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MOTHER LOVE

MOTHER DEATH

Maternal and Infant Care: Social Class and the Role of Government

by

JANE PACHT BRICKMAN

A dissertation submitted to the Graduate Faculty in History in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York.

1978

This manuscript has been read and accepted for the Graduate Faculty in History in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy

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For Elizabeth

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INTRODUCTION

Ironically, the woman who so perceptively recognized women's oppression and reacted with the first modern revolutionary declaration of women's rights perished at thirty-eight from the scourge of womankind--childbed fever. Mary Wollstonecraft, a typical victim of childbirth, died with an adherent and infected placenta, probably contaminated by her doctor when he sought to remove the afterbirth manually.

The story of the delivery of Wollstonecraft's second child reads as must millions of women's accounts of childbirth. Attended successfully by a midwife in the birth of her first child, Wollstonecraft resisted the trend of male attendance for the birth of her next. When the uterus did not expel the afterbirth naturally within an hour after the child's delivery, her midwife, as was legally required, called for a physician. The situation posed women's perpetual dilemma: in the event of any abnormality, legal restrictions upon the midwife's training and practice, and the general stasis of scientific knowledge, made her helpless. Yet the introduction of the physician, who brought progress to obstetrics in the instrumentation he could legally employ, raised the spectre of death to the suffering parturient woman by infection from his septic hands or tools thrust into the vulnerable and wounded womb.

Through most of the nineteenth century, childbirth brought associations of pain and peril. Circumstances posed the key conundrum: at the event of any irregularity, midwives could do nothing positively protective. Yet in normal births, midwife delivery meant less risk than attendance by physicians, who made septicemia a constant threat to women's lives. Indeed, during much of the nineteenth century, the possibility of death loomed ominously every time a woman brought a child into the world.

So the intellectual liberator of woman died from seemingly fixed oppression, childbed fever. Woman's emancipation began at a basic level: the ability to keep her alive. As Franklin D. Roosevelt enunciated the Four Freedoms as preconditions of humanistic life, so the prerequisite for women became the survival of the act of nature which genetically marked her as female.

In America, from 1880 through the first three decades of this century, a primary contradiction appeared: the lofty ideals of motherhood confronted a dysfunctional maternity care system. Evidence of this breakdown abounds, with none more striking than the high rate of infant and maternal mortality, data particularly distressing when viewed against the pattern of progress of other nations often seen as less developed than the United States.

To an extent unmatched in American history, great sentimentality regarding maternity marked the late nineteenth century. The myth of motherhood characterized the era. Soaring immigration and the burgeoning foreign-born population swelled the urban poor, reflecting increasingly unfamiliar attitudes and customs and highlighting class juxtaposition. Appallingly high infant and maternal death rates became obvious, together with the fact that much loss of life seemed preventable. However, early efforts at amelioration, privately funded, were scattered and haphazard: a milk station here, a maternity dispensary there. Systematic remedial efforts, particularly involving government, began only in the twentieth century.

The "factual generation" of the Progressive era helped break down the myth of maternity with statistics of maternal and infant mortality, developed primarily by the United States Children's Bureau of the Department of Labor. These revelations shocked the public. Women insisted that for motherhood to be meaningful, it--and they and their unborn and infant children--must receive protection from demonstrated risks and dangers. The demand arose for various forms of relief, including maternity insurance (i.e., mandatory rest from employment and compensation for lost earnings at childbirth) and mothers and widows' pensions.

The impact of the contradiction of fact and myth fell most heavily upon poor women. Economic necessity forced them from the socially sanctioned role of full-time motherhood. At the same time pregnancy posed significantly greater health risks for them and their children as they found themselves unable to secure adequate health care for themselves during pregnancy and for their infants.

The aggrandizement of motherhood permitted the invisibility of female employment; the fable of motherhood emerged from an industrial social structure which had constricted its work force. The prototype of maternity worked to turn women's energies inward to the privatism of the home. Women's agenda of occupations showed pregnancy and childcare as its principal elements. The "cult of true womanhood" made motherhood and work mutually exclusive.

Reformers in the early twentieth century discovered the working mother, and made one of the most significant contributions of this century in demanding that government intercede with structural buffers to make motherhood a tenable role for poor women. (Today, reformers and women demand that government make work a plausible role for mothers.) Reformers, with unrelenting force derived from irrefutable statistics, demonstrated poverty as the greatest liability to the health and welfare of women and children.

Remedial efforts focused first upon privatism, philanthropy, and charitable institutions. Later reformers called upon government to provide public assistance for maternity as women's birthright. This evolution from private maternity aid reflected the transition from nineteenth-century notions of charity to twentieth-century concepts of social work.

Early maternity relief associations, generally sectarian, did not address themselves directly to issues of medical care or poverty, but saw moral improvement and the issuance of carefully allotted alms as the cure-all. By contrast, twentieth-century maternity groups viewed healthy childbearing as a function of living conditions. They created medical programs and demanded maternity insurance plans to permit women to receive benefits equivalent to sick pay.

During the same period, medicine underwent its own two-step progress. First was the development of technical and scientific understanding--a sort of latter-day Great Awakening--in which medicine grew from an art or mysterious metaphysics into a science. Obstetrics moved at least as quickly as the body of general medicine. However, medicine entered the twentieth century as a stratified system, challenging practitioners to put the new skills into regular service in order to reach a broader range of social groups. The early twentieth-century public health movement boasts this accomplishment as its principal contribution.

