MIDWIFE PRACTICE

IN the United States the midwife has been regarded until recently as a necessary evil to be done away with as soon as possible and in the interval to be disregarded on the general principle, one supposes, that if she is not noticed she will cease to exist. Provisions for the proper education, registration, and supervision of midwives, who attend approximately 10 to 12 per cent of the births in the country, are exceedingly inadequate in most states of the Union.

These conditions are the result of various factors. In the early history of the country and throughout the expansion westward, attention to social and medical problems was subservient to the immediate necessities of food and shelter. Since there was neither time nor money to set up schools for midwives, every woman was a potential midwife as she is today in many rural areas of the country. But in this country the midwife had no such status as in Europe, where by long custom a male attendant at delivery was unthinkable, and the population was trained to regard the midwife as the normal and most suitable attendant for all but the difficult and complicated confinements.

By the time training for specialized types of professional service became a possibility in the new country that the United States still was, the principle of male midwives was gaining wide acceptance in Europe. Thus it came about that the only training in midwifery provided in this country was designed to prepare the physician to act as accoucheur as well as general medical practitioner. This did not mean that the midwife was not practicing widely; she was, but without training

or supervision of any kind. The woman who lived at long distance from a doctor, as the frontier women did, had to accept the hazard of attendance by a midwife. Those to whom a doctor was available and who could afford his services sought him out. The midwife was accepted by those who could do no better. This resulted in a social barrier to the use of midwives which still exists today. With the beginning of large-scale immigration, foreign-born groups settled in various communities, bringing Old-World attitudes toward midwives and the midwives themselves, who had been trained in the countries of their origin. This factor also strengthened the feeling which exists today that only the foreign-born or the very poor should be attended by midwives, and then only because they can afford no better.

A large number of the practicing midwives in New York City are foreign-born women who were trained in the country of their birth and came to this country and began the practice of midwifery before the present laws regarding licensure were put into effect. There is no provision in the law for examination or required "refresher" courses. It is a little hard to believe that a woman of sixty, wholly illiterate, trained forty years ago and having had no further study since that time, can be a safe attendant for a woman during her pregnancy and delivery. Yet just such women are practicing midwifery in New York City.

Laws designed to regulate midwife practice came long before any attempt to provide proper and sufficient training. The result can be imagined. Training, purely by practice or apprenticeship, could not long keep pace with the advances in the theory and practice of obstetrics. There were large numbers of women who practiced casually as midwives without training and without sufficient clientele to gain that training or increase it by experience. Such a condition of affairs, while

not officially accepted, is tacitly condoned in those states where there is no provision for training.

The practice of the midwife in New York City, as elsewhere in this country, is of course confined to the home, and that factor alone tends to determine the type of patient who comes to the midwife. Domiciliary obstetrical practice is largely confined to the foreign-born and the economically less fortunate portions of the population. The average American woman living in a city has come to believe, rightly or wrongly, that a hospital is the only safe and proper place in which to be delivered. But this is not so true of the foreign-born woman nor, in many cases, of the woman of foreign extraction. She prefers being delivered at home and her training and attitudes lead her to seek a midwife. Her assimilation in this country is altering those attitudes, but it is questionable whether that alteration is working to her advantage.

It was not until 1911 that the first school for midwives was established at Bellevue Hospital. That school is still in operation and while there have been others at different times in recent years, there is, at present, only one other school in New York City. This was recently established for the training of nurses in midwifery. There are now only three or four schools for midwives in the entire United States, although this does not give a fair estimate of the attempts at training. Many private physicians train midwives informally by giving them practical instruction as assistants in their regular obstetrical practice. This is a casual, unregulated, and variable type of training which should not be looked upon as any solution of a pressing problem.

In New York City the problem of the midwife is a special one as it relates to her integration into a densely peopled urban community where she cannot be regarded merely as a stop-gap.

