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WHY THE MIDWIFE?*

BY

J. CLIFTON EDGAR, M. D.,

New York, N. Y.

We desire to record our observations upon the midwife system in the City of New York during the past six and a half years, or from August 1, 1911, at which date the Bellevue School for Midwives began its work.

We wish to preface our remarks with the statement that we are opposed to the midwife; opposed to any plan or system by which she will be permanently retained and perpetuated as a practitioner of obstetrics.

This was our attitude in the past, this is our position to-day.

We have no desire to champion the cause of the midwife, but merely to make the best of a deplorable situation, to render her less dangerous to obstetrics.

In the past we have mainly contented ourselves with repeating that the midwife has no place in modern obstetrics, that she be

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eliminated, and let it go at that. With notable exceptions little was done to supervise or educate her, and we almost entirely lost sight of the development of substitute agencies. For the moment, and particularly during this time of war, the elimination of the midwife is an impossibility; she is a necessary evil for traditional, social and economic reasons, caring, as she does at present, for some 30 to 40 per cent. of the confinements of this country.

Much criticism attended the opening of the Bellevue Midwife School on August 1, 1911. It was alleged to be a recognition of the midwife, because attempts at her education would assist in her retention and perpetuation as a medical practitioner.

In the City of New York in 1901 there were 3121 registered midwives, caring for 40.3 per cent. of all the women confined. On January 1, 1918 there were 1658 midwives caring for 32.5 per cent. of the confinements.

Although the number of births has increased in New York, from 103,881 in 1905 to 141,564 in 1917, the percentage of cases cared for by the midwives has fallen 10 per cent., from 42.1 per cent. in 1905 to 32.3 per cent. in 1917.

There are two main causes for this decline, namely the extension of substitute measures to replace the midwife, as maternity hospitals and outdoor maternity services, but especially the increasing tendency and willingness of the foreign-born woman to employ a doctor who is a man, and not a midwife because she is cheaper and a woman.

War conditions, with the cessation of immigration, must be reckoned with in this connection, for the number of births in the City of New York shows little if any increase since 1914—140,657 in 1914 and 141,564 in 1917. Even so, the midwives cared for 5.3 per cent. fewer cases in 1917 than in 1914—37.6 *per cent. in* 1914 *and* 32.3 *per cent. in* 1917.

The decided drop in the demand for the midwife's services in New York since the European war began in 1914 without a corresponding lowering of the number of births would suggest that newly arriving immigrants are the ones chiefly employing the midwife.

Hospital records bear out the fact that foreign-born women, after their first confinement under the care of a midwife, subsequently turn to the maternity hospital or a physician for obstetric aid.

After a short residence in this country, the foreign-born woman does not usually persist in her employment of a midwife. Her ambition is eventually to be in a financial position enabling her to employ the services of a regular practitioner.

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NUMBER OF BIRTHS AND MIDWIVES IN THE CITY OF NEW YORK AND PERCENTAGES OF BIRTHS CARED FOR BY MIDWIVES.

Year	Total no. midwives	Total no. births	Attended by physicians	Attended by midwives	Percentage by midwives
1905	....	103,881	60,051	43,830	42.1
1906	....	111,772	63,661	48,111	43.0
1907	....	120,722	68,186	52,536	43.5
1908	....	126,862	71,210	55,652	43.8
1909	3,131	122,975	73,359	49,616	40.3
1910	1,515	121,067	77,071	51,996	40.2
1911	1,488	134,544	82,788	51,756	38.4
1912	1,325	135,133	82,390	52,743	39.2
1913	1,488	134,134	83,770	50,364	38.0
1914	1,448	140,647	87,650	52,997	37.6
1915	1,409	141,256	91,341	49,915	35.31
1916	1,798	137,664	91,177	46,487	32.7
1917	1,656	141,564	94,039	47,525	32.3

During the existence of the Bellevue Midwife School, 235 midwives have been graduated, 5125 confinements have been conducted by the pupils—1755 in the school, 3370 in the patients' homes—with a maternal mortality of 0.7. Three mothers only died in the school itself, a mortality of 0.05 per cent. Six others died after being transferred to Bellevue for operation.

