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| IJDM | **The Official Medical Plan to****Eliminate the Midwife: -- 1900 -1930** |
| part 3 |  |

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IV The  Flexner Report -- a biased blueprint for medical reform

The Flexner Report, published in 1910, severely criticized the lack of clinical training in U.S. med schools, especially as contrasted with the highly-prized medical training available on ‘The Continent’.

~ "The story of medical education in the country is not the story of complete success. We have made ourselves the jest of scientists through out the world by our lack of a uniform standard. Until we have solved the problem of how NOT to produce incompetent physicians, let us not complicate the problem by attempting to properly train a new class of practitioners. The opportunities for clinical (i.e. "bedside") instruction in our large cities are all too few to properly train our nurses and our doctors; how can we for an instant consider the training of the midwife as well?" [1911-C, p. 207]

~ "No one can read these figures without admitting that the situation is deplorable, and that the vast majority of our schools are not prepared to give the proper clinical instruction to anything like the present number of students. .... The paucity of material (i.e. teaching cases) renders it probable that years may elapse before certain complications of pregnancy and labor will be observed ... to the great detriment of the student. Moreover, such restriction in [*teaching*] material greatly hampers the development of the professor and his assistants by the absence of suggestive problems and his inability to subject his own ideas to the test of experience." 1911-B; WilliamsMD p.171

Since it was considered inappropriate to use private patients as teaching cases (primarily ‘upper-class’ women), the ‘lower-class’ -- often immigrant population -- of childbearing women cared for by midwives was looked to as the ideal source for this coveted "clinical material". Midwives and midwifery training were both considered to be expendable in exchange for the "greater good" as defined by Dr. DeLee’s paper on "Ideal Obstetrics".

~ "It is, therefore, worth while to sacrifice everything, including human life to accomplish the (obstetric) ideal ". Dr. DeLee, 1915 {\*}

~ "If such conclusions are correct, I feel that ...[we must] insist upon the institution of radical reforms in the teaching of obstetrics in our medical schools and upon improvement of medical practice, rather than attempting to train efficient and trustworthy midwives." 1911-B; WilliamsMD p.166 {\*}

~ "We can get along very nicely without the midwife, whereas all are agreed that the physician is indispensable." [1912-B, p.222 ]

The plan for up-grading medical education was proposed by a small number of well-placed physicians representing the interests of medical schools. They sought to increase the status and income of physicians and promote a more flattering "scientific" image of the profession of medicine and to establish as obstetrics as a  specialty branch of surgery.

~ "For the sake of the lay members who may not be familiar with modern obstetric procedures, it may be informing to say that care furnished during childbirth is now considered, in intelligent communities, a surgical procedure." [1911-D, p. 214]

~ "Engelman says: ‘The parturient suffers under the old prejudice that labor is a physiologic act,’ and the profession entertains the same prejudice, while as a matter of fact, obstetrics has great pathologic dignity ---it is a major science, of the same rank as surgery". [1915-C; DeLeeMD p. 116]

~ " ..... the ideal obstetrician is not a man-midwife, but a broad scientific man, with a surgical training, who is prepared to cope with most serious clinical responsibilities, and at the same time is interested in extending our field of knowledge. No longer would we hear physicians say that they cannot understand how an intelligent man can take up obstetrics, which they regard as about as serious an occupation as a terrier dog sitting before a rathole waiting for the rat to escape.*"* 1911-B;WilliamsMD {\*}

However, this recommendation did not of itself have any scientific basis and in fact, required  ignoring maternal mortality and morbidity statistics (both world-wide and in the US), which argued against such a plan. For instance:

~ "**Maternal mortality** in the country when compared with certain other countries, notable England, Wales and Sweden is, according to Howard, "**appallingly high and probably unequaled in modern times in any civilized country"**.

~ "...in 1921 the  **maternal death rate for our country was higher than that of every foreign country** for which we have statistics, except that of Belgium and Chile." 1925-A; HardinMD, p.347

In contemporary terms this prejudicial process is known as a "pre-cognitive commitment" and describes making a commitment to a plan of action prior to having full or accurate information. Modern day obstetrics is still predicated on this erroneous "pre-cognitive commitment" set into place during this time period and remaining unexamined by mainstream medicine today.

