New Bedford	4
Lowell	3
	33

Question 9. Number of deaths from puerperal sepsis known to have been delivered by midwives.

Fall River .....1 case.

To summarize:

Thirty-four hundred and thirty, nearly one-quarter (24¼%) of all the babies born last year, were brought into the world by the services of 112 midwives, representing nine nationalities.

In one city, 26 still births were reported.

In another city, three cases of ophthalmia and one death from puerperal sepsis. The total reported deaths from sepsis being 33.

The second part of the inquiry was in regard to the hospital facilities for obstetrics and for data on complications developing after midwife attendance.

Six letters were sent and five replies received.

Question 1. Number of beds exclusively for lying-in?

New Bedford. St. Luke's	14
Fall River. City Hosp. 7; Union Hosp. 5	12
Lawrence. Gen'l	0
Lowell. Chelmsford St. 3	

A total of 29 lying-in beds for a population of 400,000.

Question 2. Number of free or endowed lying-in beds?

Fall River. City Hospital	7
Lowell. City Hospital	3
Lawrence. All ward beds are free.	

Question 3. Number admitted 1912 to free lying-in beds?

Fall River. City 52; Union 3	55
Lowell	12
Lawrence	22
New Bedford. St. Luke's	44
	133

Question 4. Number admitted attended early in labor by midwives?

Fall River. City Hospital 6

Question 5. Number admitted to hospital of puerperal sepsis who had been attended wholly or in part by midwives?

Fall River	10
City Hospital	8
Union Hospital	2

In a population of 400,000, we find 29 beds set apart for obstetrics. Of these, 10 are free.

One hundred and thirty-three women availed themselves of this privilege, less than 1% of last year's births.

Six women were admitted to a hospital beyond the skill of the midwife to deliver.

Ten women were admitted for treatment for puerperal sepsis, following attendance of midwives. It is of note that these occurred in one city, having the highest number of midwives and midwife births; and the one death from sepsis under attendance of a midwife.

These, then, are the figures of midwife activity in a considerable proportion of our population during last year. No one would claim that the figures are absolute; the number of births in three cities were estimated, and we know that deaths as registered may be misleading or worthless. I believe, however, that these figures of still births, ophthalmia and puerperal sepsis do represent the whole number of palpable cases of each class. Less apparent or clearly defined cases may have escaped observation and consequent recording, but in these we have the established minimum.

The study does show that the midwife is a fixed agent among our newly arrived peoples. She works for a small fee, usually, I am told, among the Portuguese for $5 for attendance on the mother and subsequent daily visits for one week. She is an economic necessity.

We agree that she is a nuisance, a relic of mediaevalism and an unnecessary evil and that she must go. But she does not go. We have ignored her and prosecuted two of her kind in this State, and last year she delivered three thousand women in our cotton mill cities.

Since we cannot abolish the midwife, we can at least teach her cleanliness, the conduct of normal labor, and to recognize the onset of complications. We can secure legislation enabling constituted authorities to adopt rules and regulations for such instruction and for her admission to practice and exclusion from practice and to regulate and supervise her work.

Such legislation exists today in 13 States. Four cities in New York State have special legislation.

Rochester has operated under a special statute since 1895.

Dr. Goler, Health Officer, writing on Jan. 8 of this year says, "In 1912 there were 5,527 births reported, of which approximately 20% were reported by midwives.

"There have been either two or three arrests of unregistered midwives, but no convictions. We have but 16 midwives in Rochester, whose nationality is mostly German, though there are two Italians.

"The Board of Midwifery Examiners have very carefully weeded out undesirable applicants. Of course we believe the midwife an unnecessary evil."

Buffalo has had a special statute for more than 30 years.

Dr. Franklin G. Cram, after outlining the manner of registration, says, "I am glad to state that this has proven entirely satisfactory. These midwives do their work in such a thorough manner and file their birth returns as required by law so that I cannot recollect that we have ever had to take one of them into court.

"As to those who practice midwifery illegally, we have no difficulty whatever. Usually in such a case there is some physician or midwife in the neighborhood who will immediately report the matter to the authorities.

"We have English, Polish and Italian midwives."

BIRTHS IN BUFFALO, 1912.