The 5125 cases cared for by the midwives in the Midwife School and the patients' homes are practically all normal labor cases, as the fetal and maternal dystocia, and bleeding cases, severe toxemia and other abnormalities are sent to the Bellevue obstetric service for treatment. As far as the handling of strictly normal labor cases by the midwives goes, our results have been excellent. The records indicate that little septic infection has resulted.

A review of the work in New York for the bettering of the conditions of the midwife during the past six years is a source of congratulation.

So far as the City of New York is concerned, we venture the statement that at the present time, there is no evidence to show that the midwife is the menace to safe obstetrics, that the traditions of the past have painted her, always with the provision that she practices none but strictly normal obstetrics.

In our opinion this is due to the influence and better work of the graduates of the Bellevue School for Midwives and to the renewed activities of the Health Department of the City of New York. The influence of 235 Bellevue alumnæ is generally for good among the

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existing 1656 midwives. We unhesitatingly affirm that an obstetric patient, normal or otherwise, is safer in the hands of a graduate Bellevue midwife than in those of the casual and indifferent practitioner.

These midwives have been taught their limitations, not only what to do to the best of their ability, but what not to do; when to send the patient to a hospital or when to seek the aid of a trained obstetrician in the event of serious delay or complication.

The Bellevue graduate is a marked woman among the other midwives and is generally looked up to with envy by her less fortunate sisters, although the former occasionally back-slides and falls by the wayside into the nets set for her by the Department of Health. The criminal abortion business in 1817 was mainly, if not entirely, confined to a few of the older and nongraduated midwives, who had plied their trade for years undetected, and to physicians. There is a general uplift among the midwives. The graduates of the Bellevue School for several years have maintained an Alumnæ Association with monthly meetings at the School and a certain pride is taken in belonging to the Association by its individual members.

At the meetings, obstetric matters and the general conduct and welfare of the midwife are discussed, and talks upon ethical and medical subjects—matters pertaining to the work of the midwife—have been given during the year by Doctor John W. Brannon, President of the Board of Trustees of Bellevue, Doctor O'Hanlon, medical superintendent of Bellevue, Miss Agnes E. Aikman, resident superintendent of the midwife school, and the attending and resident staff. No one can attend these meetings without being impressed with the ambition of its members to practice clean and safe normal obstetrics to the best of their ability.

Whether it be coincidence or the result of education and supervision, the fact cannot be contradicted, that fewer obstetric tragedies the result of midwife obstetrics now find their way to the obstetric wards of the hospitals.

Not a case of ruptured uterus that could be traced to a midwife has been admitted to our Bellevue and Manhattan Maternity Services in over six years. Formerly a number of such cases came to us each year. The last five instances of ruptured uterus observed by us in hospital practice were due to rupture of the scar of a previous Cesarean section, rupture following a ventral fixation, rupture of the scar following excision of a tube, or to prolonged labor in contracted pelves. All of these cases were under physicians' care. Not a case of retained placenta, in which a midwife had previously

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administered ergot, has in recent years come to our notice. Formerly they were common enough.

Recently a midwife, a Bellevue alumna, followed one of her cases, a persistent R. O. P. position to our Bellevue Wards, in which she had actually made the diagnosis of the cause of the delay, and requested the nearest Police Precinct to transfer the case by ambulance to Bellevue. This midwife, moreover, brought with her a rough history of the course of labor, ungrammatical to be sure but nevertheless interesting.

On the other hand some midwives, but not the majority, are impossible, hopelessly stupid, and should never be allowed access to an obstetric case. This is clearly indicated by the fact that it becomes necessary to drop 35 per cent. of the pupil midwives of the Bellevue School, for general incompetency, early in their course of study.

REPORT OF THE BELLEVUE MIDWIFE SCHOOL, FROM AUGUST 1, 1911 TO JANUARY 1, 1918.

Applicants for training are accepted from residents of New York City, between the ages of twenty-three and thirty-five, who must be cleanly in their person and homes, and of good moral character. There are no fees for instruction; board and lodging are also furnished free of charge. Applicants serve a probation period of four weeks, after which they are registered pupils if they have shown suitable aptness. They must live in the school and pursue a six months' course, during which they are taught the management of normal confinements, and to recognize abnormalities. Instruction is given by a visiting obstetrician, the resident obstetricians and superintendent. In addition, practical demonstrations are given and bedside clinics are held daily in the wards of the school.