The regulation and licensure of midwives in New York City is a function of the Board of Health. At present there are 863 licensed midwives who attend approximately 10 per cent of the births annually. The law requires the midwife, in order to qualify for a license, to be a graduate of a school of midwives which is accepted by the Board of Health, but there are still many midwives in practice who obtained their licenses before this ruling went into effect. No annual re-registration is required, as is the case with physicians licensed to practice in the state. Supervision of the midwife includes a monthly visit by a nurse appointed by the Board of Health who examines her bag and her home conditions. The midwife must make quarterly reports to the Board of Health of all cases delivered by her during the period. She must report births within ten days. She is subject to an investigation in the case of a maternal death. This is the extent of the meager supervision exercised over her. No properly trained supervisor ever sees the patients delivered, and the quarterly reports may or may not be an indication of the quality of her work. There is no rule which requires the midwife to call a physician after a stipulated number of hours of labor. In many instances the midwife would be very grateful for such a rule to uphold her in her demand for help when the family refuses to accept her advice. So long as she does not get into trouble through the misfortune of having a maternal death, she is allowed to go along practically unsupervised.

In addition to this lack of official supervision and help, the midwife is constantly suffering from difficulty in the attitude of the agencies and individuals to which she ought to look for help, guidance, and cooperation. She is taught to make an attempt to have her patients get adequate prenatal care, but when she tries to do this she may meet with obstruction or entire refusal to cooperate. Clinics to which she sends her pa-

tients for care will attempt to dissuade the patient from entrusting herself to the midwife and to induce her to come to the hospital instead. Doctors will, more often than not, refuse any cooperation in the matter of prenatal care. Even when the midwife seeks assistance during delivery, she may meet with a lack of cooperation that cannot be too emphatically censured.

In marked contrast to this state of affairs is the European attitude. There the midwife is accepted by all elements of the population, official and social. She is properly trained and adequately supervised and always integrated into the general community plan of maternity service and care. The leaders of the medical profession regard her generally with respect, not disdain. She is a member of a skilled profession with a professional dignity and professional standards.

In only a few parts of this country is she so regarded. In the Kentucky mountain regions, where doctors are few, there has arisen a frontier nursing service for the care of the mountain women during pregnancy and delivery as well as for general medical care of the population. This service is performed by nurse-midwives under the most difficult and hazardous circumstances in a population where poverty, ignorance, inadequate feeding, and uncleanliness are the rules of life. A doctor is available for consultation and assistance in difficulties and for performing obstetrical operations.

In this study we visited and interviewed every midwife who was in any way associated with one of the deaths under examination. We attempted to discover from the midwife her complete professional history: her training and length of time in practice, her technique and routine methods, her results as she viewed them, as well as the details of the case under consideration. From all the data and from the general impression arising out of the interview, we have attempted an

evaluation of the midwife's competence. The usual procedures have been followed in recording the case and determining the cause of death and preventability.

We were able to locate and interview 59 midwives who had either delivered or been in contact with a patient preceding her death.

Thirty-one were either Italian-born or of Italian extraction; 22 had been practicing without additional training for twenty years or more; 17 were graduates of the Bellevue School of Midwifery; 17 had been trained in European schools; 10 had been trained by private physicians; 1 had been trained forty years ago by a sister who was a midwife in Italy.

Nineteen we judged to be competent, 20 were thought to be only fairly competent, and 20 were incompetent. In judging competence, some effort was made to determine what knowledge the midwife had of the possible complications of pregnancy and how she was prepared to meet them: her ability to judge presentation, her technique as to sepsis, the use or non-use of gloves, method of making examinations, preparation for delivery as regards antiseptics, sterile goods, etc. In addition, an effort was made to evaluate her personal qualifications for her work. There were all gradations—from the seventy-six-year-old Italian who had never heard of prenatal care and had no idea of even ordinary cleanliness and was in every way inadequate to her task, to the intelligent young graduate of the Bellevue School of Midwifery who usually saw her patients early in their pregnancies, gave prenatal care under the supervision of a doctor, was thoroughly clean, understood asepsis, and was in every way equipped for the work she was doing.

Among all the deaths, exclusive of those following extrauterine gestation or abortion, 48 followed delivery by a mid-

wife. In 2 other cases death occurred before delivery could be effected; in 30 cases the midwife had been in attendance on the patient for a more or less protracted period during labor; in 5 cases, the midwife's contact with the patient had been brief—merely seeing the patient and immediately calling a doctor or sending her to a hospital. The midwife thus had contacts with 85 of the patients, or 5.4 per cent of the total number.