Total	11,591
Attended by physicians	6,688
Attended by midwives	4,903

THE MIDWIFE IN MASSACHUSETTS: HER ANOMALOUS POSITION.*

BY JAMES LINCOLN HUNTINGTON, M.D., BOSTON.

THE number of midwives existing in Massachusetts is about one hundred and fifty. Many of these women carry on a successful practice. In almost every section of the State there are manufacturing centres where midwives exist. And yet all this is contrary to the Medical Practice Act, for by a decision of the Supreme Court of Massachusetts this Act directly covers the case of the midwife receiving money for the attendance of women in childbirth. In spite of this law, however, the statute book today explicitly states that the fee of twenty-five cents shall be paid to every midwife reporting a birth to the city registrar or town clerk. This certainly is an anomaly! But because public sentiment is too ignorant and too feeble to enforce this law, are we to believe that the law is bad and needs modification? How can this law be modified so as to benefit the community? I maintain that no change in legislation in this regard can be of the slightest benefit to the Commonwealth of Massachusetts at the present time. The only change which must be made some time is to strike from the laws concerning the Reporting of Births the word "midwife," and the demand for such a change is not sufficiently great to make it advisable to bring before the Legislature the midwife question until

* Read before The Obstetrical Society of Boston, Jan. 28, 1913.

the general public has been educated to realize the importance of obstetrics.

The change now proposed, however, is not to strengthen the Medical Practice Act, but to weaken it. The law as it now stands is a serious blot on the statutes of the State. Massachusetts is one of two States in the Union not requiring the degree of M.D., before the candidate is allowed to take the examination before the State Board of Registration in Medicine. Massachusetts further let down the bars last year and recognized the optometrists. If the midwives are now to be recognized we may fairly ask, where is it going to end?

The effect of recognizing the midwife would be dangerous in three ways.

First, in its influence upon the general public.

There is probably no other branch of medicine about which so much ignorance exists in the lay mind as the subject of obstetrics. The average American, and immigrant, too, for that matter, realizes where to seek and how to find competent medical skill for the illnesses and emergencies that beset his path, but has no idea of the importance of adequate medical attention during pregnancy, labor and the puerperium. Since the child comes into existence and later into the world by natural processes in the vast majority of cases, the need of any intelligent supervision is not recognized. The deaths and invalidism resulting from incompetent care are not traced to their source.

In many families nothing is done until the advent of the child is imminent, and then the nearest doctor or midwife is sumoned by the excited neighbor or husband, much as the fire department is called when the kitchen lamp is overturned. Any effort to introduce midwife legislation at the present day would probably meet with prompt support by the majority of our citizens who would have the feeling that the more persons available to render assistance in such emergencies the better, not realizing the vital importance of the quality of that service. Thus any effort at legislation would have an injurious effect upon the minds of the general public. It will definitely lessen the importance of proper obstetrical observation and care. They will argue (and with considerable reason) that if the State recognizes and indorses the midwife then she must be good enough for most people, and certainly if she isn't quite all that might be desired after her six months' training, why any physician after four years in the medical school must be all that the most anxious could wish for, and so with this sense of security they will call upon the general practitioner without any regard for his obstetrical training.

Second. The physician practicing medicine at the present time in Massachusetts will be seriously injured by admitting the midwife to legitimate practice. One class of practitioners will be greatly pleased and relieved if this comes about for it will immediately wash the hands of those who have been practicing in close relation with the midwives. It will show them that they have been acting wisely and well in signing birth certificates in cases they have never seen much less attended. It will make them realize even more fully that the stethoscope and the pelvimeter are no longer necessary in obstetrics. They will, with their medical diploma, naturally feel superior to the midwife and will have no pressure brought to bear upon them to improve their obstetrical knowledge. Legalizing the midwife will also work a definite hardship to those physicians in the state who have become well trained in obstetrics, for it will have a definite tendency to decrease their sphere of usefulness. When the general public is informed by its body of law-givers that any woman, after a six-months' training, is competent to take charge of an obstetrical case, the demand for the expert cannot easily be understood.