During the first two months, the work includes the care of the mothers and babies in the school; the second two months, assisting at labors in the hospital and in the tenement district, attending clinics, and postpartum calls on out-patients under the supervision of a graduate nurse. During the last two months, pupils deliver patients, first in the school and then in the district, under the direction of the resident obstetricians. In conjunction with the school, a prenatal clinic is held every afternoon at two o'clock. At the clinic, applicants for care during confinements are registered, short histories are taken, urine is examined, physical and pelvic examinations are made, instruction as to hygiene is given to the patient, probable date of confinement estimated and patients told to return

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at definite intervals. This is an important feature in the course of the pupils, as each is required to serve a definite time in the clinic and make examination under the direction of the resident obstetrician. Pupil midwives serve at least ten hours daily, every week.

Each pupil midwife in the school delivers not less than twenty cases, at least two of these must be primiparæ. As a minimum, 100 confinements are witnessed by each pupil. When this course is completed, a practical and oral examination is given by a visiting obstetrician, and if the candidate passes these successfully, a diploma is granted.

Since the establishment of the school in August, 1911, the following statistics are available:

Number of inquiries or applications from prospective midwives	1,297
Number entered school	250
Number of pupil midwives dropped from roster on account of illness, incompetence, character, etc.	83
Number of pupil midwives in school at the present time	22
Number of the graduates of the school:	
1912	25
1913	22
1914	40
1915	63
1916	38
1917	50
Total	235

NATIONALITY OF GRADUATES.

Italian	64	Danish	2	Lithuanian	4
German	37	Romanian	1	Armenian	3
American	36	Slavish	3	Indian	1
Hungarian	23	Bohemian	2	Portuguese	1
Polish	21	Russian	14	Turk	1
Irish	7	Swedish	1	Belgian	1
English	6	Finnish	6	Dutch	1
Austrian	11	Norwegian	3	French	2
Scotch	5	Swiss	1		

NUMBER OF APPLICATION OF PATIENTS.

August, 1911 to January, 1912	39
January, 1912 to January, 1913	421
January, 1913 to January, 1914	1,218
January, 1914 to January, 1915	1,351
January, 1915 to January, 1916	1,730
January, 1916 to January, 1917	1,642
January, 1917 to January, 1918	1,481
	7,882

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NATIONALITY OF PATIENTS.

August, 1911 TO January, 1918.

Italian	2062	(37.5 per cent.)	German	118	(2.1 per cent.)
American	1465	(26.1 per cent.)	Greek	87	(1.5 per cent.)
Irish	378	(6.8 per cent.)	Canadian	10	
Russian	328	(5.9 per cent.)	English	77	(1.5 per cent.)
Hungarian	165	(3.0 per cent.)	Syrian	17	(0.3 per cent.)
Austrian	309	(5.7 per cent.)	Scotch	15	(0.28 per cent.)
Turkish	143	(2.6 per cent.)	Spanish	29	(0.5 per cent.)
Polish	61	(1.1 per cent.)	Armenian	44	(0.78 per cent.)

Also smaller proportions of Roumanians, Swiss, Dutch, Bulgarians, Egyptian, Finns, Mexicans, Swedish, French, Bohemians, Arabians, etc., etc.

It is the Italians who largely demand midwife services. It should be stated also that the majority of the 1465 noted as American (born in the United States), were of Italian parentage.

PATIENTS DELIVERED.

	In school hospital	In own homes
August, 1911 to January, 1912	54	6
August, 1912 to January, 1913	184	131
August, 1913 to January, 1914	230	464
August, 1914 to January, 1915	207	630
August, 1915 to January, 1916	336	884
August, 1916 to January, 1917	321	795
August, 1917 to January, 1918	320	730
	1755	3370
Total		5125

NUMBER OF MATERNAL DEATHS AT THE SCHOOL.

1. Septic pneumonia, edema of lungs (delivery normal)........ 1
2. Accidental hemorrhage, hydramnios........ 1
3. Suicide, ruptured uterus........ 1

NUMBER DIED AFTER BEING TRANSFERRED TO BELLEVUE.