Tables 82 and 83 give the puerperal death rate per 1,000 live births classified according to attendant. These rates are

TABLE 82

DEATHS CLASSIFIED BY ATTENDANT AT DELIVERY

(*Exclusive of deaths following abortion and ectopic gestation*)

	TOTAL	PHYSICIAN		MIDWIFE, DELIVERY ONLY	NONE OR OTHER
		TOTAL	HOME DELIVERY*		
Total live births	348,310	318,701	72,496	29,519	90
Total deaths	1,564	1,442	136	48	74
Death rate per 1,000 live births	4.5	4.5	1.9	1.6	—

*Included under "Physician, total."

TABLE 83

DEATHS CLASSIFIED BY ATTENDANT AT DELIVERY, WITH CORRECTION FOR MIDWIFE CONTACTS

(*Exclusive of deaths following abortion and ectopic gestation*)

	TOTAL	PHYSICIAN		MIDWIFE, DELIVERY AND CONTACT	NONE OR OTHER
		TOTAL	HOME DELIVERY*		
Total live births	348,310	318,701	72,496	29,519	90
Total deaths	1,564	1,406	130	85	73
Death rate per 1,000 live births	4.5	4.4	1.8	2.9	—

*Included under "Physician, total."

presented only for those cases dying at or after the twenty-eighth week of gestation and those cases of less than twenty-eight weeks' gestation who died undelivered. The midwife does not deal with abortions or ectopic gestations and for that reason it was thought just to exclude those figures entirely when the data are shown in reference to the midwife. To insure still further accuracy in attempting to compare the results obtained by midwives with those obtained by physicians, the cases attended by physicians were considered in two ways: all cases attended by physicians, and cases attended by physicians at home. This last group offers the fairer ground for comparison.

The general maternal death rate for all cases, exclusive of abortions and ectopic gestations, is 4.5 per thousand live births, while that for cases delivered by the physician at home is 1.9 and for cases delivered by the midwife, 1.6. This last figure is 64 per cent below the general rate and slightly lower than the rate for cases delivered by physicians at home. It is proper to note that not all deliveries attended by physicians at home terminate spontaneously, as do those attended by the midwife, and the comparability of the two series is thus somewhat vitiated. It must, however, be accepted that there is no great disparity in the results obtained under circumstances almost exactly similar. We shall analyze still further the other variable factors.

Table 83 presents the figures and rates in the same way with the figures reclassified to include in the group ascribed to the midwife all those cases in which the midwife had any contact with the patient during her pregnancy or labor as well as those actually delivered by midwives. Out of the total of 1,564 deaths, the midwife attended 48 cases at delivery, which represents a rate of 1.6 per 1,000 live births. The midwife attended at some time, but without delivering, 37 addi-

tional cases—a total of 85 cases in which the midwife either delivered or had some contact with the patient. This figure gives a rate of 2.9, which is still lower than the rate of 4.4, the corrected figure for physicians, and 1.1 higher than the resulting rate for physicians delivering at home.

In drawing any conclusions from these figures, two factors must be considered. First, the nature of the contact varied from the cases in which the midwife saw the patient only once and immediately called a physician or sent her to the hospital, to the cases in which she remained with the patient while in labor and only called assistance when some disquieting symptom became evident. It did not appear that in any large percentage of these cases the midwife could properly be held accountable for the outcome of the case. Further, it must be remembered that there were cases delivered in hospitals which had been previously treated by physicians at home, and in order properly to compare the two groups, it would be necessary to add this number to those delivered by physicians at home. Where this is done we find an additional 33 patients who had care at home during labor by a physician before being removed to a hospital where the delivery was completed by another physician. Thus the physician delivered at home, or had home contact with, 163 patients, which is a rate of 2.2 per 1,000 births, while the midwife had contact with, or delivered, 85 patients with a resultant rate of 2.9.

The conclusions arising from these figures must be that there is no great disparity between the results of the work done by the two groups.

