THE CONTROL OF MIDWIFERY

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The only midwife problem with which I am familiar is that of our manufacturing cities with a large foreign population, of which my own city, Providence, is typical. In Providence the midwife is not indigenous. She came to us with our recent immigrants, from Russia, from Austria, from Poland, from the Azores, but chiefly from Italy.

Medical practitioners in general, and obstetricians in particular, denounce the midwife; social workers and public health nurses do not like her; and health officers do not consider her an asset to the community. The latter, however, while desirous of replacing her by something better, admit that she is not so inimical to public health as are many physicians. Thus in some cities the midwives report births and cases of ophthalmia better than do the physicians. They report births more promptly. In Providence, though there are no accurate data, midwives certainly report births more completely than do physicians. Last year 10 per cent of physicians' reports were late and only 1 per cent of the midwives'. For the prevention of infant mortality prompt returns are necessary, and the health officer is grateful to whoever makes them. There are very many physicians who know little about infant feeding, and their babies die and the health officer can do nothing about it. With the midwives' babies it is different. The nurse engineers them to the welfare station, where they are cared for by specialists. No wonder that in Providence, in 1917, the infant mortality rate of midwives' babies was 77, while of all others it was 117. It cannot be argued that this is because the midwives care for a stronger stock of women and healthier babies. About 85 per cent of the midwives' babies are of Italian mothers. In the years 1902-1909, before there was any instructive nursing service for mothers, the infant mortality rate among Italians was 138. In 1917 it was 93. The midwife, therefore, does not thus far seem to have been a hindrance to the prevention of infant mortality.

Objection to the midwife is based almost entirely on *a priori* reasoning. In the biological sciences this mode of reasoning is dangerous, though I doubt not that in this instance it is valid. Midwifery is a branch of medical practice, and we have abundant evidence that training and knowledge make for better practice. Nevertheless, there is

some truth in the old adage that "a little knowledge is a dangerou thing." We are safe in assuming that imperfectly educated physicians and imperfectly educated midwives are not as useful members of society as those who are well educated. In medicine we need the best. Even this, owing to the limitations of human knowledge, is far from the ideal. In knowledge the midwife must always be far below the physician, and it is a safe deduction that she is not an institution to be fostered, but is rather to be tolerated only until such time as an acceptable substitute can be found. We allow non-medical individuals to provide glasses for our eyes and to attend women in confinement, but in no other specialty is this permitted.

Nevertheless, it would be desirable to show by comparative statistics whether the practice of the midwife results in sickness and death. When comparison is made between the results of midwives' practice and that of physicians, it is at times apparently unfavorable to the latter. Dr. Williams, a few years since, aroused great interest by his argument that poor doctors have more deaths against them than do the midwives, and that there are many poor doctors. The majority of teaching obstetricians were of his opinion. Dr. Baker of New York says that the morbidity and mortality, both of mothers and of babies, is greater among those attended by physicians than among those attended by midwives. Dr. Van Ingen has presented figures, relating to the lower East Side of New York, which show that stillbirths are much more frequent in the practice of physicians than in the practice of midwives. The great fallacy in all such statistics is that there is a selection of cases. Difficult confinements gravitate to the physician or the hospital, while normal confinements remain with the midwife.

There are several reasons why there is a demand for midwives:

1. They are cheaper. In my own city at the present time the prevailing rate for midwives is $15, with a dollar or two thrown in the baby's bath for tub money, and for physicians $25 and upwards, though a number of physicians will take cases at the same rate as midwives. Such physicians, however, are likely to be below the average. It is believed by many that economy is the most potent reason for the retention of the midwife.

2. Many foreign women do not wish to have a man attend them in confinement, or what is probably much more common, their husbands do not wish it. This is a custom or fashion, but I cannot believe that it will prove very difficult to change it as soon as good medical service and other care is available within the mothers' means. When one sees the remarkable change in customs, clothes, food, drink, etc., among foreigners, after only a few months' residence, one can be confident that the preference for a midwife must yield to the force of American public opinion. The Italian will, in time, substitute the doc-

tor for the midwife, just as she has substituted the milliner's hat for the bright colored handkerchief that formerly covered her head. In this process of education the public-health nurse must play an important part. Her influence with a family is very great, and she can do much to teach the importance of the best medical attendance. The woman physician, too, can be utilized to give medical service to those who object to a male attendant.