1. Rupture of uterus (ventral fixation had been done)........ 1
2. Puerperal sepsis (labor uneventful, negative blood culture)... 1
3. Ruptured pelvic abscess, myocarditis........ 1
4. Placenta previa........ 1
5. Cerebral embolus........ 1
6. Eclampsia........ 1

Total........ 9

Maternal mortality, 0.7 per cent.

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NUMBER OF INFANT DEATHS AND CAUSES.

Cause	Number	Cause	Number
Prematurity	16	Abscess of parotid gland	1
Atelectasis	8	Pneumonia	3
Syphilis	2	Fractured skull	1
Generalized hemorrhages or hemophilia	7	Cong. malformation of heart	6
Malnutrition	1	Rupture of adrenal gland	1
Unknown	4	Cerebral hemorrhage	5
		Melena neonatorum	1
Total			56

NUMBER OF CASES TRANSFERRED TO BELLEVUE (MOTHERS).

Cause	Number	Cause	Number
Contracted pelvis	22	Hydramnios	2
Abscess of mammary gland	2	Phlebitis	2
Alcoholism	1	Secondary syphilis	1
Psycopathic	6	Toxemia	2
Influenza	2	Otitis media	1
Miscarriage	1	Sepsis, puerperal (one bad Widal reaction)	2
Salpingitis and pelvic cellulitis	2		
Ventral fixation	1	Hemorrhage	1
For Cesarean section	3	Retained Secundines	2
Placenta previa	1		
Total			54

Number of revoked licenses from graduates of Bellevue Hospital School of Midwives 0

Bleeding cases and those of marked maternal and fetal dystocia are transferred from the school to the Bellevue Obstetric Wards for treatment.

Hence, the majority of cases delivered at the School are normal ones. As far as the handling of these normal cases is concerned, the results have been excellent with little sepsis and practically no true ophthalmia neonatorum.

The conservative nature of the teaching at the Bellevue School for Midwives is shown by the fact that in the first four years of its existence, the forceps was used only 67 times in the first 2731 cases, or once in each forty cases—a forceps percentage of 2.4 per cent.

Not the least advantage of our primitive attempt to educate the midwife at the Bellevue School, is the thorough teaching of each candidate for graduation her limitations. The material that we have to work with is often poor, if not impossible; our standards of education as yet may not be of the highest; the six-month course allowed us is all too short for anything like an adequate training, but one important fact is instilled into the brain of each midwife, and that is the knowledge of her own limitations—the knowledge of what not to do, and when to seek the aid of a practising physician.

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If we must have the midwife among us, then let us hope that the standard of her education be placed so high that only the more intelligent will be able to successfully compete for license to practise.

SUPERVISION BY THE NEW YORK DEPARTMENT OF HEALTH.

During 1917 the Bureau of Child Hygiene of the Department of Health of the City of New York has been active in the supervision of the New York midwife. The Bureau records show a marked increase in the suppurative eye conditions other than true ophthalmia neonatorum reported by midwives, and a marked decrease in the number of cases of true ophthalmia neonatorum. It is believed that this is due to the fact that practically all midwives now use the 1 per cent. nitrate of silver solution supplied to them by the Department of Health, and that possibly a large number of the cases of nonspecific conjunctivitis is due to silver catarrh.

The Bureau of Child Hygiene of the New York Dept. of Health has encouraged the registration of expectant mothers who are to be attended by midwives for prenatal observation and care. The midwives, as a result, in 1917 voluntarily registered 1865 expectant mothers.

The New York Department of Health has further coöperated with the New York Police Department for instilling into the heart of the midwife the *fear of the law*. As a result, during 1917 the Department of Health caused the arrest of twenty-four midwives, and incidentally of four physicians, for *attempted* criminal abortion. Of the total of twenty-eight cases, ten were dismissed, three acquitted, three had sentence suspended and twelve cases are pending in the courts. Three physicians were arrested for *selling* medicines to produce criminal abortions. One was acquitted; the cases are pending in two.

Two physicians and three midwives were arrested for *producing criminal abortions*. The five cases are pending.

One physician and three midwives were arrested for *permitting* an abortion; one was dismissed, three are pending.

Thus it appears that thirty midwives were arrested in connection with criminal abortion, and at the same time fourteen regular physicians. Although the net was originally set for midwives, half as many physicians as midwives were caught in its meshes.