In Table 84 the distribution of all the deaths is given according to the cause of death and the attendant. Though the total figure is too small to make percentages significant, it is convenient to present the data in the form already established. Septicaemia is seen to be the cause of death in the

TABLE 84

DEATHS BY CAUSE AND ATTENDANT AT DELIVERY

(Exclusive of deaths following abortion and ectopic gestation)

	TOTAL		PHYSICIAN				MIDWIFE		NONE OR OTHER	
			TOTAL		HOME DELIVERY*					
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Total	1,564	100.0	1,442	100.0	136	100.0	48	100.0	74	100.0
Hemorrhage	197	12.6	174	12.1	7	5.1	9	18.8	14	18.9
Puerperal septicaemia	510	32.6	473	32.8	58	42.6	24	50.0	13	17.6
Albuminuria and eclampsia	231	14.8	208	14.4	15	11.0	5	10.4	18	24.3
Pernicious vomiting	14	.9	10	.7	3	2.2	—	—	4	5.4
Phlegmasia alba dolens and embolus	89	5.7	85	5.9	12	8.8	2	4.2	2	2.7
Accidents of labor	171	10.9	168	11.7	10	7.4	2	4.2	1	1.4
Accidents of puerperium	8	.5	8	.6	—	—	—	—	—	—
Extra-puerperal causes	344	22.0	316	22.1	31	22.8	6	12.5	22	29.7

*Included under "Physician, total."

largest proportion of cases for all attendants. The second most important cause of death among those cases which were attended by a midwife was found to be hemorrhage, while extra-puerperal causes occupied this position in the series as a whole. These results are to be expected in view of the fact that the midwife is not attending those cases requiring operative interference or having grave pregnancy toxaemias or serious illness of any sort.

Table 85 shows the distribution of deaths according to gravidity and attendant. The table lacks rates per 1,000 births, since figures for the births according to this distribution are not available. Throughout the series, deaths among multigravidae predominate—inevitably, since births among multigravidae greatly outnumber births of primigravidae. The division of deaths between those bearing the first child and those having borne previous children shows that the proportion of multigravidae is greater among those attended by physicians at home (71.3 per cent to 27.9 per cent) than it is in the series as a whole (55.9 per cent to 43.6 per cent) and still greater among those attended by midwives (79.2 per cent to 20.8 per cent). What these figures indicate as to the hazards involved for the two groups with different attendants is, of course, not to be learned from such a table since the distribution of births by gravidity is prerequisite to any attempt at such an evaluation.

It is not unexpected to find (as Table 86 shows) that the midwife has a larger percentage of foreign-born women among her fatal cases than the series as a whole or the physician. Of the 48 women who died under care of a midwife, 29, or 58.7 per cent, were foreign born while in the whole series only 43.8 per cent were foreign born. The cases in this series delivered by physicians showed 43.6 per cent foreign women, while of those delivered by physicians at home 50.0 per cent

TABLE 85

DEATHS BY GRAVIDITY AND ATTENDANT AT DELIVERY

(Exclusive of deaths following abortion and ectopic gestation)

	TOTAL		PHYSICIAN				MIDWIFE		NONE OR OTHER	
			TOTAL		HOME DELIVERY*					
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Total	1,564	*100.0*	1,442	*100.0*	136	*100.0*	48	*100.0*	74	*100.0*
Primigravidae	682	*43.6*	653	*45.3*	38	*27.9*	10	*20.8*	19	*25.7*
Multigravidae	874	*55.9*	784	*54.4*	97	*71.3*	38	*79.2*	52	*70.3*
Gravidity not reported	8	*.5*	5	*.3*	1	*.7*	—	—	3	*4.1*

*Included under "Physician, total."

TABLE 86

DEATHS BY NATIVITY AND ATTENDANT AT DELIVERY

(Exclusive of deaths following abortion and ectopic gestation)

	TOTAL		PHYSICIAN				MIDWIFE		NONE OR OTHER	
			TOTAL		HOME DELIVERY*					
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Total deaths	1,564	*100.0*	1,442	*100.0*	136	*100.0*	48	*100.0*	74	*100.0*
Foreign-born	686	*43.8*	629	*43.6*	68	*50.0*	29	*58.7*	28	*37.8*
Native-born	878	*56.2*	813	*56.4*	68	*50.0*	19	*41.3*	46	*62.2*

*Included under "Physician, total."

were of foreign birth. The general puerperal death rate among foreign-born women is considerably higher than that among the native-born. We have no figures to show how many native and foreign-born women in all were attended by midwives, but it is generally accepted that the midwife attends more foreign-born than native-born women, and, if this is true, she is attending a group of women whose childbearing as a group is more hazardous than the average, with results better than average.

