THE MIDWIFE PROBLEM IN THE UNITED STATES *

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American medical literature for more than the last decade has intermittently directed attention to the inadequacy of our laws governing midwives, which contain neither uniform provisions nor required standards. With the exception of the activities in a few cities, this situation has been allowed to drift along without regard for consequences.

The part played by faulty obstetric practice as a causative factor in high infant mortality at birth and during early infancy has for a number of years been emphasized constantly in all the efforts to reduce infant mortality. Largely as a result of this emphasis, the midwife situation has been brought to our attention in the light of a problem of national responsibility.

Statutory recognition of the midwife has existed in some states for many years, but recently the active interest in child hygiene has caused legislative bodies to pass many new regulations or to amend old ones, so that the laws are constantly changing.

Briefly summarized, existing legislation defines the position of the midwife in most states through the medical practice act, other statutes, or state board of health regulations, which in general cover: (1) Regulation of practice; (2) registration; (3) licensing and examining; (4) educational standards, and (5) penalties for violation.

Massachusetts is the one state in which the midwife has no legal status. Formerly she was required by law to report births which she attended, although by so doing she was liable to prosecution, as she was barred from practice under the medical practice laws of the

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state. This law was revised in 1920 and all reference to the midwife omitted. Lack of recognition, however, probably means that she exists, though ignored, in any locality having a foreign-born population.

Specific prohibitions in the medical practice acts or regulations of the state boards of health, although varying in definition and detail in the individual states, attempt to forbid vaginal examinations and operative procedures, and to require the summoning of a physician in all abnormal cases.

As a means of acquainting the midwife with existing legal regulations, and of affording opportunity for supervision of her work, thirty-six states require registration with either the state board of health, the local registrar or the local health officer. In seventeen states, only those midwives who have been duly licensed, after an examination, are allowed to register.

Examination, license or registration fees are customary. In some states, reexamination and new licenses are provided for at stated intervals.

Educational requirements are as yet unstandardized, and only ten states have any adequate regulation in regard to them in existing laws. Three states require the equivalent of a high school education, and two states a common school education in addition to training in midwifery in order to qualify for a license. While several states require applicants to read and write in English, others allow the use of an interpreter. Foreign midwifery diplomas are very generally recognized.

Penalties for violation of legislation concerning midwives are as varied as the regulations themselves. In general, the penalties cover either revocation of license, fine, imprisonment, or all of these.

In spite of the existence in most states of some form of law or rules and regulations, with the administrative authority lodged in state or local boards of health, it is generally recognized that, with the exception of an exceedingly few of the larger urban localities, no successful control or supervision of the midwife has been effected. Failure to enforce laws has in many instances been due not only to a lack of recognition of the gravity and enormity of the problem, but also to the lack of funds with which to operate successfully.

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Provisions of the existing legislation, such as that barring from practice all non-English speaking applicants, no matter how acceptable their other qualifications may be, would indicate that much of this legislation has been framed with the definite aim of eliminating the midwife.

Efforts in a few of the larger cities show convincingly that supervision and educational standards tend definitely toward elimination of the most undesirable midwives and not toward encouragement of the practice of the midwife. In New York City, for example, where the Bellevue School for Midwives has been in operation since 1907 and where graduation from this school or its foreign equivalent is required for license to practice, and where violations of regulations are penalized by constant supervision or revocation of license, the number of midwives was reduced in ten years from about 3,000 to 1,600. During 1922, however, New York City still had 1,539 registered midwives.

The city of Richmond, Va., as late as 1921, adopted regulations governing the practice of midwives, as wholly inadequately trained midwives attended from twelve to fifteen hundred births in that city. An initial course of instruction, consisting of lectures and demonstrations, was prepared by the health officer. More than eighty midwives attended daily this course; but, as the result of the examination which followed the completion of the course, only forty-seven permits were granted.