Various record forms for the control of the midwife's work, and

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pamphlets for aid in her business have been prepared. These include:

(1) Record of the cases attended by midwives: The inside of the sheet is kept by the midwife; the front is a summary of the activities of the midwives for the quarter; and the back is a record of the visits of the nurse and the inspector to the individual midwife. (2) Is a form of letter sent to midwives urging them to register their expectant mothers. (3) Is the form used by midwives in referring expectant mothers to us. (4) Rules and regulations governing the practice of midwives in New York City. (5) Copies of four hand-books given midwives to aid them in various phases of their practice. (6) A form of report slip used by the nurses who visit midwives. (7) A record of investigation of stillbirths occurring in the practice of midwives. (8) A form of report used in investigation of sore-eye cases occurring in the practice of midwives. (9) A report form used in the investigation of a death from conditions associated with pregnancy.

No matter from what angle one views the midwife question, the anomalous situation presents itself, namely, on the one hand physicians and even trained nurses, before they are permitted to enter upon the practice of their profession, are required to receive several years' instruction in the care and treatment of the sick, as well as special instruction in the treatment and care of pregnant and child-bearing women and new-born infants.

On the other hand midwives who care for some 30 to 40 per cent. of the confinements of the country, are frequently granted licenses to practice with practically no previous training, or as in the City of New York, a six months' training, and to begin with are often hopelessly ignorant and incompetent. Even after the weeding out of applicants for admission to the Bellevue Midwife School, it becomes necessary to drop from the school some 35 per cent. of those already pupil midwives for general incompetence and unfitness.

If we accept the figures for 1917 of Dr. Grace L. Meigs, of the Children's Bureau of the U. S. Department of Labor at Washington, there has been no diminution in the maternal mortality in childbirth in this country in recent years, apparently there has been a slight increase.

The still birth mortality of the United States averages 3.4 per cent. Over 15,000 parturients die annually.

During 1917 there were 141,564 living births in the City of New York and in the same year 6120 stillbirths were reported to the Department of Health, although the actual number undoubtedly was very much higher. This is a stillbirth mortality of 4.1 per cent. The infant mortality in the first month following labor, for the registration area of the United States is appalling.

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The situation is deplorable, especially in view of all that we have striven to attain for a higher medical education, and when we compare the obstetric mortality *with what has been done* in recent years in the prevention and lowering of the death rate of typhoid, diphtheria, yellow fever and tuberculosis. Who is to blame? Where is the leak? What is the remedy for this tremendous and unnecessary loss of life?

Both physicians and midwives are responsible. Whether the latter more so than the former is an open question. All too frequently the blame rests directly with the patient herself, who will not appreciate or cannot be made to understand the importance of prenatal care and safe obstetrics.

The midwife is still a menace to safe obstetrics, so is the recent graduate, so is the patient herself.

Broadly speaking half the obstetric maternal death rate is due to puerperal septicemia, and the remaining half to other conditions,—pregnancy toxemia, maternal and fetal dystocia and the hemorrhages. No figures are available but much of the puerperal septicemia, if not most of it, is antedated by the prepartum conditions just enumerated, possible of detection and relief during pregnancy.

We venture the assertion that the most available remedy for the moment is to be found in prenatal observation. Better obstetrics at time of labor, to be sure, but prophylactic obstetrics as well by improved prepartum care.

How shall the situation be met? Elimination of the midwife will not do it. Higher standards of medical education thus far have failed to accomplish it.

Two special problems present themselves. That of (1) the large city and of (2) pioneer rural district. The solution of the city problem, we believe, rests in the establishment of maternity centers and clinics, and of the rural in the county maternity hospital and rural nursing service along the lines proposed by Dr. Grace L. Meigs.

We have a Maternity Service Association already under way in New York, its object being to promote prenatal, puerperal and postnatal care of the poor women of New York.

Essentially, the project is for improvement in the care of obstetric patients, both mother and child. The plan is to limit the field of each maternity hospital, by dividing the City into zones corresponding to the present sanitary zones of the Health Department and establishing maternity centers and maternity clinics in each zone. The individual hospitals agree to the limited district or zone and if patients outside of the district come to a given hospital, such patients are referred to their particular district.

