

THE AMERICAN MIDWIFE CONTROVERSY: A CRISIS OF PROFESSIONALIZATION

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Although medicine itself has long been an established profession, many of the specialties within medicine have a much shorter history. This diversification is a result not simply of developments within the field itself but has also depended upon the attitude of potential patients—their feeling of a need for such specialization and their ability to take advantage of it. The role of this external factor, however, has varied considerably in the historical development of the several specialties. Surgery became differentiated as soon as the techniques developed enabling it to be practiced safely, whereas other specialties, such as dermatology, plastic surgery, or orthodontics, had to wait until a public attitude evolved which considered ills far less serious than malaria (itself once thought a natural state) as unnatural conditions which require treatment.

Such a specialty was obstetrics, which dealt with what many still consider to be the “natural process” *par excellence*. In the obstetricians’ struggle for universal acceptance they faced both medical and non-medical competition and an almost insuperable economic problem; the level of even the best obstetrical work was almost more of a hindrance than a help. The decade from about 1908 began the contest between the increasingly self-conscious obstetrical specialist and his adversaries, the midwife and her advocates. That such a debate could be carried on with great virulence is itself indicative of the importance of considerations other than the strictly medical. The result, the complete defeat of the United States’ variety of midwife and the essential triumph of a “single standard of obstetrics,” was not simply a function of the maturity of the obstetric profession.

In the United States in 1910, about 50% of all births were reported by midwives,¹ and the percentage for large cities was often higher. At the same time, and continuing well beyond this peak period, the maternal death rate in the United States was the third highest of countries which kept such records.² Midwives were employed primarily by Negroes and by the foreign-born and their children, and the midwives themselves

¹ Thomas Darlington, “The present status of the midwife,” *Am. J. Obst. & Gynec.*, 1911, 63: 870.

² E. R. Hardin, “The midwife problem,” *South. M. J.*, 1925, 18: 347.

usually shared race, nationality, and language with their customers.³ Because this was a period of unrestricted and heavy immigration (one-third of the population was foreign-born or Negro),⁴ the midwife population was swollen considerably.

At this time also, various local medical units in the nation began to assess the situation in their areas, and this resulted in a flood of articles and addresses on "the midwife problem in ———." The big eastern cities, most affected by the heavy immigration, were the most diligent in this regard and produced the bulk of the available data. In 1906, New York commissioned a study which revealed that the New York midwife was essentially medieval, very different from European midwives, for these did not emigrate as rapidly as those who expected such service. According to this report, fully 90% were "hopelessly dirty, ignorant, and incompetent."⁵ These revelations resulted in the tightening up of existing legislation, and the creation of new, for the licensing and supervision of midwives and eventually in the establishment of the Bellevue School for Midwives, an institution which lasted for thirty years. Other areas reported similar conditions.

The major failing of the midwife, which this legislation was to correct, was responsibility for maternal deaths from puerperal sepsis and for neonatal ophthalmia, both preventable with the knowledge available at the time. But it became clear during the controversy that occurred over how to deal with this problem that the midwife was by no means the sole offender in these matters. A survey of professors of obstetrics reached the conclusion that general practitioners were at least as negligent as midwives, as well as being equally responsible for preventable deformities.⁶ The overall picture of the obstetrical possibilities open to a prospective patient was not very good. Hospitalization was impossible for all but the very rich or the charity cases in the wards, obstetricians were few, and general practitioners unreliable. Use of a midwife involved many hazards, despite the fact that she was usually a sympathetic woman who would wait and work with the natural labor process (often, of course, for too long) and would also in many cases be in regular attendance for more than a week afterwards, not only caring for mother and infant, but

³ See nearly any discussion of the subject at this period, e. g., Darlington, *loc. cit.*; J. Clifton Edgar, "The remedy for the midwife problem," *Am. J. Obst. & Gynec.*, 1911, 63: 882.