Nineteenth-century obstetrical care (defined narrowly at the time, limited merely to delivery assistance) presented a clear operative dichotomy. Before 1880, only the poor gave birth in hospitals (then seen as facilities of last resort, with heavy overtones of moral reproach to the unwed mothers who filled many of the beds, rather than as life-saving, state-of-the-art institutions), while wealthy women delivered at home, under the care of midwives or, more commonly, physicians. Until then, no one applied real science to birth for anyone, whether at home or in hospital. Yet when science and technique matured, institutional roles reversed, with hospitals beginning to offer more sophisticated and safer care. As wealthier women then began looking to hospitals for in-patient maternity care, institutional maternity services increased. Hospital personnel welcomed and accommodated to this change. In order to support the staff, equipment, and laboratories the new scientific regime required, hospitals became privatized, relying increasingly upon income from paying patients. Hence at the same time hospitals could discard their moralistic stance and become medical facilities, they shunted aside the poor, always the backbone of institutional care. Low income groups, when they got medical aid at all, received it as charity.

Medical science entered the twentieth century nurtured by and dependent upon the wealthy. Although nineteenth-century practitioners also focused on wealthy patients (with reinforcing ideology which saw the poor as bulwarks of health), physicians nonetheless relied upon poor hospital patients as their sole reservoir of clinical material. An unspoken agreement between hospital staff and indigent patients exchanged care for staff clinical evaluation. Hence the poor served a necessary functional role in nineteenth-century medical America. The recession of moralism by new medical skill brought the wealthy to the hospital, left few attendants interested in home medical service, and made the poor dependent upon medical largess for their care.

Even as the public health movement sought to force medicine across class lines with some degree of success, stratification persisted. Reformers found it impossible to eliminate hospitals' distinctions between paying and free patients (indeed, it is only today, with government regulation, that new hospital construction in New York may not include wards or other areas with more than four beds per room).

In retrospect, while public health leaders attempted to open the potentials of medicine to all classes, they actually created a tiered medical distribution system in new form. Medicine remained private for people of means, its

quality control a function of the marketplace. Public medicine, on the other hand, designated itself for the poor, with its quality dependent upon agencies' ability to cull private donations and government generosity. Notwithstanding the clear demonstrations that fragmentation of service delivery blocked progress, the public health movement did not successfully attack medicine's economic basis. No one doubted that centralization saved lives, yet health care could not become a uniform-quality system.

The politicization of medicine (e.g., the recognition that health is primarily a function of social condition and that social class is a greater determinant of health than ignorance or intelligence) released individuals from blame. This redefinition of medicine in the early twentieth century bears important consequences for the analyst of women's issues.

Initial interest in women's health seems a reluctant gesture, since health workers' principal motive was to save infants' lives. Yet once observers saw mothers' survival as important for children's sake, other elements of women's lives drew attention. The discovery that the overwhelming majority of infant deaths resulted from conditions within the mother constituted one of the most outstanding contributions of the public health movement. Earlier advocates focused upon educating the mother for intelligent child

care. This emphasis presupposed mothers' ignorance as the genesis of unconscionably high death rates of infants, a subtle assumption to personalize blame. When statistics breaking down the causal factors of infant death destroyed this remedial approach, health reformers had to unravel the conditions and demands of women's lives. Health and social workers found the pressures upon poor women insoluble without outside government assistance, which would include new institutional or structural buffers. They discovered that poverty destroyed woman's health, and that the inherited poverty of her ancestors made her offspring less capable of post-uterine survival. Moreover, reformers recognized the impossibility of working and mothering in poverty without outside relief, leading to the movement for day nurseries, mothers and widows' pensions, and health and maternity insurance. Statistical and investigative revelations of poor women's health and lives uprooted the myth of motherhood.

The Sheppard-Towner Act of 1921 brought an American first--the initial federal social security measure--but also represented an act of avoidance, a disappointment to the philosophy and activity which spawned it. The Act made modest grants of federal funds to states which committed their own resources, under which workers established and staffed educational programs in prenatal and infant health

work. After eight years, funding ceased and the program vanished.

Compared to European legislative responses to inequitable health coverage, the provisions of the Sheppard-Towner Act appear meager, as they do in light of state legislation providing monetary grants to mothers and proposals guarantying minimum health coverage through insurance (akin to European statutes). The Sheppard-Towner Act did not even meet up to the possibilities of the reform context from which it emerged. The Act avoided health insurance, which would have provided the only equalizer, and relied instead upon the great American panacea, education. Indeed, this reliance ignored the substantial experience of the public health movement, whose leaders had soon realized that social conditions (the stasis of poverty), and not individual ignorance, ruined lives. More than anything, the Act demonstrates, through the strong political and medical opposition it engendered, the deep and abiding antinomy between rhetoric and reality as it applied to women's lives.