In order for medical politicians of the era to have pursued this dubious course of action, two crucial facts had to be ignored. First, that childbearing itself in healthy women is not fundamentally dangerous and does not routinely benefit from surgical skills. It was poverty, overwork and forced childbearing that were the genuine problems facing mothers and babies of that time period and which contributed to an alarming rate of death and disability. Secondly, it failed to account for the serious harm -- including death for both mother and baby -- which could and did result from the routine use of medical and surgical interventions. Most unfortunate of all, these harmful interventions did *not* address the underlying health problems of poverty and overwork.

The great improvement in maternal-child health that has occurred over the course of the 20th century is the result of an increased standard of living -- sanitation, education, a better diet, adequate housing, improved working condition and the safety net of social programs. Only a tiny portion of this improvement can be attributed to obstetrical care. In many instances, the underlying cause of the problems later "cured" by obstetrical science were caused by poverty or social ignorance.

At the time this takeover of midwifery was being engineered by a handful of influential American physicians, the five industrialized countries with the best maternal-infant outcomes had midwifery-based models of care for healthy mother and obstetrical care for complicated ones. The five that had the worst either had physician-centered maternity systems (USA) or little access to science-based medical care. The United States was in the ignoble position of being in the bottom five.

~ "The "International Year Book of Care and Protection of Children: gives emphasis to the fact that the Untied States has still a higher rate of maternal mortality than any other of the principal countries of the world and that *in the United States* pregnancy causes more deaths among women ages 15-40 years of age than any other disease except tuberculosis. Twenty five thousand women die in the United States every year from direct and indirect effects of pregnancy and labor. Three to 5% of all children die during delivery and thousands of them are crippled." 1925-A .p. 350]

~ "Statistics (Howard) show that the [*overall*] stillbirth rate in the birth registration area is 60% higher than Stockholm (2.16%); that rates for New York (4.38%) and Philadelphia (4.39%) are 35% higher than Birmingham, (England) (3.24%) and over 100% higher than ...Stockholm." [1922-A; ZieglerMD, p.405]

~ "These rates ...of 88.48 per 10,000 birth are on a par with those of Sweden 110 years ago; are 75% higher than those of England and Wales 60 years ago; are 120% higher than England and Wales in 1911-1915 and exceed the rates of England and Wales for 1918 by nearly 75% for puerperal fever and 150% for all other afflictions of the puerperal state combined. Howard shows also that New York City’s rates 46.11, which is much lower than that of any other American city, is 35% higher than that for Birmingham, England (33.49)." 1922-A; ZieglerMD

It is an interesting note that Germany itself, much admired by American physicians for its "gold standard" of allopathic medicine, was one of those countries that had a midwifery-based system during this time period (early 1900s). Even today German law requires the presence of a midwife at every birth, *even when obstetrical care is necessary*. Midwives have historically been recognized as guardians of normal birth and a necessary aspect of safe maternity care, providing laboring mothers with a vital quality of emotional support that would otherwise be absent.

IV. Strategies to Abolish the Independent Practice of Midwives

The strategy to abolish the profession of midwifery (as practiced by midwives) was multifaceted and included a legal, legislative and public education approach described as "elevating the public conscience".

A. Propaganda

Medical propaganda centered around the false idea that physician-attended deliveries were safer than giving birth with a skilled midwife. This was not true but the statistical information to refute it was not generally available to the lay public. This propaganda campaign *misrepresented the dangers of childbirth* and *inflated the abilities of medically-based care to eliminate them*, while denigrating midwives. In the following quote Dr. DeLee answers the question of how this campaign to "elevate the public conscience" was to be carried out and what exactly the goal of it was to be:

~ "How can this be done? Let us begin with the Women’s Clubs in the United States. Let us tell them of the facts we have learned here today. The Woman’s Clubs in the US are an enormous power, and they are growing more powerful in the civil and social betterment of this country. If we can disseminate among the women of our land the facts regarding obstetrics, there will rise an undeniable clamor for good obstetrics. The public will be forced to furnish the materials, and the patients for the proper instruction of the doctors. They will build maternity hospitals the equal, if not the superior of any surgical hospital." [1911-B; DeLeeMD]