⁴ Darlington, *ibid.*

⁵ Edgar, *loc. cit.*

⁶ J. Whitridge Williams, "Medical education and the midwife problem in the United States," *J. A. M. A.*, 1912, 58: 1-7.

also assuming such duties as were necessary to keep the household functioning normally.

The most obvious cause of this medically unsatisfactory situation was the general opinion that the midwife was an adequate birth attendant. Her success was due to the fact that the rigors of childbirth were still considered normal and risks in the process unavoidable. The general attitude was that nature really controlled the process so that there was little constructive assistance that could be given. This feeling was clearly dominant among the public, although there were signs of change; it was also an important attitude within the medical profession as a whole. One observer, in assessing the lack of interest in obstetrics generally, noted that the word "obstetrics" comes from a Latin word meaning "to stand before" and added, "or as a sneering colleague once said, 'to stand around.'"⁷

The best evidence that this was the judgment of the medical profession was the status of the teaching of obstetrics in United States medical schools. Dr. J. Whitridge Williams, professor of obstetrics at Johns Hopkins University, made a comprehensive report on obstetrics as it was studied in United States medical schools in 1912; he found that although medical schools had been improving rapidly, obstetrics was by far the weakest area.⁸ He sent a questionnaire to professors of obstetrics of 61 schools rated by the American Medical Association as acceptable (they required entrants to have at least a high school degree) and to 59 non-acceptable schools, receiving 32 and 11 replies respectively. Among his results were the following: Of the 42 professors of obstetrics, only five limited their outside practice to obstetrics, 21 to obstetrics and gynecology, and 17 were in general practice. Only ten had served in lying-in hospitals for more than six months. Only nine had seen more than a thousand cases of labor as preparation for their post, 13 had seen fewer than 500, five fewer than 100, and one had never seen a woman deliver. Six schools had no connection whatsoever with a lying-in hospital for teaching purposes, and only nine had as many as 500 cases a year for teaching material. The average medical student witnessed but one delivery, and the average for the best 20 medical schools was still only four. Half the schools required a period of service of less than a year in training assistants for

⁷ C. E. Ziegler, "How can we best solve the midwifery problem," *Am. J. Pub. Health*, 1922, 12: 409.

⁸ Abraham Flexner came to much the same conclusion in his discussion of the clinical years in American medical schools. *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching*. Bulletin no. 4. New York, 1910, p. 117.

their own staff, a level, according to Williams, at which a student is still unable to recognize, much less cope with, a serious emergency. Several of the professors admitted that they themselves were incapable of performing a Caesarean section. Williams concluded that there was only one medical school in the country properly equipped for teaching obstetrics, and he regretted that it was not Johns Hopkins. The result of this neglect of obstetrics, he saw clearly, was that poor schools with poor facilities and poor professors were turning out incompetent products who lost more patients from improper practices than midwives did from infection.⁹

But the obstetricians themselves were fighting this conception of the insignificance of their field. They argued again and again that normal pregnancy and parturition are exceptions and that to consider them to be normal physiologic conditions was a fallacy.¹⁰ It was this view which contributed to much of the unnecessary operative interference that occurred in this period. Amused critics pointed out that women often delivered themselves while their doctors were scrubbing up for a Caesarean,¹¹ but other results, such as the use of high forceps previous to sufficient dilation, were less fortunate for the health of mother or child.

It was these two fundamentally different approaches to the process of childbirth, based on opposite views of its naturalness, which were responsible for many of the arguments which appeared during this period about the future of the midwife. At one extreme were those who advocated outright abolition of midwives, with legal prosecution of those who continued to practice. This was the official attitude of the state of Massachusetts and also that of most eminent obstetricians.¹² Less adamant was a second group, led by Dr. W. R. Nicholson of the Pennsylvania Bureau of Medical Education and Licensure, which favored eventual abolition, with the existing midwives closely regulated until substitutes could be furnished. A third group was pessimistic about ever abolishing the midwife and thus felt that regulation plus education would elevate the midwife to the relatively safe status she had achieved in England and on the continent. This attitude was reported from Newark, New York State generally, and New York City and Buffalo particularly. Finally, there were those, especially in the South, who felt that if, somehow, midwives could be made to wash their hands and use silver nitrate for the babies'

⁹ Williams, *op. cit.*, fn. 6 above.