The period between 1880 and 1930 saw many citizens beseech the government to become the instrument in the movement from individual remedies to collective resolution. But while European governments responded to similar demands with compulsory health coverage, the fight for health insurance continues in America even today. This period of obstetric

history ends with the recognition that almost all maternal deaths could be prevented, had physicians applied the knowledge then available. Even today the primary causes of infant death in the first year of life are natal and prenatal; that is, causes arising from conditions of women. To attempt to discern the reasons for the discrepancy between knowledge and application represents a principal goal of this dissertation. Also significant are the efforts to evaluate the reasons for and the effect of the divergence of American and European medicine and the respective roles of government.

As America began to address the issues of improved obstetrical and infant care, other questions arose. Why did this happen when it did? Why was there intense pressure to save children, with women's survival becoming important only later? How did the fragmented and balkanized prenatal, maternity, and infant services coalesce and evolve into a public, rather than private, endeavor? To what extent did this process parallel the evolution in American medicine to preventive health care? Was this change in goals reflected in an expansion of the target groups of health care from the narrow range of the upper and middle classes? What was the role of contemporary popular literature of maternity advice? Did authors address the real risks and dangers of childbearing? Was the literature of counsel normative and

prescriptive? If so, how did it work upon women of all socioeconomic classes? What was the role of midwives, and why do they still play a central part in the obstetrical process in Europe while practically none at all in the United States? Finally, what was the state of development of obstetrics in the United States in 1930? What were the risks of childbearing and infant survival, and were they within the reasonable expectations of contemporary medical knowledge?

This study seeks to provide a panoramic view of organized American maternity health care from its systematic establishment in the nineteenth century through its growth and maturation to 1930. Maternity care is defined broadly to include the component parts of the often dialectical but nonetheless singular unity of women's experience: healthy delivery and infancy and satisfactory child-rearing, reconciled with survival demands, both economic and psychological.

The study focuses upon New York City for several reasons. New York was the nation's greatest metropolis. Even before the federal government appropriated its first nickel of funds for child welfare, New York established its municipal Bureau of Child Hygiene. The public health movement concentrated itself in the city, as did the core of the social work explosion. The city, especially through its

Department of Health, served as a national leader, setting the stage for centralized coordination. In establishing control and education for midwives, in its early prenatal work, in its intense efforts with infants, in its city-wide health exhibits, and in its work in the schools (including the first municipally-salaried school nurses), New York set American standards. And, of course, New York City's major hospitals, teaching institutions, and eminent practitioners, as well as large (and increasingly immigrant) population, offered an ideal farrago of problems and possibilities for the archetypical urban laboratory.

New York City was also the adopted home of Henry J. Garrigues. In a sense, this study begins and ends with Garrigues, who in the 1880s demonstrated that physicians and hospitals could nullify practically all fatalities from childbed or puerperal fever. Garrigues set down his principles of antisepsis for hospital organization and for major operative procedures. In the late 1920s, the United States Children's Bureau repeated almost every one of his pronouncements in attempting to retard unnecessary and scandalous obstetric deaths, of which puerperal fever caused almost half.

Yet still there were some who would not listen. The central contradiction in obstetric history marred the potential of American medicine to minimize risk and death in

childbirth. The system simply failed to apply the new knowledge evenly and consistently, as indeed it does in many respects today. This contradiction persists largely because medicine remains a free enterprise business, while the federal government refuses to assume a true centralizing and controlling role.

The diminution in maternal and infant mortality resulted from the medical centralization achieved by the public health movement. Conversely, the failure to diminish mortality (as the potential of medicine might have, and as it did in Europe) stemmed from the failure to centralize as fully as many public health leaders urged.

Women's tragedy as it evolved within the maternity care system lay less in the medical view of pregnancy and delivery as pathological events, as some contemporary historians suggest, than in the class system of medicine which serves them. This dissertation attempts to outline reformers' efforts to ameliorate the class bias of medicine and the resistance which these efforts yielded. It posits the notion that the unnecessary death of any woman in childbirth is the most grinding and cruel oppression imaginable; that women cannot call themselves free until medicine is diverted from a bifurcated framework.

CHAPTER I

THE PAIN OF PREGNANCY

> In a rebellious fury, she had an impulse to utter imprecations; her soul was filled with bitter hatred of the man who had brought this fate upon her, and of this unknown infant who was killing her. She strained herself in a supreme effort to be rid of her burden. Suddenly her womb seemed to empty itself, and her sufferings abated. The nurse and the doctor leant over her and picked up something. Then that stifled sound, which she had heard once before, thrilled her: the little plaintive cry, the feeble voice, as of a cat mewing, of the new-born baby, penetrated her heart and soul and all her poor, exhausted body. Unconsciously she stretched out her arms, in a glowing transport of joy, towards the new bliss that had come into her life. In a moment she found herself free from pain, and happy--happy as she had never been before. Soul and body revived, for she knew that she was a mother.
>
> --Guy de Maupassant
> A Woman's Life

Tracing the historical antecedents of obstetrics requires a review of the ancient practice of midwifery, of women collaborating to bring forth life. Well into the nineteenth century, women shunned the presence of male practitioners in the lying-in chamber. Yet tradition ultimately succumbed to historical transformation. As long as obstetrics remained primarily an art, women's professional preeminence would continue unchallenged. Once incorporated into the learned body of medical knowledge, when theoretical and technical discoveries gave it scientific rank and compelled systematic study, male encroachment followed.