When Alabama's amended state law regulating midwife practice became effective in January, 1920, the city of Birmingham instituted classes for the midwives then licensed in the city. After a discouraging year of weekly classes, giving instruction in prenatal, maternity and infant care, it was decided to eliminate the midwife as far as possible from the city. The few who continued to practice contrary to instructions were prosecuted. Simultaneously, efforts were made to enlist the interest and cooperation of physicians in communities where midwives were extensively employed. The physicians agreed on a minimum charge for delivery, while prenatal and postnatal care was provided through volunteer medical service in a community clinic and by a visiting nurse service.

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TABLE 1.—*Summary of Laws and Regulations Governing Midwives in the United States, in Force, March, 1923*

State and Date of Enactment*	Examined and Licensed by State	Educational or Other Requirements	Registration	Laws and Regulations Governing Practice	Penalties for Violation of Requirements of Practice	Report Births	Report Ophthalmia and Use Prophylactic
Alabama........ Laws 1919	No; by county board	Knowledge of midwifery; freedom from communicable disease; moral character	Local	....	....	Yes	Yes †
Arizona.......... R. S. 1913 and St. Bd. of Health Rules	Permit only	Endorsement of physician of district	Local	Shall not give drugs, give injection into birth canal or make internal examinations; shall secure physician for abnormal cases	(Permit valid so long as law and rules obeyed)	Yes	Report and advise use of prophylactic
Arkansas........ St. Bd. of Health Rules 1913	....	....	Local	....	....	Yes	Report and advise use of prophylactic
California....... Medical Practice Act 1917	Yes	Four years' high school, specified professional training and examination	Local	Shall not give drugs, use instruments, make internal examination or give injection into birth canal; shall attend normal cases only; must have specified equipment	Revocation of license; $100-$600 or 60-180 days, or both	Yes	Report; use of prophylactic optional †
Colorado........ Medical Practice Act 1917	Yes	Examination in such subjects as board deems necessary	Local	Shall not give drugs or anesthetics, use instruments or practice medicine in any other form	Revocation of license; $50-$300 or 10-30 days, or both	Yes	Yes
Connecticut...... General Stat. 1893	Yes	Graduation from school of midwifery; certificate of character and examination	State and local; annual	†..	....	Yes	Yes †
Delaware......... Rev. Code 1915	....	....	Local	....	....	Yes	Yes †
Florida.......... Laws 1915	....	....	Local	....	....	Yes	Report only
Georgia.......... Code 1915	....	....	Local	....	....	Yes	Yes
Idaho........... Laws 1911	....	....	Local	....	....	Yes	Yes †
Illinois.......... Medical Practice Act 1917§	Yes	Graduation from graded school and from school of midwifery, and examination	Local	Shall not give drugs or attend abnormal cases	Revocation of license; not over $100 or 6 months or both	Yes	Report only;† may advise or use with consent of parent