¹⁰ See for example, J. F. Moran, "The endowment of motherhood," *J. A. M. A.*, 1915, 64: 126; J. L. Huntington, "The midwife in Massachusetts: her anomalous position," *Boston M & S. J.*, 1913, 168: 419.

¹¹ "Discussion—midwife problem," *New York State J. Med.*, 1915, 15: 300.

¹² For an impressive list, see Huntington, *op. cit.*, fn. 10 above, p. 420.

eyes, that would, because of a host of economic and cultural reasons, be the most that could be expected.¹³

Since all but those who held the first position believed that at present there really was no substitute for the midwife, and thus she had at least temporarily to be endured, their views can be conveniently called the public health approach. Their concern was for the immediate future. The first group based its arguments on the necessity of developing obstetrics for the long-term good of American mothers, and so can be identified with the professional approach. An early analyst of this division in medical opinion described it as a conflict between the practical and the ideal,¹⁴ but the actual arguments involved a great deal more than that.

The public health exponents did, in fact, always claim to be realistic, and they accused the professionals of "criminal negligence."¹⁵ The aspects of the situation which they were in a position to consider were certainly important. Since midwives were registering 50% of all births, it did not seem likely that the medical profession could expand sufficiently to take care of all. Some public health officials were not even sure that such expansion was desirable. Arguments against it included the record of the medical profession as a whole, the economic problem of supporting the higher prices charged by doctors, and the attitude of the women themselves. There was also a subterranean problem of status: doctors were often considered less manageable than the more easily supervised midwife.¹⁶

With regard to the question whether the medical profession ever could absorb all the obstetric cases, Dr. Florence E. Kraker of the Children's Bureau in Washington felt that the midwife problem would actually grow as the preference for hospitals and laboratories among doctors increased, causing them to desert rural areas.¹⁷ Even if sufficient expansion were possible, it would still be necessary, according to New York City Public Health official Dr. S. Josephine Baker, to keep midwives and make them safe, because immigrant women, and particularly their husbands, would allow no male attendants. They expected the simple nursing care and household help that a doctor would not provide, and for this they expected to pay the customary small fee. Providing only doctors for these groups

¹³ W. A. Plecker, "The midwife problem in Virginia," *Virginia M. Semi-Monthly*, 1914-1915, 19: 457-458; Jeidell and Fricke, "The midwives of Anne Arundel County, Maryland," *Johns Hopkins Hosp. Bull.*, 1912, 23: 279-281.

¹⁴ A. K. Paine, "The midwife problem," *Boston M. & S. J.*, 1915, 173: 760.

¹⁵ Clara D. Noyes, "The training of midwives in relation to the prevention of infant mortality," *Am. J. Obst. & Gynec.*, 1912, 66: 1053.

¹⁶ *Loc. cit.*, fn. 11 above.

¹⁷ Hardin, *op. cit.*, fn. 2 above, p. 349.

would force them either to pay a higher fee or to use clinics with their implication of charity. Above all, they rejected hospital delivery, which would badly upset the home situation.¹⁸

What encouraged the proponents of the public health view most was the actual progress which had been made through legal recognition, education, and supervision of midwives. England was the chief source of inspiration, since Parliament had, as recently as 1902, established a Central Midwives Board "to secure the better training of midwives and to regulate their practice." Following this change, infant mortality, which had been 151 per 1000 in 1901, dropped to 106, in 1910, with a commensurate decrease in maternal mortality.¹⁹ A committee of the Russell Sage Foundation, after studying the results, was entirely in favor of the change. In particular, they found that rather than replacing obstetrical practice with trained midwives, it had "increased, improved, and upheld the work of the obstetrician."²⁰ Germany was also much admired by those of public health persuasion, since the midwife there was a scrupulously regulated institution, trained in government clinics and working in a set district in a defined relationship with a government doctor.²¹ The level of obstetric training received by German midwives was recognized as superior to that of most United States doctors.²²