No one ever duplicated the prestige and power of midwives in ancient Greece and Rome. In Greece, midwives' responsibilities extended well beyond care during labor. Better characterized as women's counselors, they served as hygiene and sex guides, as contraceptive distributors, as abortionists, and as matchmakers.[1]

The midwife's status deteriorated steadily with the onset of the Christian era. Medieval theology held women responsible for the world's sin and childbirth became women's common burden; church fathers complacently justified the pain and suffering of childbirth as the penalty for Eve's sin. Travail and possible death would expiate man's carnal transgression.[2] While the scruples of modesty militated against male attendance at birth, prejudices against female education locked midwives into ignorance, since medical and anatomical texts were published in Latin.[3] The initial impact of urbanization exaggerated the consequences of the declining hygienic standard; disease spread rapidly and the toll from childbirth soared. Inevitably, the midwife rather than the environment took the blame.

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[1]Abraham J. Rongy, Childbirth Yesterday and Today: The Story of Childbirth Through the Ages to the Present (New York: Emerson Book Company, 1939), p. 76.

[2]Howard W. Haggard, Devils, Drugs and Doctors: The Story of the Science of Healing from Medicine-man to Doctor (New York: Harper and Brothers, 1929), p. 4.

[3]Rongy, Childbirth: Yesterday and Today, p. 79.

The ultimate debasement of the female came with the practice of intrauterine baptism. As early as the seventh century ecclesiastical authorities permitted midwives to perform the rite of baptism. These authorities then required midwives to execute the service if it appeared that the infant might die before a priest arrived. Mother and child might perish, but the soul would be saved.[1] Mechanical obedience to ritual, rather than science, prevailed.

The eighteenth century marked the watershed in the history of midwifery. When widespread knowledge of the forceps (a family secret for four generations)[2] became

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[1]Ibid., p. 87; see also Haggard, Devils, Drugs and Doctors, p. 4; Thomas R. Forbes, The Midwife and the Witch (New Haven, Conn.: Yale University Press, 1966), p. 141; George Rosen, From Medical Police to Social Medicine: Essays on the History of Health Care (New York: Science History Publications, 1974), p. 281: "While the [medical] hospital was created, it was simultaneously also a religious and spiritual institution, while being a philanthropic institution and an agency of poor relief. Spiritual care, prayer, and religious provisions for the dying were predominant in every Christian hospital. Even when hospitals were taken over from the ecclesiastical authorities by municipalities in the later Middle Ages they were not secularized."

[2]The forceps, two double curved blades, inserted separately into the birth canal to fit either side of the child's head, allowed extraction when the mother's propulsive powers failed or when rapid labor was indicated. The Chamberlens, Peter the older and the younger, invented them ca. 1588 and passed down their knowledge only to their descendents who continued in the family tradition of midwifery. These practitioners teased the public with hints of instruments which would assist in difficult labors. One account, perhaps apocryphal, suggests that anxious physicians bribed Hugh Chamberlen to divulge the secret. In return, they received only one blade of the mysterious tool. Hugh, Jr. finally let the secret leak in the early

available, midwifery became a male-dominated specialty. This technique lent dignity to a field physicians had traditionally avoided.[1] Ecclesiastical and state authorities swiftly enacted legal prohibitions precluding midwives' use of forceps.

In Colonial America, the midwife predominated. New Amsterdam employed a salaried midwife for the poor, while in the South each plantation had its recognized female birth attendant. The colonial midwife, however, enjoyed little prestige or recognition in the form of remuneration or through formal training.[2] Although some colonies established licensing procedures (New York and Virginia

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eighteenth century. Logan Clendening, Source Book of Medical History (New York: Dover Publications, 1942), pp. 179-81. See also Palmer Findley, Priests of Lucina: The Story of Obstetrics (Boston: Little, Brown and Company, 1939), p. 165; Haggard, Devils and Drugs and Doctors, pp. 51-53.

[1]In 1880 an American physician spoke of the preceding years, "The prejudices of the community were so strong against the employment of male midwives that none were inclined to engage in it, as even physicians generally held the same prejudice, and considered any physician who engaged in this practice as occupying lower professional opinion than those engaged in other branches of medicine and surgery." Milbrey Green, A Sketch of Obstetrics and Gynecology in America, The Annual Address Delivered before the Massachusetts Eclectic Medical Society, June 4, 1880 (Boston: Alfred Mudge & Son, 1880), p. 2.

[2]Claude E. Heaton, "Obstetrics in Colonial America," The American Journal of Surgery 45 (September 1939):606-07; Carl Bridenbaugh, Cities in the Wilderness. Urban Life in America, 1625-1742 (New York: Capricorn Books, 1964, orig. pub. 1938), p. 90; Claire G. Fox, "Toward a Sound Historical Basis for Nurse-Midwifery," Bulletin of Nurse-Midwives 14 (August 1969):76-82.

maintained particularly stringent supervision of midwives' capacities) and bestowed midwives with certain civic authority based upon their peculiar expertise (court testimony, for example), midwives continued to practice as individual empiricists, never coalescing professionally. This low social profile attenuated their position once the trade aroused interest among male physicians.

Halfway through the eighteenth century, attitudes changed. American physicians, now privy to the technical revolution in obstetrics, began to consider it a legitimate field of medical practice. Physicians' escalating interests coincided with women's reconsideration of propriety. By the mid-nineteenth century the prejudice against the male accoucheur crumbled.