3. The midwife performs more or less household service for the family, "tidying" the rooms, preparing the meals, and caring for the older children; but apparently there is a tendency for the midwife to do less and less of this sort of work.

There is evidence to show that midwifery is decreasing. Dr. Woodward stated that in the District of Columbia, between 1896, the date of the adoption of the law regulating midwives, and 1915, the number of births attended by midwives in the District of Columbia fell from 50 per cent of the total births to less than 10 per cent. In 1918 it was 5.5 per cent. This was due chiefly to the elimination of midwives by examination. In New York, in 1905, 42.1 per cent of all births were attended by midwives, while in 1917 the per cent was 33.5. The decrease has been especially rapid since the opening of the war, which is interpreted as indicating that it is the newcomers who are most inclined to rely upon the midwife. In Providence the proportion of births attended by midwives increased with the increasing tide of Italian immigration up to 1913, when over 33 per cent of all births were attended by them. In 1918 the percentage was 27.5. An encouraging feature in Providence has been the almost complete disappearance of the Jewish midwife. Ten years ago nearly 150 births annually were attended by Jewish midwives. Last year there were but four so attended, although we have a Jewish population of nearly 20,000. This seems to be due largely to the appreciation on the part of Jewish women of the value of medical service. In Rochester the number of midwives and the number of births attended by them has decreased during the last eight or ten years. In other cities, as Newark, it is stated that the proportion of births attended by midwives has remained quite constant.

Various plans have been adopted, or proposed, for solving the midwife problem. One is absolutely to forbid her practice by statute law. This is true of Massachusetts now and was true in Rhode Island up to last year. In neither of these States was any serious attempt made to enforce the law and to drive out the midwives. When I saw that the midwife was to remain in Providence I tried to secure her cooperation, with the result that her births are more completely and promptly reported than before, as are her cases of ophthalmia, and her babies are promptly brought under the care of public-health nurses and physi-

cians, so that the infant mortality rate of midwives' babies has been reduced nearly 70 per cent.

Another plan, which may be developed in different ways, is to license the midwife. This has as yet been attempted in only a few States. The statutory provision should be as broad as possible so as to allow opportunity for experiment and the development of new methods of control. The Rhode Island law provides that "the State board of health is hereby authorized and directed to make rules for the regulation and practice of midwifery, and for the licensing of midwives." The New York statute, authorizing the enactment of a sanitary code by the public health council, provides that this code "may contain provisions regulating the practice of midwifery."

Under such general provisions the licensing may amount to a mere registration, or it may develop into an elaborate system under which midwives are carefully examined, educated, trained, and supervised.

The advocates of licensing are divided into two groups. One of these believes that the midwife is but a temporary institution, is unnecessary, and can sooner or later be eliminated. They would issue a license annually, perhaps establish moderate standards of conduct, and gradually eliminate those midwives shown to be careless, dirty, ignorant, or neglectful. They would not attempt to teach obstetrics to the midwife, or to raise her social or economic status, fearing that, by so doing, her position would be made more permanent. The midwife who is educated in a school and who has a diploma will be independent and will resent efforts to draw away her clientèle. She will believe that she has rights which she must defend. On the other hand, the midwife who is made to feel that she has no real status, that she is allowed to practice only on sufferance, and that she is dependent on the good will of the health officer, will not dare to make much fuss if she sees her patients leave her. Dr. Stone, our superintendent of child hygiene, finds that our best qualified midwives are the least tolerant of advice and correction. If the midwife has no real status, she can the easier be made to obey the rules of the department; thus such midwives can often be made to report births and inflamed eyes more promptly than the physicians. Perhaps they may even be made to report pregnancies. Under control, such midwives are not dangerous to the babies, as is shown by the Providence figures previously given. That they are not dangerous to the mother is indicated by data from Philadelphia, where there were only 17 deaths in about 12,000 confinements attended by supervised midwives.

Others think that the midwife will surely remain with us for a long time and they prefer to attempt to improve her status. They would fix educational standards, and by definite supervision of her work see that these standards are lived up to, thus following the ideas of most

European countries. Thus the New York code requires that midwives must possess a diploma from a recognized school or must have received personal instruction from a licensed physician, of which instruction he must make a report. A school for midwives had previously been established at Bellevue Hospital in New York City in 1911. The New York State Department of Health has planned for the supervision of midwives through the medium of nurses. These nurses cover chiefly those parts of the State outside the great cities. New York City had previously undertaken similar control in 1911.