Major progress had also been made in the United States itself. Newark, after adopting a program of "conference, lectures and personal visits," reported a drop in the three years, 1914-1916, in maternal mortality from 5.3 to 2.2 per 1000 for the city as a whole, and a level of 1.7 per 1000 among mothers who "received prenatal supervision from the Child Hygiene Division and were delivered by midwives." This was aggressively compared with the rate of 6.5 for Boston, where midwives were banned. For 1916, again, Newark's infant mortality rate below one month was 8.5 for the special category, as opposed to a city rate of 36.4. The reporting of births was greatly improved, silver nitrate was in universal use, and Board of Health Officer Levy was highly pleased with his results.²³ In Philadelphia a similar program, which emphasized in addition control through registration, gave its director "hope to show statistics unequaled

¹⁸ Josephine Baker, "The function of the midwife," *Woman's M. J.*, 1913, 23: 197.

¹⁹ Noyes, *op. cit.*, fn. 15 above, p. 1054.

²⁰ *Ibid.*, p. 1052.

²¹ A. B. Emmons and J. L. Huntington, "The midwife: her future in the United States," *Am. J. Obst. & Gynec.*, 1912, 65: 395-396.

²² Hardin, *op. cit.*, fn. 2 above, p. 347; Emmons and Huntington, *op. cit.*, p. 395.

²³ Julius Levy, "The maternal and infant mortality in midwifery practice in Newark, N. J.," *Am. J. Obst. & Gynec.*, 1918, 77: 42.

in the history of the world.”²⁴ Midwives, more secure in their licensed status, were calling doctors earlier and oftener, neonatal ophthalmia had vanished, and all at relatively little cost.

Besides pragmatically recognizing the midwife's possibilities, many of her promoters felt a strong sympathy for her and her deficiencies. Ira S. Wile defended her on the grounds that it was “unfair to criticize the lack of an educational standard which has never been established.” He felt that abolition was no more the answer than it had been for nurses of the “Sairy Gamp type,” eighteenth century doctors, or present-day obstetricians, all of whom, by absolute standards, were very bad indeed.²⁵ Midwives also gained sympathy from their adherents because of the rudeness with which the “arrogant,” “unrealistic” obstetricians treated them. Those most in favor of the midwife seemed bent on elevating her to a professional status well above that of a nurse. Recognition was to build self-respect and pride; caste and dignity would bring a more intelligent type of woman into the profession.²⁶

It was with these general attitudes that the public health exponents faced the task of elevating the American midwife. The consensus which developed was that midwives should have training for at least six months to a year, including instruction on pregnancy, asepsis, care of labor, and of mother and child after confinement, and, above all, recognition of conditions that indicate when a doctor is needed. These requirements, coupled with legal proscriptions against vaginal examinations, drugs other than laxatives, douches, and the use of instruments, would, they felt, render the midwife a useful member of the community. The further elaboration of linking the midwife to a clinic and to a physician who would make examinations and be available for emergencies was advocated by some, but the problem of maintaining doctors in government employ presented such difficulties that many public health officials were forced to ignore the possibility that a doctor might not be available when needed.²⁷

What is important in the plans discussed and occasionally established by public health officials is that in general these men were not simply embracing a distasteful necessity that would otherwise have been avoided. There were some, of course, who felt this way: the official who established the Philadelphia system was well aware of “the incongruity of allowing

²⁴ W. R. Nicholson, “The midwife situation . . .,” *Tr. Am. Gynec. Soc.*, 1917, 42: 632.

²⁵ “Schools for midwives,” *M. Rec.*, 1912, 81: 517.

²⁶ *Ibid.*, p. 518.