Physicians introduced the concepts of modern obstetric technique into this country in the Colonial period. After studying in Europe, William Shippen, Jr. returned to Philadelphia in 1762 and delivered the New World's first lectures on obstetrics the following year. Shippen advocated the incorporation of obstetrical theory and practice into medical training. Two years later, he and another Philadelphian, John Morgan, collaborated to form the first medical college in America. Prior to the medical school at the College of Philadelphia, colonial doctors trained

through apprenticeship or, for the wealthy few, in Europe, in Britain, and especially at the University of Edinburgh.

In 1767, two years after Shippen began the medical program in Philadelphia, Samuel Bard established the second medical school in the colonies at Kings College in New York City. The college boasted a medical faculty of six men; among them, John Van Brugh Tennent held the first chair of obstetrics. While Tennent was professor of obstetrics, it was Bard, professor of theory and practice of physics, who later wrote America's first textbook on obstetrics.[1] This attests to the generalist quality of the early American physician. If he attended births at all, he did so merely as part of a rounded busy practice.

After the Revolution, the country sprouted new medical schools (Harvard in 1782, Dartmouth College in 1797, Transylvania University in Kentucky in 1802, and later the College of Physicians and Surgeons in New York City, the

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[1] Heaton, "Obstetrics in Colonial America," p. 608; Irving S. Cutter and Henry R. Viets, A Short History of Midwifery (Philadelphia and London: W. B. Saunders Company, 1934), pp. 155, 160, 170; Martin Kaufman, American Medical Education. The Formative Years, 1765-1910 (Westport, Conn.: Greenwood Press, 1976), pp. 18-24; Whitfield J. Bell, Jr., The Colonial Physician and Other Essays (New York: Science History Publications, 1975); Daniel Boorstin, The Americans. The Colonial Experience (New York: Vintage Books, 1958), pp. 230, 233. In 1791, after the merger of the College of Philadelphia with the University of the State of Pennsylvania, Shippen became Professor of Anatomy, Surgery and Midwifery at the newly-created University of Pennsylvania.

University of Maryland, Yale, and the College of Physicians and Surgeons in the Western District of New York), only some with offerings in obstetrical training.[1] The real stimulus to medical assumption of midwifery came not from the medical schools themselves, but from an increasingly urban society which met the problem of destitution and illness with hospitals. At the first commencement of Kings College's medical class in 1769, Bard entreated the school's friends and patrons to contribute money for the establishment of a hospital to treat the poor and provide clinical training for medical students. Here lay the genesis of New York Hospital, established in 1771.[2] In 1801, the Society of the New York Lying-In Hospital, after seeking unsuccessfully to maintain itself independently, became the lying-in ward of the Hospital. Other cities followed similar patterns. Either municipal authorities attached lying-in facilities to almshouses, or philanthropic men and women created separate institutions for the destitute in confinement. The result was the same. The institutions provided the physician with

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[1]Heaton, "Obstetrics in Colonial America," p. 608; Cutter and Viets, A Short History of Midwifery, pp. 160, 170; Kaufman, American Medical Education, pp. 24, 26-27. Harvard, for example, did not establish a chair of obstetrics until 1815. In that year Walter Channing (1786-1876) became Harvard's first Professor of Obstetrics, holding the position for nearly forty years. (In 1864 Channing became the first to employ ether during childbirth.)

[2]Kaufman, American Medical Education, p. 24.

clinical subjects and eroded public sensibilities against his presence in the lying-in chamber. Gradually, wealthy women--anxious for the quick and easy delivery which physicians' tools seemed to promise--turned to the doctor for childbirth attendance at home.

Before widespread knowledge of the causes of infection and its prevention through antisepsis, physicians employed new obstetrical techniques with great peril to the lives of the women whom they attended. Outfitted with their surgical tools but ignorant of the etiology of infection, physicians brought childbed fever--primarily the scourge of maternity institutions--into the homes of the wealthy. Daniel Boorstin confirms that "the crude statistics of death from puerperal sepsis in Virginia before 1860 show a much higher mortality rate among whites attended by doctors than among Negroes attended by midwives."[1]

Academically, obstetrical training remained superficial, and the United States produced no notable scientific achievements and only few reputable practitioners until later in the nineteenth century. Medical education in general deteriorated progressively from about 1800, culminating in 1830 with state abolition of medical licensing requirements; a medical diploma (from schools which had lowered both standards of admissions and degree requirements) became

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[1]Boorstin, The Americans. The Colonial Experience, p. 216.

the license to practice.[1] By mid-century, medical schools created departments of midwifery, although the subject of obstetrics received rather glib attention.[2] Professors taught obstetrics in combination with gynecology and pediatrics; within this academic matrix, preceptors emphasized gynecology, the area in which American physicians made most significant innovations.[3] Not until the 1880s, when

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[1]John Duffy, The Healers: The Rise of the Medical Establishment (New York: McGraw-Hill Book Co., 1976), p. 291. Kaufman explains the disintegration of American medical standards as the result of a frontier, subsistence society whose citizens could not afford appreciable time away from the rural homestead economy. He counters the opinions of other medical historians who have argued that declining academic medical requirements followed the growth of proprietary medical schools, unaffiliated with colleges of arts and science. Kaufman suggests that the deterioration would have occurred anyway; that the trend among schools for shorter and less demanding courses of study began earlier to accommodate the necessities of a rural society. See American Medical Education, pp. 27-28, 36-37, 39-40.