The hospitals with their nurses and social workers in coöperation with those of the maternity centers and clinics follow up each patient

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registered for the district and see to it that she, the patient, presents herself to the proper assigned hospital for prenatal care.

The centers, hospitals and clinics "comb the district" so to speak for abnormal cases and see that treatment is forthcoming.

To illustrate the working of the first maternity center, established at 219 East Seventy-ninth Street, in the so-called Zone VII, this being the district to which the Manhattan Maternity is now confining its work, let me state that during January, 1918, twenty patients suffering from various prenatal and postpartum conditions were referred by the doctors and nurses of the maternity center to the Manhattan Maternity. Nine of these women received into the hospital were instances of pregnancy toxemia. Five were primiparæ, four multiparæ, the blood pressure ranged from normal to 228 mm.; all had albumin in the urine, four had casts, and one had blood; gastric disturbances were present in all and edema in most; eleven convulsions occurred in one woman and two in another after admission; seven had labor induced by Champetier de Ribes bags; the two convulsive cases went into labor spontaneously. In only one instance were forceps used. In one twin case version and breech extraction was demanded. In a fetus dead from prolapse of the cord, perforation and extraction were performed. All the nine mothers are alive to-day.

Of the ten children, there being a twin case, one was lost from prolapse of the cord, one was stillborn at term, probably from toxemia, and one, a 3-pound macerated fetus, was delivered. This last patient had experienced seven previous stillbirths. She had a negative Wassermann reaction. One can hardly question but that the saving of all the mothers and the seven babies out of ten was due to the early recognition and treatment of the preëclamptic state.

A plan for better and safer obstetrics in our outlying rural districts, as Doctor Meigs suggests, must recognize two main problems: (1) The best practical care of normal cases and (2) the detection of abnormal cases and their care.

Doctor Meigs suggests a unit plan for a rural county to include:

1. *A rural nursing service, centering at the county seat, with nurses especially equipped to discern danger signs of pregnancy.* The establishment of such a service would undoubtedly be the most economical first step in creating the network of agencies which will assure proper pre- and postnatal care for normal and abnormal cases.

2. *An accessible county center for maternal and infant welfare at which mothers may obtain simple information as to the proper care of themselves during pregnancy as well as for their babies.*

3. *A county maternity hospital, or beds in a general hospital, for proper care of abnormal cases, and normal cases when necessary.*

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4. *Skilled attendance* at confinement *accessible* and obtainable for each woman in the county.

The growth and spread of two such plans, the maternity center and clinic for the city and the rural nursing, maternity county center, and county hospital for the outlying rural districts, would offer a remedy for the reduction of the present maternity and infant mortality, and at the same time supply the only practical substitute measures for the midwife.

We can thus visualize in the not too remote future a gradual but certain lessening of the number of midwives. Possibly the rural districts will hold out the longest.

Until the substitute measures present themselves supervision and education of the midwife are our only resources to lessen the midwife evil.

There is no speculating on postbellum conditions, but at the moment these substitute agencies to replace the midwife are lacking in about one-third of the confinement of this country. The hospitals care for only approximately 35 per cent. of the births of the City of New York.

When the substitute measures are forthcoming, the demand for the midwife will automatically lessen and cease.

The present drive throughout the country for the reduction of infant and maternal mortality and the ever increasing importance attached to prenatal care as a prominent factor, is certain eventually to react against the recognition and existence of the midwife. *The importance of prenatal observation and care in the lessening of infant and maternal mortality can scarcely be overestimated.*

So long as the recognition of the midwife exists, pregnancy toxemia, eclampsia, maternal and fetal dystocia, will claim an avoidable and unnecessary toll of infant and maternal mortality.

By education and supervision the midwife may be rendered reasonably safe perhaps for strictly normal labor, safe even for a minimum of sepsis, safe for the prevention of ophthalmia neonatorum, but she is *not* safe and no amount of education can fit the material with which we have been brought in contact with for the early recognition and care of prenatal complications, and maternal and fetal dystocia, which cause most of the infant and maternal mortality. Who shall determine what is a strictly normal labor? The midwife? Never! She is too incompetent. Only the trained obstetrician can do so.