But the third and most important harm that this proposed law is capable of doing will be its effect upon the teaching of obstetrics. There is a very definite move on foot in America to strengthen the courses in obstetrics, to teach the students, by having them deliver not six cases but thirty, forty or fifty under careful supervision during their medical school days—not only that but to teach them further that no man should consider himself competent to cope with the complications of pregnancy and labor until he has rounded out his course by an internship in a lying-in hospital. In other words, the modern tendency is to lift obstetrics to the level of medicine and surgery. There is less and less talk of the "normal case" so frequently spoken of by those in favor of the midwife as a practitioner. The trained obstetrician knows that no case is normal until it is over. At any moment complications are liable to arise capable of taxing the skill of the obstetrician to the utmost. In these emergencies time is a great factor and while often medical aid may be summoned in time to render service, in a certain definite number of cases, unless a trained man is within easy reach the resulting delay means certain death for infant or mother, sometimes both. This modern teaching of obstetrics is directly in accord with the principles of preventive medicine. The obstetrician, by his care of the pregnancy, tends to prevent miscarriage, premature delivery and toxemia, and by his preliminary examination, selects the operation that he may have to perform, to give the surest chance for a strong living infant and a healthy mother. This the midwife obviously cannot do. She must, of necessity, be dependent upon the physician when trouble arises. Thus any logical method of developing a midwife system must include some definite standard of obstetrical ability on the part of the medical profession, else the midwife will call in vain for help.

If the midwife is to be trained, she must have that training in schools where she can be brought in contact with the patient in labor. At the present time Boston, while better off than

many medical school centres, is not over-equipped for teaching the students that come here for instruction in the out-patient departments of the different hospitals. Needless to say, any such considerable decrease in the number of cases as would follow the establishment of midwife schools, to say nothing of the activity of these graduates, must seriously injure the teaching facilities here in Boston.

Another phase of the effect of midwife practice on medical education must be considered. If it is true that fifty per cent. of all the labors in this country are conducted by midwives, then it must also be certain that the details of half the obstetrical cases of today are forever lost. The midwife contributes nothing to the knowledge of obstetrics.

The midwife exists only for the immigrant portions of our population. It is hard to see how she can make much progress among our native-born population. The physician exists for all classes and it is much more important to have the medical student receive the first consideration in any plans for education.

Let us see how the trained obstetrical teachers of America regard this question.

Williams,[1] professor of obstetrics in Johns Hopkins, urges among other obstetrical reforms "Gradual abolition of midwives in large cities and their replacement by obstetrical charities. If midwives are to be educated, see that it is done in a broad sense and not in a make-shift way. Even then disappointment will probably follow."

De Lee,[2] professor of obstetrics in Northwestern University Medical School, writes, "When public opinion has been raised and educated regarding obstetrics the midwife question will solve itself. With an enlightened knowledge of the importance of obstetrical art, of its difficulties, of its high ideals, the midwife will disappear; she will have become intolerable and impossible."

Dr. Paul Titus[3] of the Elizabeth S. Magee Infirmary of Pittsburgh, who was on the staff of Prof. Menge, writes, "I worked in the Frauenklinik in Heidelberg long enough to become thoroughly acquainted with midwife education and I feel that midwives educated or uneducated are unnecessary and vicious. 'Education' improves their *obstetrical ability but very little* but it does do this one thing—it makes them dangerous abortionists since it gives them an idea as to the value of asepsis and thus makes them more successful in that criminal field, and in direct proportion to their success and sense of self-security increases their business in this respect."

Dr. Skeel[4], of Cleveland, writes, "If obstetrics has any right to a place with the other branches of medicine; if its correct practice requires the wide knowledge and the skilled technic of the educated physician; if modern science has placed it on a coördinate plane with surgery, pediatrics, etc., then the proper solution of the midwife problem is not her education but her elimination."

Davis,[5] professor of obstetrics, Jefferson Medical College, Philadelphia, says, "It is my belief that midwives are a menace to the health of the community, an unnecessary evil and a nuisance. It is true that they furnish interesting pathologic cases, but this is no excuse for their existence."

Dr. J. R. Freeland,[6] obstetrician to West Pennsylvania Hospital in Pittsburg; former assistant master Rotunda Hospital in Dublin, writes, "In Great Britain, with 30,000,000 inhabitants, there are approximately 37,000 cases available annually for the instruction of midwives. The United States would need about 110,000 cases annually to train midwives to the standard required in Great Britain *which would still mean very unsatisfactory work.* The students would suffer and midwives would have to call as consultants men whose training in obstetrics had been much inferior to their own. Therefore it seems advisable to use the available material for the training of students, gradually raising the standard of obstetrics and by this means the elimination of the midwife would be only a matter of time."