²⁷ See, among others, Hardin, *op. cit.*, fn. 2 above, p. 349; Plecker, *op. cit.*, fn. 13 above, p. 457; J. A. Foote, “Legislative measures against maternal and infant mortality,” *Am. J. Obst. & Gynec.*, 1919, 80: 550; Edgar, *op. cit.*, fn. 3 above, p. 883.

or actively sanctioning by license, the doing of distinctly medical work by non-medical persons. We cannot adduce a single argument in its favor except . . . *necessity*.”²⁸ But the others were expressing an ideal of obstetric service whereby the ubiquitous process of childbirth could be carried on cheaply and easily, respecting modesty and the integrity of the household, and in a more natural and personal way than if rendered by doctors.

The solution offered by the obstetric profession, on the other hand, was not merely an ideal of obstetric care, but also a very realistic solution for the obstetricians' difficulties. Until this last great wave of immigration, graduating obstetricians had always found sufficient numbers of patients. J. L. Huntington, a Boston obstetrician who was partly responsible for Massachusetts' unique position and was the most vocally concerned of the professionals, observed that the midwife was not—yet—a native product of America. She comes with the immigrant, “but as soon as the immigrant is assimilated, . . . then the midwife is no longer a factor in his home.”²⁹ It was this latest influx of immigrants from southern Europe which had given the midwife problem such dimensions, and, if left alone, her numbers would again dwindle with the slowing of immigration. But if she were given official recognition so that immigrants' sons and grandsons expected such service for their wives, the obstetric profession would, he felt, face grave difficulties. Huntington believed, therefore, that the greatest danger in recognizing the midwife lay in the effect of such recognition on the general public. If the midwife was sufficient, then calling a G. P. would be the height of caution, and there would be no need felt for obstetricians.³⁰ He and other obstetricians believed recognition of midwives would set the progress of obstetrics back tremendously. The 50% of all cases handled by midwives were useless for advancing obstetrical knowledge. Elevating the midwife and training her would decrease the number of cases in which the stethoscope, pelvimeter, and other newly developed or newly applied techniques could be used to increase obstetrical knowledge. The need for strengthening obstetrics courses in medical schools would diminish, and practicing doctors would think themselves so superior to the strengthened corps of midwives that they would feel no need for improvement.³¹ Lowering the standard of adequacy would lower all standards.

Because they believed this situation existed, the obstetricians had very

²⁸ Nicholson, *op. cit.*, fn. 24 above, p. 626.

²⁹ Emmons and Huntington, *op. cit.*, fn. 21 above, p. 399.

³⁰ Huntington, “The midwife in Massachusetts,” *op. cit.*, fn. 10 above, p. 419.

³¹ *Ibid.*

different perspectives from the public health exponents. Some physicians felt the arrangement in Germany was far from ideal, so that even if such a system could be transplanted to the United States the resulting standard of obstetrics would be inadequate. Although German midwives learned obstetrics of high quality in their six month course, that time was considered insufficient to instill an "aseptic conscience." Further, even in Germany their relationship with the physician was not one of "perfect harmony." According to Huntington's analysis, since it was profitable for a midwife to deliver each case herself, she might postpone calling a physician in time of danger; the physician, as well, might also be insufficiently cautious if he were called in, since the responsibility for complications remained with the midwife. Huntington argued further that in the United States such a plan would be impossible because (stating clearly the issue which so troubled some public health officials) the American medical profession could never be forced by law to respond to the call of the midwife in trouble.³²

From the professional standpoint, the solution in England was also a bad one. In fact, the more midwives there were, and the more successful they were, the worse the situation would be for the community at large, according to Huntington, because this would aggravate a "double standard of obstetrics." The thirty thousand English midwives had not only taken cases that would have been better cared for by doctors but had also taken enough practice away from physicians to obtain a livelihood.³³ Dr. Charles Ziegler, who was later to become cynical about the whole debate, also complained of the estimated five million dollars collected annually in the United States by midwives "which should be paid to physicians and nurses for doing the work properly."³⁴ The relationship between the ideal of a "single standard" and the issue of economic competition came up clearly again when obstetricians saw the midwife to be in league with "outside" influences—optometrists, osteopaths, neuropaths, Christian Scientists, and chiropractors—who were all invading the legitimate field of medicine.³⁵ Massachusetts had just licensed optometrists; "if the midwives are now to be recognized we may fairly ask, where is it going to end?"³⁶

The professional ideal, of course, was that all women be delivered by an obstetrician, privately, or, if they could not afford such care, in a

³² Emmons and Huntington, *op. cit.*, fn. 21 above, pp. 397-400.