[2]It was not until the 1850s that British medical schools offered courses in obstetrics. Not until 1866 did British schools require satisfaction of qualifying examinations in midwifery for a medical degree. See Juliet Mitchell and Ann Oakley, eds., The Rights and Wrongs of Women (Middlesex, England: Pelican Books, 1976), p. 31.

[3]In gynecology, the two great names in the nineteenth century were Ephram McDowell, who successfully performed the first abdominal surgery for the removal of an ovarian tumor, and James Marion Sims, who after four years of experiments on slave women perfected the surgical technique for the correction of vesicovaginal fistula. McDowell lived from 1771 to 1830. Born in Virginia, he moved to Kentucky where he learned medicine through apprenticeship and several courses at the University of Edinburgh. In 1809 he performed the first ovariotomy; in the following years he continued to operate successfully, but the medical profession gave no credence to his announced successes until

American students sought training in Germany and brought back knowledge of antisepsis, germ theory, and the etiology of puerperal fever did obstetrics assume the status of high academic art--and even then, only in the elite medical colleges.

Modern obstetrics is the story of male practitioners employing new techniques discovered largely after male professional ascendence.[1] Tradition and often legal proscriptions bound midwives to noninterference in labor and led them to defer to surgeons--even if mere barber-surgeons, despised and degraded by the medical profession. Thus male handling of abnormalities meant that men would receive credit for the scientific leaps of obstetrics. The mastery of childbirth, eliminating the possibility of random death and overcoming physical obstacles to safe delivery, began in the eighteenth century with the emergence of technical

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1824. In 1855, after moving to New York City, Sims collected the necessary funds to establish the Woman's Hospital of the State of New York which specialized in gynecological surgery. See Duffy, The Healers, pp. 136-39; Gert H. Brieger, ed., Medical America in the Nineteenth Century. Readings from the Literature, Ephram McDowell, "Three Cases of Extirpated Diseased Ovaria", pp. 166-68; Boorstin, The Americans. The Colonial Experience, p. 238.

[1]For contemporary polemical treatments of the emergence of obstetrics as a male science, see Suzanne Arms, Immaculate Deception: A New Look at Women and Childbirth in America (Boston: Houghton, Mifflin Co., 1975); Barbara Ehrenreich and Deirdre English, Witches, Midwives and Nurses: A History of Woman Healers (New York: Sears Mountain Press, 1973); Adrienne Rich, Of Woman Born: Motherhood as Experience and Institution (New York: W. W. Norton and Co., 1976).

advances. (Perhaps only of symbolic import, with male supersession, supine delivery replaced the midwife's obstetrical chair;[1] woman gave birth in bed, on her back, strapped down.[2])

Version, or the method of turning a child in the womb for better traction in complicated deliveries, as well as cesarean section, were ancient practices, somehow buried and forgotten for centuries and rediscovered in Western Europe in the eighteenth century. Throughout the early Christian period, church authorities adhered to the principle of male intervention in delivery as they required midwives to call upon surgeons in emergencies (obstetrical surgery, however, was rarely more than the hook extraction--piece by piece--of the dead fetus, performed by barbers).[3] Yet obstetrics

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[1]Roy P. Finney, The Story of Motherhood (New York: Liveright Publication Corporation, 1937), p. 148; Henry J. Garriques, A Textbook of the Science and Art of Obstetrics (Philadelphia and London: J. B. Lippincott Company, 1902), p. 1; Rongy, Childbirth: Yesterday and Today, pp. 96-97.

[2]Women's health activists, who see a parallel between women's powerlessness and the childbirth process, emphasize the change to the lithotomy position; lying down becomes synonymous with passivity. Furthermore, these activists contend the supine position is contraindicated. When delivery is upright, the force of gravity aids with the expulsion of the child; the reclining position, while perhaps more convenient for the attendant, makes resort to forceps more common. Arms, Immaculate Deception; Rich, Woman Born.

[3]In Medieval Europe, many medical schools formally banned the teaching of surgery; by the thirteenth century there were some educated surgeons who attempted to establish

did not assume an independent dignity among physicians until Ambroise Paré, a French surgeon, revived the procedure of version.[1] With the popularization of version and the forceps--the ability to turn and remove a living child from the womb--obstetrics became a recognized field of study and medical research.

Forceps enabled the attendant to grasp the infant's head and extract the child when maternal exhaustion or fetal distress threatened; physicians discarded the dismembering operations of the barber surgeons as mechanical hands produced live issue.[2] Further obstetrical development would await a century's interlude. The hiatus in obstetrical progress came during a period of heightened medical sophistication. Medieval barriers against the study of anatomy and physiology were shaken and the study of medicine, now grounded on the concrete, lost many of its metaphysical aspects.

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surgery as a respectable craft and eliminate the barber. Nonetheless, surgeons remained out of the medical mainstream, snubbed by practicing physicians. See Brian Inglis, The History of Medicine (New York: World Publishing Co., 1965), pp. 84-85.

[1]Herbert Thoms, Our Obstetric Heritage: The Story of Safe Childbirth (Hamden, Conn.: Shoe String Press, 1960), p. 21; Haggard, Devils, Drugs and Doctors, pp. 41-42; Inglis, History of Medicine, p. 80.