Ziegler,[7] professor of obstetrics in University of Pittsburgh, writes, "I am opposed to educating and licensing midwives to practice obstetrics in this country for several reasons; first, because I believe it unnecesary, since I am convinced that a plan can be evolved and practically carried out which will give to every child-bearing woman in the country competent medical attendance; and second, because I do not believe it possible to train women of the type of even the best of midwives to practice obstetrics satisfactorily."

We are not satisfied with the present situation here in Massachusetts or anxious to allow it to continue. We feel that there ought to be a tremendous campaign started in our medical schools, and in every city and town in Massachusetts where midwives exist or where obstetrics is practiced in a make-shift way. We believe that in every town or city equipped with a District or Visiting Nursing Association and with a hospital that could devote a few beds to this cause, the problem would be simple, effective and self-suporting. The factors in the complete scheme should be (1) a pregnancy clinic, (2) a social service worker, (3) the visiting nurse, (4) the hospital beds for the serious complications,—all these under the charge of the obstetrically trained physician. To this might be added handy women and wet nurse directories.

The patient applies to the pregnancy clinic, the family is visited by the Social Service worker and an estimate is made of what the patient should contribute to the support of the institution, or where poverty exists, what charity the patient needs. At the time of application the patient's history is taken, and physical examination made; the pelvis is measured and exam-

ined; the blood-pressure is taken and the urine tested, and if all is normal the patient is turned over to the visiting nurse, who makes monthly and later weekly visits, taking the blood-pressure and doing the rough test for albumin, seeing that the patient is following out the directions for the hygiene of pregnancy as outlined for her at her initial visit. Should all progress normally, the obstetrically trained physician is summoned when the patient is in labor; this he conducts with the assistance of the nurse. The nurse makes the visits during the puerperium, reporting daily to the physician, and if all goes well the patient is only seen by him when ready for discharge. That such a clinic could be run as a self-supporting institution seems certain, even the physician should in most cases receive some compensation for his time. In 1910 the out-patients of the Boston Lying-in Hospital, contributing on the average $1.28 per patient paid all the expense of the Out-Patient Department, with a surplus of $807.82. In 1911, with an average of $1.27 per patient, the Out-Patient Department turned over a surplus of $833.31. Certainly it would seem that this answered the question of the economic necessity for the midwife.

A recent writer[8] on this subject has said: "We are totally indifferent as to what becomes of the midwife as compared with the vitally important question of how we shall provide competent medical service for the hundreds of thousands of the very best of our women while they are fulfilling the sacred obligations of maternity." I feel, however, that it would be perfectly possible to provide for the midwife and at the same time follow out our scheme for the Lying-in Dispensary. The midwives in the community should be informed that they can choose between giving up their livelihood or cooperating with the Dispensary, but that in either case they can no longer deliver women in labor. Then those midwives who show evidence of education and are able and willing to follow the aseptic precautions of the obstetrical nurse can be employed in that capacity by the Dispensary, while the others can in many cases be employed as handy women, going into the house and taking charge of the work and waiting upon the mother during her period of incapacity. Such a scheme could be developed in a community where the law was in the hands of men of sufficient education in this regard to see that the law was enforced.

It would seem as if we had reached that stage of social education where the rights of all should be recognized and respected. How can we with any justice suggest one class of service for the poor and ignorant and another for the well to do and educated? No other branch of medicine tolerates this dual standard—two classes of practitioners, one semi-trained and the other thoroughly educated. This is a problem to be solved by the obstetrically trained physicians and not by pediatricians, statisticians and board of health men unassisted by expert obstetrical advice. No man unless he is thoroughly trained in obstetrics is likely to realize the utter hopelessness of ever solving the obstetrical problem of the poor by the services of the midwife.

The course lies open. Massachusetts is in a position where public ignorance and apathy will readily allow the adoption of the midwife system—a system which has never proved successful in any country. But if we as obstetricians will firmly stand our ground and by exerting every effort educate the community in the importance of obstetrics, we can by the aid of our present law gradually solve the anomalous position of the midwife and place Massachusetts at the forefront in the march of Preventive Medicine.

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