³³ *Ibid.*, p. 394.

³⁴ Charles E. Ziegler, "The elimination of the midwife," *J. A. M. A.*, 1913, 60: 34.

³⁵ *Op. cit.*, fn. 11 above, p. 299.

³⁶ Huntington, "The midwife in Massachusetts . . .," *op. cit.*, fn. 10 above, p. 419.

hospital-medical school complex. Thus, at a stroke, the midwife would be eliminated and the basis established for enormous advances in obstetrics, since students would then get ample training. In suggesting such a system for New York City, Dr. J. Van D. Young felt that even if it were inaugurated at state expense, "the ultimate good to the profession and to the people would be enormous" and rapidly repaid, and, also, that it would attract serious obstetrical students to New York.³⁷

The professionals saw only one way by which their goals could be reached and those of the public health approach thwarted. There had to develop a demand from the public for a higher standard of obstetrics. "We can teach the expectant mother what she deserves, and when she demands it she will get it."³⁸ They urged accordingly that every mother has a right to such care as shall preserve her and hers in life and health, the care which, they said, the midwife cannot provide since the necessary skills are difficult to teach. Combating the "fallacy" of normal pregnancy and delivery was necessary not only to enhance the value of obstetric skills but also to make the American mother not merely respect, but fear, possible danger and so consider no precaution excessive.

Behind both these perspectives on the midwife problem was a complicating factor with which neither side dealt adequately. The economic realities of the situation and the costs of the various programs should have been given far more consideration. Since these economic aspects were working against the obstetricians in particular, they were the most guilty in this respect. In general, the public health approach overstated the economic obstacles to the realization of the obstetricians' ideal, whereas the obstetricians tended to ignore such obstacles, with one significant exception. The problem was that the training of an obstetrician was expensive, and his practice had to be sufficiently lucrative to draw able men into the field. In addition, the expansion of hospital and laboratory facilities to train new men and for their use in practice was expensive. Public health officers, who always have many places to spend every appropriation, are not in a position to weigh these facts and their possible consequences; the chief attraction of the midwife for them was that she was cheap. Levy, who established the Newark system, considered as only rhetorical the question whether those who can only afford midwives "should be delivered in finely appointed hospitals at public expense."³⁹ Others presented the obstetric ideal as a sort of *reductio ad absurdum*. The

³⁷ J. Van D. Young, "The midwife problem in the State of New York," *New York State J. Med.*, 1915, 15: 295.

³⁸ George C. Marlette, "Discussion," in Hardin, *op. cit.*, fn. 2 above, p. 350.

³⁹ Levy, *op. cit.*, fn. 23 above, p. 41.

obstetricians, on the other hand, ignored this difficulty altogether because of their hope of changing what was then a very annoying fact: the same family will pay easily for surgery but expect to pay meagerly for attendance during pregnancy and confinement.⁴⁰ All that would be needed was propaganda to solve what they felt was not really an economic problem.

Huntington felt he had another answer to the "economic necessity for the midwife." Boston Lying-in Hospital ran an Out-Patient Department to provide obstetric training for medical students, and the patients, contributing an average of \$1.28 each, in 1910 paid "all the expense" of the Department, with a surplus of \$807.82.⁴¹ But his conclusion that the finest hospital care was itself inexpensive can be seriously questioned. The Boston medical school complex attracted prospective obstetricians from all over the country. Cases used for teaching amounted to nearly 20% of the total number of births in Boston in 1913.⁴² Huntington thus claims an amazing percentage, and few other areas could hope to rival it, considering the scarcity of obstetricians at that time; yet it still left 80% of the births unaccounted for. It can perhaps be safely inferred that the costs of giving the rest similar treatment would rise rapidly, once deliveries had to be accomplished without the help of unpaid medical students. Yet even if the costs were indeed relatively low for caring for everyone on such a basis, the necessary expenditures on facilities to make room for all would be beyond the economic horizon of public officials forced to account closely for their use of public funds.