The midwife can never stand upon her own responsibility. For safe obstetrics the obstetrician must ever perform the prenatal examination and care. He must ever be at hand for the maternal

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and fetal dystocia of labor and the complications of the postnatal period. *The maternal mortality in childbirth in the United States is still 15,000 a year.*

In spite of present high obstetric maternal and infant mortality, never before has the standard of obstetric work by physicians been so high, in the City of New York at least, as it is to-day. Better and safer obstetrics is being practised by physicians every year. This is indicated by the ever diminishing number of obstetric tragedies, the result of incompetency and neglect received into our maternity wards.

One cannot but be optimistic as regards the future of safe obstetrics in the hands of the coming generation of physicians.

No such pleasing outlook for obstetrics in general applies to the midwife. Her fitness for safe obstetrics is self-limited. And yet she attends between 30 to 40 per cent. of our confinements.

28 West Fifty-sixth Street.

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DR. J. CLIFTON EDGAR, New York City, read a paper entitled

"WHY THE MIDWIFE?"

(For original article see page 242.)

DISCUSSION.

DR. WILLIAM R. NICHOLSON, of Philadelphia, expressed himself as being fully in accord with the views enunciated by the essayist. The idea was prevalent that if a man thought his duty lay in any way toward the education or the control of the midwife, he therefore was a strong supporter of the midwife idea. This was a mistaken idea.

In the city of Philadelphia in the last four years 33,320 cases had been under supervision. Of that number, 33,278 had been inspected, that is, after the baby was born a woman graduate acting as inspector went to the home and saw the baby and the woman and the midwife who conducted the case after labor. There were rules compelling midwives to send for help after a certain number of hours. They could send for any doctor of their choice if they so desired. No one had any legal right to prevent them from doing this. These midwives had had, out of 30,278 delivered cases, thirty-two deaths. Four of these deaths occurred in the hands of an unlicensed midwife, and they had had twelve cases of septic death. They had delivered in the hospital thirty-two cases only out of 30,000 confinements. They had not lost an eye from ophthalmia neonatorum for three years. The supervision of the midwife should be controlled by the State, and the women who were to be delivered by midwives must be inspected and records kept of the places where they lived.

DR. GEORGE W. KOSMAK, of New York City, stated that the midwife, like poverty and taxes, would probably be with us for a great many years to come. The existence of the midwife should be recognized, but we should try and do what we could to get along without

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her. There were a number of accessory factors which must be considered in any study of the midwife problem. First and most important, was that of nursing aid. He thought the obstetric situation would be greatly improved if the doctor, practising among the poorer classes, could be supplied with an efficient nursing system. Unfortunately, in this class of cases, if the patient was able to provide a nurse, she was generally of a character that made her worse than useless. She was usually dirty, she had to do the household work and take care of the children, and it would be very much better if her ministrations to the patient could be entirely done away with. Then another problem was that of housing, and still another question was that of supervision. Dr. Nicholson's plan of having women visited by inspectors was a good one, but this inspection should continue beyond the time when the women were up. It was important not only to provide for the prenatal care of these women but postnatal. A great many cases of subinvolution and other complications of pregnancy could be better treated if these women were directed two or three weeks after the baby was born to go to some center in which a postpartum examination could be made and the various complicating conditions noted.

Dr. John O. Polak, of Brooklyn, said all of those who had maternity experience were well aware of the fact that they could not get away from the midwife problem. In a limited way in Brooklyn they had been able to do what Dr. Edgar had suggested. They had improved the mortality, both infant and maternal, very materially by working in conjunction with the midwife. Through social service work in collecting these cases that had been in the hands of midwives, the nurses taught the women the necessity of prenatal care or work and encouraged the midwives to bring them to the clinic. During the last year many midwives had availed themselves of the privilege of bringing cases to the prenatal clinic very frequently. He believed we could teach patients that they needed better obstetrics. Instead of antagonizing the midwives and not helping them out, obstetricians should teach them that they were going to help them.

Dr. Ralph H. Pomeroy, of Brooklyn, stated that every primipara should be considered an abnormal case, and if such cases were taken out of the hands of the midwife, the women would go to a hospital for supervision. If all maternity hospitals would exclude multiparæ and midwives were prohibited from taking care of primiparæ at their homes, we would get a real start. That must be decided by federal or state authorities.

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