[2]Frederick C. Irving, Safe Deliverance (Boston: Houghton, Mifflin Co., 1942), p. 207; Findley, Priests of Lucina, p. 306.

Historical development of obstetric technique, and the potential of minimizing childbirth risk, are essentially nineteenth and twentieth century phenomena. Although ergot had long been employed by midwives to bring on abortion, the medical profession recognized its prophylactic application in parturition only after Dr. John Stearns of New York City published the results of his experimentation in 1822. Since then, ergot has been used primarily to control postpartum hemorrhage.

Toxemia is perhaps the most debilitating complication of pregnancy; when left untreated, it develops into eclampsia, a severe convulsive condition. Eclampsia is preceded by symptoms of headaches, blurred vision, edema, and vomiting. Only after the first quarter of the twentieth century, with the observation of women throughout pregnancy and prenatal monitoring of their urine and blood pressure, did eclamptic casualties begin to diminish.[2]

As early as 1843, obstetricians speculated as to the cause of eclampsia. In that year, John Charles Weaver Lever found albumin in the urine of toxemia patients. Although physicians then equated puerperal albumineria with Bright's

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[1]Findley, Priests of Lucina, pp. 78-79.

[2]Nicholson J. Eastman, "Obstetrics and Gynecology," in 75 Years of Medical Progress, 1878-1953, Louis H. Bauer, ed. (Philadelphia: Lea and Febiger, 1954), p. 96. As late as 1920, between 20 and 30 percent of maternal deaths resulted from eclampsia.

(kidney) disease, Lever's observations introduced urinalysis into the model prenatal health program.[1] It was not until the 1920s, however, that the two diseases were properly distinguished. (Blood, of course, carries bodily wastes to the kidneys, where they are transformed into urine. The pre-eclampsic patient suffers from arterial constriction which disables the kidneys' waste removal properties. With the relief of the patient's high blood pressure, normal kidney functioning resumes.)[2] Ironically, even into the twentieth century, many physicians treated convulsions by inducing labor. This led frequently to death from shock, a classic instance of iatrogenic short-sightedness.

As late as 1894, Fordyce Barker, a nineteenth-century professor of obstetrics, recommended bleeding the convulsive woman, relieving "the vascular tension of the brain," and administering diuretics combined with heavy doses of purgatives. This treatment terminated in the induction of premature labor. While by the twentieth century the "heroic" medical therapeutics had been thoroughly discredited, doctors still managed threatened or actual

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[1] Irving, Safe Deliverance, p. 227.

[2] Ibid., pp. 230-31. However, the cause of toxemia is unknown even today.

[3] Fordyce Barker, The Puerperal Diseases. Clinical Lectures Delivered at Bellevue Hospital (New York: D. Appleton and Company, 1894), p. 99.

eclampsia by accouchement forcé, "the forcible dilatation of the intact or partially dilated cervix, followed by version and extraction of the child."[1] If this method failed to induce vaginal delivery, the attendant performed a cesarean section.

By 1930, if proper dietary regime failed to quiet toxic symptoms and eclampsia followed, medical therapy ignored the pregnancy and treated convulsions, through sedation.[2]

The new procedures of internal manipulation of fetal position and mechanical expulsion remained a mixed blessing to women, as the introduction of hands and instruments into the womb caused unbearable pain. The application of anesthesia to childbirth made life-saving interventions relatively comfortable (although it may also have released a certain restraint upon the practitioner).

For centuries, hemp and opium had been used to mask birth pains. Nineteenth-century birth attendants relied upon laudanum, which may have alleviated pain but also served to prolong labor by delaying contractions.[3] While anesthesia was an American discovery, credit for the first

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[1]J. W. Williams, Obstetrics: A Text-book for the Use of Students and Practitioners (New York: D. Appleton and Company, 1903), p. 347.

[2]Eastman, "Obstetrics and Gynecology," p. 96.

[3]Findley, Priests of Lucina, pp. 236-37.

application of pain relief in childbirth belongs to James Young Simpson, Professor of Obstetrics at the University of Glasgow. In 1847, he demonstrated the anesthetic qualities of chloroform, its safe use, and its advantages over ether in the lying-in chamber.

Simpson fought bitterly against the religious establishment, which opposed any relief for women's pain in childbirth. Theologians quoted the Scriptures, urging that pain was a necessary component of childbearing,[1] while Simpson counterattacked with selected Biblical passages. The real breakthrough occurred in 1853, when Queen Victoria approved the use of chloroform in the delivery of her seventh child.[2]

The germ theory of disease revolutionized medicine, as Louis Pasteur's discoveries transformed the uncertain art into a research and preventive science. What Pasteur accomplished for medicine Joseph Lister did for surgery. That germs--airborne or transmitted by the practitioner's hands or equipment, causing infection--could be controlled by

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[1]Roy P. Finney, The Story of Motherhood (New York: Liveright Publishing Co., 1937), pp. 156, 160, 170. See Genesis III:16: "Onto the woman, he said, I will greatly multiply thy sorrow and conception; in sorrow thou shalt bring forth children; and thy desire shall be to thy husband and he shall rule on thee."