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Indiana......... Medical Practice Act 1897	Yes	High school, 4 years, or equivalent; diploma from obstetric school, and examination	Local	....	From $25 to $200 or revocation of license	Yes	Report and use in suspected cases
Iowa............ Laws 1897	Yes	....	Local	....	....	Yes	Yes
Kansas.......... Gen. Stat. 1915	....	....	Local	....	....	Yes	Report and use with limitations†
Kentucky........ St. Bd. of Health Rules 1915	Permit only, given by county health officer	Attendance at annual course of instruction; understanding of essentials of hygiene; freedom from communicable disease	Local, annual	Shall not give drugs, use instruments, give injection into birth canal; make internal examination or attend abnormal cases; shall observe other specified sanitary rules	(Permit valid so long as law and rules obeyed)	Yes	Yes †
Louisiana....... Act 1918	Yes	Such examination as required by state board of medical examiners	Local	....	....	Yes	Yes †
Maine...........	....	....	......	....	....	Yes	Report; use prophylactic unless parents object
Maryland........ Code of 1910	Yes	Ability to read and write; certificate of physician showing attendance at 5 cases; 3 certificates as to character	Local	Shall not give drugs, use instruments, make internal examinations or attend abnormal cases	From $5 to $10; revocation of license for third offense	Yes	Report only
Massachusetts...	....	....	......	....	....	....	....
Michigan........	....	....	......	....	....	Yes	Yes
Minnesota....... Gen. Stat. 1913	Yes	Diploma from school of midwifery or examination	No	....	Revocation of license	Yes	Report and use prophylactic unless parents object †
Mississippi...... St. Bd. of Health Rules 1912	Permit given by county health officer	Attendance at class instruction; investigation as to character, cleanliness, etc.	Local	Shall not give drugs, use instruments, give injection into birth canal or attend abnormal cases; must have specified equipment	From $5 to $100 or 60 days, or both	Yes	Yes †
Missouri........ Rev. Stat. 1909	Yes	Examination in obstetrics	Local	Shall engage in no other branch of medical practice	From $10 to $50 or 10 days to 2 mos. or both	Yes	Yes
Montana........ Rev. Code 1921	....	....	Local	....	....	Yes	Report; use of prophylactic optional †
Nebraska........	....	....	......	....	....	Yes	
Nevada.......... Rev. Laws 1912	....	....	Local	....	....	Yes	Yes
New Hampshire.. St. Bd. of Health Rules 1916	....	....	Local	Shall not give drugs or use instruments; local health boards must have physician or nurse visit all cases attended by midwives	....	Yes	Yes †

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TABLE 1.—*Summary of Laws and Regulations Governing Midwives in the United States, in Force, March, 1923—(Continued)*

State and Date of Enactment*	Examined and Licensed by State	Educational or Other Requirements	Registration	Laws and Regulations Governing Practice	Penalties for Violation of Requirements of Practice	Report Births	Report Ophthalmia and Use Prophylactic
New Jersey....... Laws 1910	Yes	Common school; certificate or diploma from school of midwifery or maternity hospital having 1,800 hours' instruction, and examination	Local	Shall not give drugs; shall secure physician in all abnormal cases of mother or infant	$200 or 100 days if fine not paid; revocation of license	Yes	Report;† use of prophylactic optional
New Mexico...... St. Bd. Public Welfare Rules 1921	Permit and examination annually	Attendance at series of 10 classes of instruction, signing of midwife's pledge and freedom from communicable disease	Local	Shall not give drugs, give injection into birth canal, use instruments or make internal examination; shall call physician in all abnormal cases, and have specified equipment	Certificate may be annulled	Yes	Yes
New York........ General Laws 1922 ¶	Examine and license annually	Ability to read and write (waived for foreigners); either diploma from school of midwifery or other satisfactory evidence	Local	Shall not give drugs, use instruments, remove adherent placenta, perform version or treat disease; shall attend normal cases only	License revoked	Yes	Yes
North Carolina.. Statutes 1919	Permit only	Must not be addicted to drugs or habitual drunkenness	State	Disinfection of hands of practitioners required	From $5 to $10	Yes	Yes †
State and Date of Enactment*	**Examined and Licensed by State**	**Educational or Other Requirements**	**Registration**	**Laws and Regulations Governing Practice**	**Penalties for Violation of Requirements of Practice**	**Report Births**	**Report Ophthalmia and Use Prophylactic**
North Dakota... Laws 1907	....	....	Local	....	....	Yes	Report; use prophylactic in suspected cases
Ohio............ Medical Practice Act 1910	Yes	High school or equivalent, diploma from school of midwifery or license of foreign country, and examination	Local	Shall not perform version, treat breech or face presentation or other abnormal conditions, or use instruments	Refusal, suspension or revocation of license for unprofessional conduct	Yes	Yes
Oklahoma....... Laws 1917	....	....	Local	....	....	Yes	Yes †
Oregon.......... Laws 1915	....	....	Local	....	....	Yes	Yes