Only two writers proposed a solution which would make ideal obstetric care possible for all, given all the existing conditions. A. K. Paine, Huntington's only apparent critic in his home state, said that our method of government was not suited to the rigid requirements which the properly regulated midwife demands, but that the "obstetric poor" could be handled on a community basis, if the community would assume the responsibility.⁴³ Because of the stress Paine gave community responsibility, his argument clearly implied public institutions staffed by government employees and run with tax funds on some level or another.

Charles Ziegler, who earlier had complained of the money wasted on midwives, was a Pittsburgh obstetrician who was concerned with the midwife problem. What happened to him when he attempted to approximate ideal obstetric care for all puts an interesting light on the importance of the "ideal" elements in the original professional argument. Ziegler's

⁴⁰ Paine, *op. cit.*, fn. 14 above, p. 761.

⁴¹ Huntington, "The midwife in Massachusetts . . .," *op. cit.*, fn. 10 above, p. 421.

⁴² Paine, *op. cit.*, fn. 14 above, p. 762.

⁴³ *Ibid.*, pp. 763-764.

experiment also involved inexpensive delivery of the poor and, although he got his funds privately, he had even then the idea that what was essentially obstetric charity should not be borne solely by obstetricians, but should be subsidized by the community.⁴⁴ Although he had no access to public funds, he evidently could generate other sources of aid by his enthusiasm for his project. Ziegler wanted to establish a dispensary which could give the best care to those who usually did not get such care, i. e., those not in either of the extreme income categories. The aim was to demonstrate how much mortality statistics could be improved, in the hope, of course, that the result would provide encouragement for others to try to achieve the same result. Six years after opening the dispensary in 1912, \$80,000 in contributions had been spent caring for 3384 confinements on both an in- and an out-patient basis. Fifty-six per cent of the cases were foreign-born and sixteen per cent were Negroes. There were two sets of results. First, maternal mortality was 17 per 10,000 as opposed to a national average of 88.5.⁴⁵ This was a remarkable result for the time and clientele. The other result was that the Allegheny County Medical Society found Ziegler guilty of breaches of professional ethics by "solicitation and attendance on cases in families able to pay for a physician [and] . . . solicitation and attendance on cases where a physician had previously been engaged."⁴⁶

Ziegler himself was suspended from the society, and, in 1918, his hospital was commandeered for government service, finishing his experiment.⁴⁷ Ziegler concluded after all this that, given the existence of such patients, the cost of caring for them properly (about twenty times Huntington's figure of \$1.28), and the strength of the enemies made in the process, the only solution would be municipal, state, and federal aid, not as charity, "but as a matter of wise public policy and of justice to those to whom we look for the perpetuation of our family and national life."⁴⁸ He saw the whole obstetric problem as an economic one in which many people could not pay for the services they deserved; an institutional redistribution of such services was therefore necessary.

He believed that his solution would bring opposition from the medical

⁴⁴ Ziegler, "The elimination of the midwife," *op. cit.*, fn. 34 above, p. 34.

⁴⁵ Ziegler, "How can we best solve the midwifery problem," *op. cit.*, fn. 7 above, pp. 407-408.

⁴⁶ *The Weekly Bulletin. Official Journal of the Allegheny County Medical Society*, vol. V, no. 7 (February 12, 1916), p. 5.

⁴⁷ Ziegler, "How can we best solve the midwifery problem," *op. cit.*, fn. 7 above, pp. 412-413.