New Jersey has adopted much the same plan as New York.

In Pennsylvania midwives are licensed by the bureau of medical education and licensure, and are also supervised by the same bureau. The system is best developed in the district in which Philadelphia is situated. In this district there is a supervisor, a specialist in obstetrics, who has under him a number of women physicians who act as inspectors. The midwife must call upon the inspector for advice in every abnormal delivery, and definite rules are given to guide her judgment. In practice nearly every patient is seen by the inspector. The midwives receive considerable systematic instruction, but, as I understand it, the authorities look to the ultimate extinction of the midwife and think that this result will be endangered if the requirements are such that women of some education will be led to prepare themselves, at some expense, for midwifery as a "profession." In Pittsburgh close supervision of the midwives is maintained by nurses.

In Providence the "baby nurses" of the health department have, for some time, sought, by personal instruction given to each midwife, to make her more cleanly and in other ways to take better care of her cases. She has been made to report births and sore eyes promptly. She is shown the necessity for sending for a physician in case of any abnormality and is warned of the danger of delay. Many midwives secretly prescribe medicines, and the endeavor is made to break up this practice. Very much was done along these lines before we had a license law, and now it is hoped that the State board of health will refuse licenses to those women who do not follow directions.

If midwives are to be supplanted, some substitute must be offered which appeals to their patrons as desirable. Perhaps the most important reason why the midwife is preferred is because she costs less than a doctor. If the midwife is to be supplanted by a physician, the latter must not cost more than the former, and the supplanting process will be more rapid if he does not cost as much.

A free out-patient obstetrical service certainly draws cases from the midwives. Wherever there is a medical school, such a service is necessary for teaching purposes. Even if the patient is able to pay a midwife, I consider it entirely legitimate to draw her away by free treat-

ment, particularly as the patient is to be used for teaching purposes. Moreover, some compensation may be received even from this kind of a service. Thus at the Boston Lying-in Hospital the out-patients contributed on the average, in 1916, $1.38 each, which was an appreciable help in meeting the low cost of the service. That such a service pays from a public health standpoint is shown by the fact that maternal mortality in the last 5,000 out-patients was .04 per cent. That this low rate was not secured by sending an undue number of difficult labor cases into the hospital is indicated by the mortality of the house cases, which during substantially the same period was 1.1 per cent, certainly not abnormally high.

Unfortunately, or rather fortunately, most of our cities are not supplied with a medical school, so some other means than the utilization of medical students has to be found to provide obstetrical service for the poor. An out-patient service would seem to be best provided in connection with a maternity hospital. The country certainly needs a much larger maternity service than it now has. Many general hospitals are, however, now adding a maternity service, often because a number of States are requiring of their licentiates in medicine a hospital internship with a prescribed obstetrical training. This will certainly draw cases from the midwives, and will at the same time, by the training thus secured, make the young doctor a better obstetrician, a most desirable result.

The cost of out-patient obstetrical work is a matter of much moment in these times when there are so many demands on philanthropy and so many lines of municipal health work. We must all admit that it is a great injustice to ask so much gratuitous public service of physicians. Many of us are trying to draw away from this practice, though it will probably be a long time before all such public medical service will be adequately paid for. The tendency in some places is to utilize internes, or other members of a resident hospital staff, for out-patient work of all kinds. In this way the out-patient worker is likely to be paid something besides his board, and he may even be paid a fair compensation, yet I am sure that less money will be required in this than in any other way, and that this arrangement will better satisfy the medical man. The utilization of a resident staff for out-patient work also makes for efficiency, as the work can be supervised by the hospital management and the service is sure to be more prompt and regular. Hence out-patient obstetrical service would seem to be desirable in connection with maternity hospitals whenever possible.

At Manchester, N. H., a city of about 80,000 people, out-patient obstetrical service is carried on by the district-nursing association, which has a medical man for director of the service. Young physicians, just coming to the city, do most of the work, and they are glad to do it, as

they are thus brought in touch with the more influential people. The city has many textile operatives, and it is estimated that about 10 per cent of all confinements are in need of free service. About 6 per cent are now served by the dispensary.

The "pay clinic" has, for various types of medical service, been strongly advocated in Boston as a means of securing efficient treatment for a class of persons who can pay only a moderate sum, but yet sufficient in the aggregate to afford modest compensation to the physician. It was deemed advisable in East Boston to establish such a service in connection with the Maverick Dispensary, a private institution, not connected with any hospital. This has been running only a short time, but is drawing cases from the midwives. A charge of $15 is made, just the amount charged by midwives, and of this $10 goes to the physician. The physicians are men who are glad temporarily to take this service to perfect themselves in obstetrics.