In Chapter V, page 148 *et seq.*, we have discussed the classification of our cases according to the economic status of the patient. Some of the data given there are repeated here for the light they throw on the present discussion. The general death rates for the various economic groups, presented in Table 87 (compare Table 62) should be kept in mind in the study of Table 88 (compare Table 64) which gives the distribution of deaths by economic group for each type of attendant.

Thus, while 17.6 per cent of all the deaths occurred in Group A, 43.8 per cent of the fatal cases delivered by midwives belonged to this group, 19.1 per cent delivered at home by physicians, and 16.3 per cent of all deaths delivered by physicians whether in home or hospital. Of all fatal cases delivered by midwives, 79.2 per cent came from Groups A and

TABLE 87

DEATHS BY ECONOMIC GROUP

(Exclusive of deaths following abortion and ectopic gestation, and of non-resident births and deaths)

	TOTAL	GROUP A	GROUP B	GROUP C	GROUP D
Total live births	341,879	56,019	155,457	125,241	5,162
Total deaths	1,520	275	653	572	20
Death rate per 1,000 live births	4.4	4.9	4.2	4.6	3.9

TABLE 88

DEATHS BY ECONOMIC GROUP AND ATTENDANT AT DELIVERY

(Exclusive of deaths following abortion and ectopic gestation)

	TOTAL		PHYSICIAN				MIDWIFE		NONE OR OTHER	
			TOTAL		HOME DELIVERY*					
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Total	1,564	*100.0*	1,442	*100.0*	136	*100.0*	48	*100.0*	74	*100.0*
Group A	275	*17.6*	235	*16.3*	26	*19.1*	21	*43.8*	19	*25.7*
Group B	653	*41.8*	600	*41.6*	65	*47.8*	17	*35.4*	36	*48.6*
Group C	572	*36.6*	547	*37.9*	41	*30.1*	10	*20.8*	15	*20.3*
Group D	20	*1.3*	20	*1.4*	1	*.7*	—	—	—	—
Non-resident	44	*2.8*	40	*2.8*	3	*2.2*	—	—	4	*5.4*

*Included under "Physician, total."

B, while of all live births during the period, only 61.9 per cent belonged in these two groups. It may be inferred that the midwife is working in homes where the surroundings are of the poorer and less well-equipped type. Forty-three and eight-tenths per cent of all the deaths following midwife deliveries were in definitely slum areas, with all that means in uncleanliness and overcrowding.

In Table 89 we show the results when preventability is indicated according to the attendant. This table shows a higher percentage of preventability (75.0 per cent) in the deaths among women attended by midwives than among the cases in general (62.9 per cent) or among those attended at home by a physician (61.0 per cent).

When the figures are further subdivided to show to whom the responsibility was ascribed, the division of those cases where delivery was by a physician shows the attending physician responsible in 74.2 per cent of the cases, the patient in 24.7 per cent, and the midwife in 1.1 per cent. Among the preventable deaths where delivery was attended at home by a physician, the responsibility was ascribed to the physician in 54.2 per cent of the deaths, to the patient in 44.6 per cent, and to the midwife in 1.2 per cent (one case). The division of the responsibility in the cases delivered by midwives shows the physician responsible in 19.4 per cent, the patient in 27.8 per cent, and the midwife in 52.8 per cent of the cases. Those instances in which midwives were held responsible for deaths following deliveries by physicians, and vice versa, were due to transfer of the cases from the midwife to the physician in the course of labor.