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Pennsylvania.... Laws 1913 and Dept. of Health Rules	Yes	Graduation from approved school of midwifery; or other satisfactory evidence, and examination in English language only	Local	Shall not prescribe drugs or perform operations other than tying cord; shall notify inspector of all abnormal cases, also of delayed labor; other sanitary requirements	From $10 to $50 or 10 to 50 days, or both; license may be revoked or suspended	Yes	Yes
Rhode Island.... Laws 1918	Licensed only	....	......	State board of health makes rules and regulations	Not over $100 or 6 mo., or both; license may be revoked	Yes	Yes †
South Carolina.. St. Bd. of Health Rules 1920	Permit only	Completion of course of 10 lessons given by state board of health; signing of midwife pledge	Local	Shall not give drugs, give injection into birth canal or make internal examinations; shall secure physician for abnormal cases and obey rules of personal hygiene	Permit may be revoked	Yes	Report; use of prophylactic advised
South Dakota...	....	....	......	....	....	Yes	Report only †
Tennessee........	....	....	Local	....	....	Yes	Yes
Texas............	....	....	......	....	....	Yes	Shall use prophylactic †
Utah............	....	....	Local	....	....	Yes	Report; advise use of prophylactic †
Vermont.........	....	....	......	....	....	Yes	Yes †
Virginia.......... Laws 1918 St. Bd. of Health Rules	Permit only	....	Local	Shall not give drugs, give injection into birth canal (except when ordered by doctor); make internal examination or attend abnormal cases; shall obey other sanitary rules	Revocation of permit	Yes	Yes †
Washington..... Act of 1917	Yes	Common school education, diploma from school of midwifery, application endorsed by physician, and examination	Local	Shall not prescribe medicine or drugs; shall call physician in abnormal cases; shall report puerperal contagion or infectious disease to health officer	Revocation of license; $80-$200 or 10 days to 6 mo., or both	Yes	Yes
West Virginia....	....	....	......	....	....	Yes	Yes †
Wisconsin........ Statutes 1919	Yes	Diploma from college of midwifery, evidence of good moral and professional character, and examination	Local	Shall not administer drugs, use instruments or any artificial means, remove adherent placenta, or undertake any other form of medical practice	Revocation of license; $25-$100 or not over 6 mo., or both	Yes	Yes †
Wyoming........	....	....	......	....	....	Yes	Yes

* Date refers to passage of act without reference to subsequent amendments.
† Gratuitious distribution of a prophylactic is made by the state health authorities.
‡ Bill defining practice before present general assembly.
§ This law declared unconstitutional by the Illinois Supreme Court.
¶ New York City and Rochester have special laws.

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The extension and adaptation of this plan to include the more isolated districts of the surrounding county have been contemplated for some time, but as yet have not been satisfactorily worked out because of the difficulty in securing medical service.

The experience of these few cities, as well as that of others which might be given, serves to demonstrate to the satisfaction of an element of the medical profession—the highly specialized urban practitioner—a method of desirable and effective elimination. We have long heard that the one sure way to eliminate the midwife was to educate her. Sufficient emphasis, however, seems not to have been placed on the fact that elimination has been effective in its results only so far as medical and nursing facilities have been substituted for the untrained midwife. It is to be noted that, in all of these eliminative urban demonstrations, such public institutions as visiting nursing service, prenatal and maternity consultative service, or even actual confinement and postnatal medical and nursing care have been initiated. Obviously, such services exert no unimportant influence in raising the standard of practice among the licensed midwives of these communities, with the result that those remaining under supervision are generally admitted to be an asset in public health work. In New York City in 1917, nearly 2,000 women were brought to the prenatal clinics by midwives.

STATE PROGRAMS

The intense interest in maternal and infant hygiene during recent years has caused new attention to be paid in practically every state to the midwife problem, which consequently assumes a national aspect.

Within the past year, or, more definitely, since the initiation of activities made possible by the funds provided by the enactment of the federal Maternity and Infancy Act, thirty-one states have simultaneously undertaken to attack the long neglected problem of midwife practice. Two reasons for finally facing the problem suggest themselves, namely, (1) a public opinion already expressed in the statutory regulations of a large majority of the states, and (2) the fact that the subject is innocuous and scarcely likely to engender opposition from the medical fraternity.