Enough has been said to show that in the United States a variety of views prevail as to the midwife and that there are various ways of dealing with her. Those who would dispense with her service have different plans for doing so. This is the period for experiment, and our Federal system, with its forty-eight legislatures, favors experimentation. It is too early to standardize and not a time for dogmatism. It is not unlikely that different plans will be found best for different parts of the country. Meanwhile my own conclusions, applicable chiefly to our cities with large foreign populations, are as follows:

1. The midwife is unnecessary and can gradually be eliminated.
2. There should be an annual registration, and supervision should be maintained.
3. The foreign population must be educated, the most valuable agencies being nurses and clinics.
4. Prenatal clinics are needed and especially an enlarged outpatient obstetric service, partly free and partly pay.
5. More maternity wards are needed.
6. There should be better obstetric training for medical students, which will be made possible by greater opportunity for clinical instruction.

DISCUSSION

Dr. Julius Levy (State Board of Health, New Jersey): I want to recall some of the points that Dr. Chapin made very tellingly and clearly. He made the point that midwives are not so bad as some doctors; he made the points that births are reported more frequently and more promptly by midwives than by doctors, that there is less ophthalmia than in cases handled by doctors, and that midwives are more disposed, under advice and instruction, to use silver nitrate. He also made the point that infant mortality is lower among cases handled by midwives; and then he wants us to believe that we are to eliminate midwives!

As far as our studies can show, experience has proven that under regulation and supervision and proper instruction our standards are better maintained by midwives than by doctors as they exist. And I may add that where that does not occur it is not the fault of the midwife but of the public-health officer. I will not claim that with the same kind of regulation and supervision of doctors the results would not be better, but Dr. Chapin also stated that he discovered it was much easier to regulate and supervise the midwife than it was the doctor.

Dr. Chapin also pointed out that as the midwife became educated she was more difficult to handle. You notice she is getting a little like the doctors and the results are not always as good.

I ought to suggest that I do not think that obstetricians need fear the existence of the midwife in perpetuity. Elevating her status I think is a sly way to eliminate her, if you really wish to eliminate her, because as you elevate her standard she demands more for her service, and when she demands more for her service, she is in competition with the doctor. By the law of the survival of the fittest, if the doctor is a superior individual, he will survive.

Sir Arthur Newsholme (Late Principal Medical Officer, Local Government Board, England): So far as England is concerned, at the present time 75 per cent of all confinements are attended by midwives, whose practice on the whole is satisfactory. Favorable statistics could be quoted similar to those that Dr. Chapin has quoted as regards Providence. But we have midwives in England under absolutely complete control. Midwives that are on the register to practice can be removed from the register if they are guilty of malpractice or inefficiency. They are so removed frequently. They are subject to regulation and systematic inspection by local supervising authorities; so that any midwife who gets a bad reputation or has an excessive number of complications is sure to be hauled over the coals and her practice will diminish very seriously. In those various ways we have secured that midwifery is a fairly safe profession.

Moreover, the Local Government Board has arranged for Government grants to fifty per cent of the total expenditure for the employment of midwives, these grants being given to the rural authorities and to the poorer districts and towns where midwives are located, the other half of the total expenditure being paid by volunteer subscribers or by the local authorities.

In addition every midwife is required when any complication occurs to call in a doctor. There has been great difficulty in the past in providing a fee for this doctor, and now it is made obligatory upon the local authorities to pay this doctor's fee, so that no doctor can be excused for not going at once when the midwife requires his assistance in any complication, however minor that complication may be. I think you will agree that, if the practice of midwifery by midwives is to continue, we have in that way safeguarded it.

In the last twelve months I have also been advocating that an additional duty should be imposed on midwives, to which I personally attach the greatest possible importance. This is that if for any reason during the time (ten days or a fortnight) that the midwife continues her attendance after confinement, the mother proposes to give up breast feeding, it is the duty of the midwife to notify the medical officer of health of that fact at once, so that he or his assistants may visit that house at once to see that breast feeding, which is the most essential element of the welfare of the child, shall be continued if it be possible to continue it. This has now been secured by a regulation of the Central Midwives' Board.