In forming a judgment as to preventability of death in the cases attended by midwives, the Advisory Committee has been inclined to ascribe the responsibility to the midwife except where it was clearly shown that such could not be the

TABLE 89

DEATHS BY PREVENTABILITY AND RESPONSIBILITY OF ATTENDANT AT DELIVERY

(Exclusive of deaths following abortion and ectopic gestation)

	TOTAL		PHYSICIAN				MIDWIFE		NONE OR OTHER	
			TOTAL		HOME DELIVERY*					
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Total deaths	1,564	*100.0*	1,442	*100.0*	136	*100.0*	48	*100.0*	74	*100.0*
Not preventable	581	*37.1*	548	*38.0*	53	*39.0*	12	*25.0*	21	*28.4*
Preventable: total	983	*62.9*	894	*62.0*	83	*61.0*	36	*75.0*	53	*71.6*
Responsibility ascribed to										
Physician	678	*69.0*	663	*74.2*	45	*54.2*	7	*19.4*	8	*15.1*
Patient	276	*28.1*	221	*24.7*	37	*44.6*	10	*27.8*	45	*84.9*
Midwife	29	*2.9*	10	*1.1*	1	*1.2*	19	*52.8*	—	—

*Included under "Physician, total."

case. There is so little uniformity in the training of the midwife that there is no *a priori* assumption of her familiarity with the fundamentals of her work as is the case with the physician. The result represents the highest possible figure for the percentage of preventable cases among those attended by midwives.

Puerperal septicaemia is, of course, the most frequent cause of death in the whole series examined, as we have shown in Table 84. Death was caused by septicaemia in 50.0 per cent of the cases delivered by midwives, and in 32.6 per cent of all the cases. This is only an apparent preponderance of septicaemia in cases attended by midwives, as Table 90 indicates. This table shows the rate of fatal puerperal septicaemia per 1,000 live births classified according to the attendant. The general rate is 1.5 per 1,000 live births while the rates for those delivered at home by physicians and by midwives were both .8. This fact may be regarded as potentially very significant in relation to septicaemia, as these two groups are similar and comparable; the deliveries are non-operative and are conducted under home conditions which are not of the best.

The figure for total deliveries by physicians shows a rate nearly double that of the home deliveries. The operative in-

TABLE 90

SEPTICAEMIA DEATHS CLASSIFIED ACCORDING TO ATTENDANT AT DELIVERY

	TOTAL	PHYSICIAN		MIDWIFE	NONE OR OTHER
		TOTAL	HOME DELIVERY*		
Total live births	348,310	318,701	72,496	29,519	90
Septicaemia deaths	510	473	58	24	13
Septicaemia death rate per 1,000 live births	1.5	1.5	.8	.8	144.5

*Included under "Physician, total."

cidence in hospitals is perhaps chief among the manifold factors which may account for this. The home is not regarded as a suitable theatre for operative work and labor is allowed to proceed to its spontaneous conclusion. It is to be considered whether or not the facility with which interference can be undertaken in a properly equipped hospital does not tend to increase the incidence of such interference regardless of real indications—witness the term "prophylactic forceps," which name alone puts the indication for it, not in existing circumstances, but in future eventualities. As we have said, the circumstances of the home preclude that. The home is, moreover, less contaminated by virulent organisms; the patient has fewer attendants and is not in close proximity to other patients who may be a source of infection. There is, however, no possible way of arriving at a just figure for the septicaemia rate in spontaneous deliveries because the rate taken from deaths following spontaneous deliveries must be determined on a figure including all deliveries, no figure for the total incidence of spontaneous deliveries being available. It is evident that this lowers the rate in question in proportion to the percentage of operative deliveries in the total deliveries.

The highly trained specialist is not working in the home; that type of practice is largely confined to the general practitioner, so we may not ascribe the results to a higher degree of skill. It is rather to the combination of the circumstances to be met with in the home—spontaneous deliveries and uncontaminated surroundings with proper attendants—that we must look for an explanation. From the figures it would appear that domiciliary obstetrical practice must undergo further consideration and probable re-evaluation.

We have presented the data relating to the midwife with the results and conclusions which have been set out in their proper place. To the Committee it seems fair to say that con-

trary to the generally accepted opinion, the midwife is an acceptable attendant for properly selected cases of labor and delivery. There has never been a contention that she has any place except for the normal delivery at home, but we have seen that her results are as good as those obtained by the physician under what are justly regarded as comparable circumstances and for comparable cases.