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TABLE 2.—*Numbers of Midwives Authorized to Practice, Percentage of Births Attended, and Maternal and Infant Mortality Rates for the States for Which Such Data Are Obtainable*

State	Midwives: Authorized to Practice	Midwives: Others Estimated	Midwives: Percentage of Births Attended	Mortality Rates per Thousand Live Births in Birth Registration Area Bureau Census 1921: Maternal	Mortality Rates per Thousand Live Births in Birth Registration Area Bureau Census 1921: Infant
Alabama	1,862	*	32	...	..
Arizona	45	*	12	...	..
Arkansas	181†	*	17	...	..
California	104	*	8	6.8	66
Colorado	15	25	*	...	..
Connecticut	123	*	16	5.3	73
Delaware	200	*	16	6.3	98
Florida	*	2,000	38	...	..
Georgia	1,800	*	*	...	..
Idaho	100	*	*	...	..
Illinois	1,115	*	*	...	..
Indiana	254‡	*	5	6.9	71
Iowa	40	*	0.1	...	..
Kansas	*	*	*	6.4	63
Kentucky	2,500	*	18	6.3	62
Louisiana	230	1,808	47	...	..
Maine	**	65	*	7.4	88
Maryland	339	346	22	6.7	94
Massachusetts	**	117§	*	6.5	76
Michigan	**	1,162	7	6.9	79
Minnesota	145	*	*	5.7	59
Mississippi	3,218	991	48	9.5	68
Missouri	803¶	*	*	...	..
Montana	334	*	3	...	..
Nebraska	**	20	2	6.6	59
Nevada	*	*	*	...	..
New Hampshire	7	None	*	6.2	87
New Jersey	415	262	27	5.9	74
New Mexico	**	*	*	...	..
New York	1,976	*	11#	6.3	75
North Carolina	2,500	4,000	35	7.3	75
North Dakota	*	*	*	...	..
Ohio	*	*	*	7.2	75
Oklahoma	None	*	*	...	..
Oregon	16	*	*	7.4	51
Pennsylvania	*	1,500	*	6.8	88
Rhode Island	47	*	*	7.1	93
South Carolina	996	3,715	*	9.8	96
South Dakota	**	133	3	...	..
Tennessee	815	1,000	12	...	..
Texas	**	300	*	...	..
Utah	*	350	*	7.3	73
Vermont	**	None	*	7.3	78
Virginia	6,036	*	35	7.0	79
Washington	50	*	4	7.8	55
West Virginia	**	*	*	...	..
Wisconsin	361	*	10	5.8	72
Wyoming	*	*	*	...	..
Total	26,627‖	17,794‖			

* Information not supplied.
** Do not examine, license or register.
† In six counties only
‡ Number licensed since 1897.
§ In a surveyed district only.
¶ Number registered since 1887.
# Does not include New York City.
‖ Includes only numbers reported.

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For purposes of information, comparison and evaluation, the federal Children's Bureau has recently sent out a questionnaire in order to determine just what activities relating to the midwife have developed under the various state programs for the promotion of the welfare of maternity and infancy. According to the reports received, thirteen states have already begun or are planning to begin initial state-wide surveys, while six states are making only county or community surveys. Ten states acknowledge that they know very little about midwives; others claim that the problem is a negligible one; eight states—Maine, Michigan, Nebraska, South Dakota, Texas, Vermont, West Virginia and Wyoming—do not register, examine or license midwives, although the majority of these states do require reporting of births.

The midwife problem in the United States is a peculiarly conglomerate one because of the many nationalities and races of which our cosmopolitan population is composed, each with its special traditions and customs.

Contrast the Southern states, having thousands of totally untrained and illiterate "grannies" (Mississippi, 4,000; North Carolina, 6,500; Virginia, 6,000), with New Hampshire, having only seven registered midwives. Incidentally, there are ninety towns in New Hampshire without a resident physician, and a recently enacted law provides an annual appropriation of $1,000 per town as part of a physician's salary in the hope of inducing young physicians to settle in rural communities.