Furthermore, the Local Government Board has given grants for the formation of maternity homes and maternity hospitals, and it has been prepared, and expressed its anxiety, to pay fifty per cent of the total cost of these hos-

pitals and homes without any limit of the total amount which is thus payable. Such maternity hospitals and homes, I am glad to say, are springing up in many parts of the country. They are, in my view, one of the greatest needs of town life. It is a great shame that it should be so, but it is the fact that in a large proportion of the tenement houses of our big towns it is not possible for a confinement to take place under conditions that can be regarded as anything approaching satisfactory.

The Local Government Board pays doctors' fees; we pay for maternity homes and hospitals; and we also pay for the provision of home helps. We were glad to have the help of the Women's Cooperative Guild in securing that additional boon. We were pushing it at the same time, and we eventually succeeded in getting the Treasury to give money without any limit of the amount for the provision of home helps. That is somewhat similar to domestic service; the helpers visit the homes of women who have been recently confined; provide assistance during confinement and afterwards; and, if the mother is ill during pregnancy, see that she has a physician or nurse to attend her.

Dr. S. Josephine Baker (Division of Child Hygiene, Health Department, New York City): It is a very great pleasure to have heard Sir Arthur Newsholme speak of the control of the midwife in England, because it is exactly duplicated by our control in New York City. We have a six months' preliminary education at municipally controlled schools for midwives.

By the constant supervision of the midwife, and the elimination from practice of every midwife who violates our regulations, the number of practicing midwives has been reduced in ten years from 3,000 to 1,600. There is one sure way of eliminating the midwife, and that is to educate her. Midwives are a condition and not a theory. In seeing what can be done with midwives it is essential to remember that poor people who have to deal with them are guided by practical considerations rather than by academic theories.

I think Dr. Chapin quite unwittingly did us a little injustice when he said the infrequency of stillbirths and the low mortality among mothers and babies attended by midwives were due to the fact that hard cases were transferred to the doctors. That is true, but they were counted against midwives. Every case that had a midwife in attendance at any time was counted as a midwife case. Of course the complicated cases went to the doctors and were reported by them as deaths, but not reported against them in the final sense. But that shows what have been the practical results of the control of midwifery in New York City.

I think that we can grant that whatever improvement has been made in obstetrical practice in New York has been counterbalanced by the improvement of obstetrical practice in every other large city in the country. Why is it then, that in a study of the maternal mortality rates in seven large cities of the United States, made by the Children's Bureau, these rates were shown to be increasing or stationary in every one of them with the exception of New York City, and New York City showed a decrease? The only difference between New York City and the other cities is our method of control of midwives.

Beginning ten years ago with no method of finding out whether there were cases of blindness, we had literally thousands of cases of ophthalmia, and literally hundreds of cases of blindness—no way of computing how many we had. Last year—we do not claim these are exact figures—with the most painstaking methods that we could devise by a follow-up of every case of sore eyes reported by the midwife, by a follow-up at the hospitals where ophthalmic cases might come, by every means we could devise to control the situation, we found that out of 135,000

births in New York City we had 35 cases of ophthalmia and one case of blindness.

Nothing that I know of has changed in regard to the practice of doctors, but a very great deal has changed in regard to the practice of midwives. I am an advocate for the strongest kind of supervision, the most thorough control, and above all the education of the women to such a high standard that only a woman of extraordinary intelligence and ability will be able to be a midwife.

Dr. Mary Sherwood (Baltimore, Maryland): It occurs to me that possibly we might look at this from another angle. There is no topic that provokes so much discussion as this question of the midwife. And after all it is not the question of whether the midwife is better than the doctor, or whether the doctor is better than the midwife. The question is, is the midwife or the poorly trained doctor good enough?

Is there anyone who will discuss the practice of obstetrics from the point of view of surgery? Is not obstetrics a branch of surgery, and is it not entitled to the kind of care we are inclined to give, and always do give to a hospital matter—surgical operating room, all the appliances of modern surgery, all the precautions of modern surgery? Is obstetrics something that can be compromised with poor doctors and with midwives?

Dr. Helen MacMurchy (Department of the Provincial Secretary, Toronto, Canada): I think the best way to make students understand that it is a matter of surgery is to make them realize that at the time of birth we have to care for what is really an enormous open wound. Of course it is quite true that that wound is physiologically produced. It is quite true that the danger of infection through that wound is very much reduced by the wonderful provision of nature for shutting these gaping avenues of infection. But nevertheless that is what it is.

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