⁴⁸ *Ibid.*, p. 407.

profession, "as they are opposed to any plan which includes municipal or state aid looking toward the solution of the problem on a public-health or public-welfare basis."⁴⁹ For although Ziegler's solution ostensibly fulfills the obstetric ideal by granting every American mother her "right," by his method the natural elevation in status of obstetricians which would otherwise have occurred might be jeopardized.

Today the prospective American mother theoretically has access to high quality obstetric care. If she is from a relatively urban environment, this is available through clinics, or through a private obstetrician, for whom a group insurance plan might help pay. If she is from a rural area, a general practitioner graduated from a medical school, whose quality, both overall and in obstetrics, has greatly improved, is likely to be available. Obstetrics, both as a branch of medicine and in professional status, has advanced significantly. Can this result somehow be attributed to the developing superiority of obstetrics as performed by obstetricians, or could the forces arrayed against them have been exaggerated by the obstetricians, making the whole issue just a paper debate?

It appears that despite the potential obstetric superiority of obstetricians over midwives, the triumph of the former was probably due most to the fact that the circumstances debated in this period changed radically. It is certain that the relevant health conditions were not improving in those areas where the midwife was first being superseded. Although in Washington the percentage of births reported by midwives shrank from the 1903 high of 50% to 15% in 1912, infant mortality in the first day, the first week, and the first month of life had all increased in this period. Also, New York's dwindling corps of midwives achieved significant superiority over New York's doctors in the prevention of both stillbirths and puerperal sepsis.⁵⁰ Rather, the obstetricians triumphed because, before the public health programs became firmly established in the public mind, the obstetrician gained tremendous advantages from other sources. Immigration decreased significantly during the war and was afterwards reduced legally to a small fraction of the numbers experienced just before the war. This put time entirely on the side of the physicians, a considerable advantage in itself, while concurrently the economic problem *per se* was greatly reduced. This did not occur simply because of the "prosperity" of the 1920's, which may have had no impact at all; rather, the secular trend towards limitation of family size accelerated to include nearly the entire

⁴⁹ *Ibid.*, p. 413.

⁵⁰ Baker, *op. cit.*, ftn. 18 above, p. 196.

population. In 1919 in New York City there were 1700 midwives who were responsible for 40,000 births, or 30% of the total. In 1929, though there were still 1200 midwives, they delivered but 12,000, 12% of the total.⁵¹ Not only did the average deliveries per midwife shrink decidedly from 23 to 10 births a year, but also total births decreased by 25%. With the limitation of births, it is possible that pregnancy and anticipated delivery seemed sufficiently rare to be generally equated with major operations and worthy of greater expense.

The other secular shift in attitudes from which the obstetricians benefited was a new, general demand for improved obstetrics, the change for which they had been most devoutly hoping. The midwife controversy itself was in some ways a reflection of this change. It was not merely the benevolent concern of public health officials about their vital statistics which was instrumental in effecting all the legislation regulating the midwife. Also responsible was a growing public demand from women, who were becoming increasingly self-conscious about their own welfare, and who were still infected with the reforming zeal of the Progressive Era which was to lead to their enfranchisement. These were, after all, the women who shortly afterward were to deluge their Congressmen and Senators with pleas for the passage of the Sheppard-Towner Bill. This bill, which Ziegler worked for, provided Federal money to the states for the "protection of maternity." With "womanhood" no longer rooted in the domestic, "natural" environment, or perhaps reflecting the struggle for release from such roots, the "natural" way of doing things was losing its appeal for the many emerging American women, and the obstetrician was increasingly there to reap the results of a growing anxiety about childbirth.

In summary, then, the professionalization process was very sensitive to external conditions and attitudes. If conditions had not changed so propitiously, if an economic problem and a conflict of attitudes had continued to exist, the obstetrician might well have found himself in the position of the present-day psychoanalyst with the public realizing that his skills solve but a small part of a complicated problem.

⁵¹ Hattie Hemschemeyer, "Midwifery in the United States," *Am. J. Nursing*, 1939, 39: 1182.