New York State, exclusive of New York City, reports that the total number of licensed midwives is diminishing annually, and at present there are twenty-two counties of the state with no licensed midwives. The 428 midwives who were permitted to practice in the state in 1922 represented twenty-three nationalities—the Polish, Italian, German, native born American and Slavic predominating. Groups of these nationalities or others will undoubtedly be found in all the densely populated industrial and mining states. Colorado reports fifteen registered midwives as representing six foreign nationalities. In the Pacific states, the large number of Japanese midwives adds another phase to

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the situation; while the Southwest, where among the Spanish-Americans practically every married woman in rural areas is a potential midwife, presents its distinctive problems.

Parallel with this diversity in nationality runs a comparable divergence in numbers practicing. The 1920 occupational report of the Bureau of the Census reported 4,773 midwives practicing in the United States. Recent inquiry into this subject brings the report that the total number of midwives authorized to practice in thirty states is 26,627, although, with few exceptions, the number registered is admittedly not the total number practicing. The estimated total from the same states is about 45,000. Even this number is undoubtedly an underestimate. The percentage of births attended by midwives varies from 48 in Mississippi to 2 in Nebraska. In one state (North Carolina) the percentage of negro births attended by midwives was 73.5, in 1921.

Michigan's recently completed survey shows that there were 96,035 births reported in 1921, and that 6,632 birth certificates were returned by 1,162 midwives. One birth in every eleven and one-half occurred without the attendance of a physician.

Virginia reported 69,116 births in 1921, one third of which were attended by the 6,036 registered midwives. Among this number were 1,418 white midwives.

Confronted with such concrete facts as these, the state health authorities are somewhat perplexed in their effort to find practical means of handling the midwife situation. However, eighteen progressive health departments have already decided that trained, licensed and supervised midwives should be provided at least for rural communities. In ten states the number of midwives is sufficiently large to warrant the employment of a supervisor of midwives. In many of the states, provision has been made for some type of instruction of midwives, either through printed matter in the form of letters giving simple rules and regulations, or bulletins, or by class or individual instruction. Class instruction is given by a physician, usually a health officer, by public health nurses, and in one state by a registered midwife. Class meetings vary in number from one or two single meetings to regular monthly

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meetings or a series of meetings at shorter intervals. The instruction consists of an explanation of the laws governing the practice of midwifery, the limitations of the midwife, and elementary teaching of the technic of a normal delivery and subsequent care of mother and infant.

One state department has on its staff two women physicians who speak several languages, and who instruct midwives working in centers of foreign population.

Another state employs a well trained woman obstetrician who travels about the state in the capacity of consultant. In isolated rural communities, both physicians and midwives bring her their cases, especially those which are complicated, for consultation.

As a result of these methods of instruction, states report not only a marked improvement in the type of care which the midwife gives, but also that physicians are being called much more frequently for abnormal or complicated cases. Three states report a decided decrease in the number of registered midwives following the introduction of this instruction and supervision. One of the sparsely settled but widely extending Western states is considering the practicability of subsidizing, from church funds, well trained midwives in order to provide and insure for women on the isolated farms at least some trained service during childbirth.

PROBLEMS RELATING TO OBSTETRICS AND PEDIATRICS

The material here presented indicates the plans which have already been instituted in the effort to meet the problem of making available, outside the large urban centers, better care for mothers before, during and following childbirth.

While the developments outlined indicate only the public health aspects of the midwife problem, largely because of the fact that regulatory supervision is vested with the public health departments, definite problems of concern and interest to two special branches of medicine, namely, obstetrics and pediatrics, are also involved.