~ "When public opinion has thus been raised and educated regarding obstetrics, the midwife question will solve itself. With an enlightened knowledge of the importance of obstetrical art, its high ideals, the midwife will disappear, she will have become intolerable and impossible." [1911-B; DeLeeMD]

Many physicians of the day insisted that midwives were ignorant, dirty and dangerous. The fact that midwives of whatever educational background still had better statistics than physicians only served to infuriate the medical establishment. In truth, a significant number of midwives (40-60% in cities on the eastern seaboard) had been formally educated in reputable European schools of midwifery. These highly-regarded training programs required midwifery students to manage a minimum of 20 deliveries under the watchful supervision of their instructors. There was also a school of midwifery started in NYC at Bellevue Hospital in 1911.

~ "New York City is entitled to the honor of having established the first School for Midwives in the United States under municipal control."[1911-G] ......

~ "Each midwife must witness or assist in at least 80 deliveries and in addition, deliver a minimum of 20 cases. When this course is completed, a practical and oral examination is given by a visiting obstetrician and if the candidate successfully passes these a diploma is granted." [1915-A; EdgarMD p. 98]

At this same time, medical students were only required to observe 6 deliveries and often graduated from medical school with virtually *no clinical experience*. The common complaint by public health officials was that newly graduated physicians offered maternity care without sufficient clinical training, routinely attempted to hastened birth through the injudicious use of drugs and surgical instruments and frequently did *not* follow public health regulations

In contrast, health officials and other physicians observed that midwives as a group were co-operative in upgrading their skills, followed the directives of public health officials, and had better compliance with laws requiring treatment of newborn eyes and filling of birth certificates than physicians. While it was true of a minority of midwives were untrained and or unskilled, whatever real or imagined deficiency in midwifery education and practice that may have existed during this era, the obvious ethical response would have been to support the establishment of midwifery training programs and regulation of practicing midwives.

B. A Few Good Men and Women -- Physicians who knew better

Obviously not all physicians of the day were fooled by these political motives masquerading as a high ideals. While medical politicians promoted massive amounts of misinformation, a small number of midwife-friendly physicians and public health officials who knew first-hand of the excellent success of responsible midwives were vocal in their support of midwives.

~ "The practice of midwifery dates back to the beginning of human life in this world. At this supreme moment of motherhood it is probable that some assistance has always been required and given. Its history runs parallel with the history of the people, and its functions antedate any record we have of medicine as an applied process. To deny its right to exist as a calling is to take issue with the eternal verities of life. The only points upon which we may argue are the training required for its safe and lawful practice, and the essential fitness of those who follow this calling requisite for the safeguarding of the mother and child." [1911-G; BakerMD, p. 232]

It is thanks to the honesty of these physicians and their concern for childbearing women and babies that we have the documents and statistical records which expose these institutionalized prejudices against midwives. Many of these midwife-friendly physicians managed midwifery training programs or were public health officers. Their well-documented criticisms were recorded in medical journals of the day, complete with tables of compelling statistics clearly demonstrating the scientific basis of their observations. Unfortunately, this crucial information was uniformly ignored by medical politicians.

In 1915 Dr. P.W. van Peyma, Buffalo, NY, 40 years of experience working with midwives and was a member of the Board of Examiners in Midwifery for 25 years stated that:

~ "The essential difference between a midwife and a physician is that (physicians) are free to hasten delivery by means of forceps, version, etc. This, in my experience, results in more serious consequences than any shortcomings of midwives. ...Time is an element of first importance in labor, and the midwife is more inclined to give this than is the average ... physician. ... The present wave of operative interference is disastrous. ... The situation would not be improved by turning (the clients of midwives) into the hands of such medical men ....".

~ "Obstetric training in the medical colleges is recognized as inadequate, [yet] there is no voice raised to eliminate the doctor from the practice of midwifery. Dr. Hirst is at present circularizing the State Board of Health to establish a standard for obstetrical experience for (physician) candidates for licensure, and ... he suggests the personal delivery of 6 women. In NYC, the midwife is required to have the personal care of 20 women before a permit is granted to her.