Of the midwives seen and interviewed, it is significant and must be borne in mind that less than a third were judged to be competent and in the face of incompetence or only fair training and ability the results were by no means prejudicial to the midwife.

It is proper to consider what the desired end in midwife practice and control should be. Proper training is the first requisite and there is an increasing tendency among part of the medical profession to see that it is provided. Very recently a new school has been established under the supervision of a group of obstetricians for the purpose of training nurses as midwives. After proper training there must be suitable, adequate, and cooperative supervision and control of that practice.

The midwife should have a position in the scheme for providing maternity care. It remains for the medical profession to define what that position should be. She is able to supply attendance and nursing care for a smaller compensation than the costly training of a physician requires, but the necessity for every woman to have adequate care during pregnancy and at delivery, and to have the services of a physician if and when those services are needed, must be kept in mind.

It is necessary, first of all, to provide midwives who are properly trained. It would not seem absolutely necessary that a nurse's training be a prerequisite to training as a midwife, but in order to extend the practice of employing midwives as

accoucheuses in normal parturition, a different type of woman must be brought into the field. The present type of non-nurse midwife would prove wholly unacceptable to certain classes of the community. While the only slightly educated woman with adequate training may be a capable midwife, the more educated patient will demand a different type of attendant. The two groups need not be mutually exclusive. There should be opportunities for both to receive the necessary training.

The standards met by such a school as that maintained by Bellevue Hospital would insure adequately trained women. Licensure should then follow an examination to prove the candidate's fitness for her work. The midwife should be encouraged and, if necessary, required to return for short courses at certain intervals. Her training must prepare her to understand the mechanisms of normal labor and delivery. She must be able to detect the signs of the abnormalities of pregnancy, and she must be able to measure the pelvis accurately. She must be thoroughly familiar with a simple method for maintaining asepsis. Finally, she must be equipped to give suitable care to both mother and infant during the puerperium.

It is to be desired that every woman be examined during pregnancy by a properly qualified obstetrician. In this way, abnormalities, constitutional defects, and possible sources of danger to the mother or foetus may be properly managed. This is essential; but if the inclination is to attempt to induce the patient to give up the services of a midwife for no better reason than that she is a midwife, it is impossible to expect the midwife to cooperate with a group who stand ready to undermine her practice. Such practices between physicians have met with violent denunciation; between the physician and

midwife they are deserving of the same censure. If she is to be expected to cooperate with the physician, the physician must be ready to cooperate with her. If scrupulous fairness were exercised in the matter of judging the suitability of individual cases for midwife care, cooperation by the midwife would be forthcoming. It would be destructive of her own interests to withhold it and if she knew that she was to be held strictly accountable for the results if she failed to advise her patient to seek medical advice, there would be no difficulty.

Supervision should be extended and given some real meaning both as a check on the midwife and as an aid to her. She should be required to report births within forty-eight hours, and such reports should be followed by visits of an adequately trained supervisor. Nurse-midwives could no doubt be used admirably in this capacity with physicians directing them. In this way the disturbances of the puerperium could be guarded against and quickly treated.

A set of regulations concerning the conduct of labor would be necessary to a proper supervision. The requirement that a physician be called after a stipulated number of hours in labor would greatly assist the midwife in avoiding the difficulties of obstructed labors. Physicians must be ready to give her assistance when she needs it.

In many instances poorly trained, always inadequately supervised, the object of only faintly disguised and often open antagonism, lack of cooperation, and contempt, the midwife still attends almost 10 per cent of the deliveries of New York City with as good results both for mothers and babies as the physicians under similar circumstances. We believe she has proved her value in face of the pressing problem of assuring proper care for all women at an outlay that is not prohibitive.

Without her, those women who cannot afford physicians must become city charges, and we know that the municipal facilities could not stand this further strain.

The medical profession must accept the midwife as one of its adjuncts. Physicians must make themselves responsible for her proper training and supervision as such. They must regard her as an ally in the effort to reduce the morbidity and mortality associated with childbearing. Both officially and privately, there must be an alteration in the prevailing attitudes toward her. There must be a readiness to cooperate with her to insure the results both physician and midwife are anxious to achieve.