It is at once obvious that much of the success of pediatrics depends on the normality of the expectant

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mother and of the unborn infant, and on the conditions which provide normal birth and adequate skilled care in the first weeks after birth. Faulty technic in the care of the new-born largely determines whether his future will be one of invalidism or of health. In most instances, midwives are of the same nationality as the women they attend, and retain most of the practices, traditions and superstitions that have been transmitted for generations in these groups. Midwives are frequently consulted by mothers regarding the care of the infants for six months or more after birth. If one is familiar with some of the age-old, unclean practices of foreign midwives, one is not surprised at the frequency with which tetanus, undoubtedly due to dirty cord dressings, is found in the new-born. One marvels that any infant survives the well meaning colored midwife's routine during the interval between birth and the appearance of breast milk, when almost invariably a pacifier of raw white pork is given soon after birth for its supposed laxative effect, supplemented at frequent intervals by curious and oft-times obnoxious concoctions known as "teas."

Improved reporting of births has been credited to the midwife as soon as she comes under supervision. The fundamental importance of early and accurate birth registration is appreciated by all workers interested in preventive health measures.

Marked improvement of ophthalmia neonatorum has occurred among midwives' cases since improved legislation now makes the use of a prophylactic by physicians and midwives compulsory in twenty-nine states. Free prophylactic outfits are being distributed in twenty-four states, while the reporting of inflammatory eye conditions is compulsory in forty-five states.

The midwife's relation to the public health official is in the main that of compliance with statutes or rules or regulations of the health department, while to the obstetrician or general practitioner her responsibility is more definitely outlined. Many of the state regulations specify the conditions under which a physician must be called, such as abnormal symptoms during pregnancy, miscarriage, hemorrhage, abnormal presentation, retained placenta, convulsions, and prolapse of cord. Most of these regulations have been dictated by bitter experience, but with no specific effort to assist the

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midwife in her imposed responsibility of securing skilled assistance. Training and supervision have so far tended to diminish the numbers of practicing midwives, without providing adequately trained medical or nursing substitutes.

Interest in maternal and infant hygiene is now growing at an unprecedented rate, and I believe that it is safe to predict that public demand for more and better prenatal care, skilled care at confinement, whether at home or in the hospital, and adequate postnatal care of mother and infant will result in such provisions being considered essential needs in every community in the very near future.

For the last few years, in the medical schools, efforts have been directed toward the teaching of better obstetrics. All obstetricians are familiar with the average poor standard of confinement care given by the general practitioner in rural sections, often through no fault of his own. In several states an effort to raise the standard of rural obstetric care is being undertaken through extension services of state universities and their medical schools. Films are being used for teaching purposes in county medical societies, the head of the department or an assistant obstetrician serving as instructor, thus bringing postgraduate work to the rural practitioner.

In several states the maternity and infancy programs include the preparation by local club women of sterile obstetric packages for rural home confinements. The obvious value of such an undertaking is not only the definite assistance to the attending physician but also the education of the community.

My purpose in this paper has been, not so much to reiterate the legal status of the midwife in this country, as to show the trend of rapidly developing activities in this long-neglected field.

While existing legislation gives the midwife recognition but controls her ineffectually, if at all, the problem still to be solved is whether adequate provision shall be made for medical attendance at every confinement and the midwife abolished, or whether midwives shall be trained and practice under strict supervision and control. Obviously, there is no point in eliminating

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even the untrained midwife without making qualified substitutes available.

With almost one half of the states already undertaking the supervision and training of the midwife, perhaps one may conclude that from the point of view of the public health administrator, control at least is at present a necessity. Whether or not uniformity of regulation, training and supervision on a national scale similar to that of most foreign countries is feasible or desirable is a problem suggested for future consideration. A small group of New York obstetricians has decided that one of the greatest needs in maternity service is public health nurses with a special course in midwifery, particularly in rural areas where there are either very few physicians or none at all. Such a course is now being offered as an affiliated one with the Bellevue School for Midwifery.

The problem of the midwife in the United States is sufficiently important and complex for national concern and responsibility, and the medical profession will be looked to for its solution, since a rapidly crystallizing public demand for better medical and nursing care, as it relates to maternity and infancy, is involved.

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