~ "The irregular practitioner of medicine is still permitted to be an obstetrician with an experience that is inferior to that possessed by more than half of the midwives. Let us be fair to the midwife, I say, and if she is below the ideal we have for her, though we have never crystallized that ideal into law, let us give her the opportunity to rise and educate herself under proper supervision." [1911-G; BakerMD, p. 224]

~ Dr. Ira S. Wile, New York City: "But it is manifestly unfair to criticize the lack of an educational standard which has never been established. When nurses were of the Sairey Gamp type, *elimination was not the cure.* When apprenticeship was the open sesame to the practice of medicine ...*elimination was not the cure*. Education, training, regulation and control solved these problems just as they will solve the midwife problem. Establish an educational standard, provide sufficient facilities for giving the adequate training, secure the legislation essential to provide the supervision and control and then raise the standard of the midwife so that no further fault may be found. Let us to fair to the midwives and their patients. Let there be an evolution of **this class of public servant** and not a hasty attempt to check their possible development." [1911-G; BakerMD, p. 244] {\*}

C. Domiciliary or "Outdoor Services" -- a normal part of hospital services

During this same period of time, domiciliary or home-based birth services were a normal part of the care provided by hospitals. Domiciliary birth services were not seen as a competition with hospital-based services but rather an extension of care and merely another way that the community could be served by the hospital. This was referred to as their "outdoor service" and described a system in which birth services were provided by a doctor (often an intern or resident) and a nurse who were sent to the home at the mother’s request. It was remarkable for the lower number of complications, especially puerperal sepsis, and the lack of animosity or prejudice against it by the medical community. The outcome statistics from these "outdoor services" were described as the goal or standards to which the hospital "indoor" (in house) service should aspire.

~ "It is in the outdoor (domiciliary) service especially that we are able to appreciate the approach to the irreducible minimum {of mortality} to be obtained in private practice and where the figures are not distorted by the inclusion of the emergency failure of others." [1917-A; HarrarMD]

~ "From the organization of the service of the Lying-In Hospital in 1890 until July, 1917, the institution has cared for, in the wards and in the homes of the patients, 115,439 women. Of these ... 37,483 were parturient and recent admissions to the wards, and 70,743 were labors conducted in the tenements." [1917-A; HarrarMD]

~ "For purposes of study it is necessary to divide the mortalities in to groups. In the outdoor service, in 69,081 actual confinements, 218 women died. .... This represents one death in every 317 women confined, or 0.31 per cent mortality. .... On the indoor service, of 23,130 regular applicants confined, 109 died. This is one death in every 212 women confined, or 0.47 percent.."[1917-A; HarrarMD] {\*}

Unfortunately, as indigent women were brought into the system as teaching cases (receiving free care) it was discovered that they were willing to pay a small sum for their 2 week stay ($1.28) and that even that small amount represented a profit to the hospital. By the early 1920s, maternity patients were beginning to be viewed as not only as valuable "clinical material" for medical education but also as a source of profit to the hospital. Contemporary obstetricians, who know nothing of this era of hospital-organized outdoor (or domiciliary) services, are quite vocal in expressing the opinion that homebirth is risky ("the earliest form of child abuse"). This prejudice is no surprise when coming from people with no knowledge of this historical precedent and no contemporary experience with home-based birth care as provided by skilled midwives in conjunction with easy access to good medical consultation and hospital backup.

~ "The hospital is to care for all who, for one reason or another, cannot secure proper attention at home and the dispensary for those are delivered at home. In the majority of them, her presence in the home is necessary to order and discipline. Then too, the cost of caring for patients in hospital is much greater than in their own homes." [1912-B, p.231] {\*}

~ "The Boston Lying-In Hospital Out-patient department (domiciliary service) cared for 2,007 cases with no deaths, the dangerous cases being sent to the hospital, where all recovered." [1911-D, p 216]

~ "But another encouraging and very practical feature has been that these 2,007 patients voluntarily contributed to the support of the hospital the some of $2,571 or, on the average, $1.28 contribute by each patient and the total expenses of the out-patient department were $1,763, leaving a net gain of $807". [1911-C, p. 211]

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last updated 11/28/06 01:10 AM