[2]Haggard, Devils, Drugs and Doctors, p. 117. When Queen Victoria again asked for chloroform in the delivery of her eighth child, opposition to the alleviation of pain in childbirth was eliminated in Great Britain.

antisepsis changed surgery from the dreaded, life-threatening last resort to a life-preserving procedure. Surgeons' status leaped; from menial practitioners they became the elite of organized medicine.[1]

In obstetrical surgery, cesarean section is the most complicated and traumatic procedure. With the advent of antisepsis and later asepsis, its acceptance was similarly expanded.

The history of cesarean section extends to the ancients and their custom of separate burial of the mother and child. Medieval Christians revived the operation, attempting to extract a living child from a dying mother and hence save another soul for Christianity.[2] Notwithstanding this discovery and employment of anesthesia, mortality from cesarean section through the first half of the nineteenth century was enormous; most women died from surgical shock or

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[1]William G. Rothstein, American Physicians in the Nineteenth Century. From Sects to Science (Baltimore: The Johns Hopkins Press, 1972), pp. 253-58. As used herein, antisepsis refers to the destruction of unwanted disease-producing microorganisms (e.g., through the use of germicidal agents), while asepsis means the state of absence of or freedom from such microorganisms.

[2]Findley, Priests of Lucina, pp. 372, 375. While Greek physicians countenanced abortion if pelvic deformity threatened normal delivery, medieval Christians banned it, advocating cesarean section instead. The latter promised certain death for the woman. Until the late nineteenth century, women with deformed pelves faced ominous labor. Haggard, Devils, Drugs and Doctors, p. 26.

infection.[1] Landmarks in the diminishing risk rate of cesarean section included Max Sanger's 1882 monograph noting the necessity of uterine sutures, Roentgen's discovery of X-rays in 1895, the capacity to transfuse safely with the recognition in 1900 of distinct blood groups, and the development of systematic prenatal care which would reduce the need for the operation. By 1939, the discovery of antibiotics virtually eliminated the risks of infection.[2]

Perhaps the most unnecessary of all obstetrical risks, most tragic because it is not intrinsic to the birth process itself, is puerperal or "childbed" fever, a septic infection of the reproductive area. Although ancient medical recorders noted the "disease," its scattered occurrence merited only casual attention. By the seventeenth century, however, it had become the scourge of Europe, its epidemic proportions undiminished for two centuries.[3]

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[1]Findley, Priests of Lucina, p. 378. The first cesarean section performed in the United States where both mother and child lived was in 1887.

[2]Theodore Cianfrani, A Short History of Obstetrics and Gynecology (Springfield, Ill.: Charles C. Thomas, 1960), pp. 403, 409, 418; Irving, Safe Deliverance, pp. 137, 252; Eastman, "Obstetrics and Gynecology," pp. 91, 95.

[3]According to Frank G. Slaughter, Europe was hit with two hundred epidemics of puerperal fever between 1652 and 1862; a wave of the disease crossed Europe between 1773 and 1776, annihilating more than one-tenth of the population of lying-in hospitals throughout the continent. With the creation of maternity hospitals and wards, the fever emerged; within six months of the establishment of the first lying-in hospital in

Until the twentieth century puerperal fever was almost always fatal. Undoubtedly the only blessing was that death came relatively quickly, within twenty-four hours of contraction, for the hours before were filled with agonizing horror. As the fever soared widely, women were overcome with chills, severe abdominal pain, distention and vomiting; next, in reverse rhythm, women perspired exhaustively, with delirious hallucinations, often followed by a period of lucid tranquility, then coma and death.[1]

In fact, puerperal fever is not a disease, and even the name is somewhat misleading, emphasizing as it does the febrile qualities. It is a severe form of septicemia located in the pelvic region of the lying-in woman. In its most fatal form, it is caused by the streptococcus microbe; the staphylococcus or gonococcus produces milder manifestations of infection. Responsibility for its transmission generally lay outside the woman herself, on the hands of her attendants, on their instruments, and potentially on the

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London, ca. 1750, 24 women died of the fever. In Vienna's noted Allegemeine Krankenhaus, in 1822 an epidemic killed one of every six women confined there. While version and the forceps promised safe delivery in abnormal labor, these early procedures often killed women with septic infection. Immortal Magyar Semmelweis, Conqueror of Childbed Fever (New York: Henry Schuman, 1950), pp. 3-6.

[1]Thomas F. Cock, Manual of Obstetrics (New York: Samuel S. Wood and W. M. Wood, 1853), p. 204.

sheets, towels, or pads with which they draped and dressed her.[1]

If not an indictment of the male accoucheur, it is nonetheless an unavoidable observation that childbed fever essentially lay dormant while the midwife reigned. Her practice of noninterference, an outcome of legal restrictions against her employment of operative procedures, her isolation from other disease, and an oral tradition calling for patience before the unfolding of natural processes worked to minimize her responsibility as an agent of infection. Obstetricians did not merely provide the hands and instruments to carry germs; they resisted the notion of sepsis obstinately, even when presented to them in definitive and scholarly fashion.

Increasingly urbanization made childbed fever one of the most serious public health problems in western Europe. Public hospitals serving the indigent emerged from the concentrated population. Unfortunately, the initial effort to cure frequently resulted in a sentence of death. Charity hospitals bred disease and cross-infection, with beds crammed into unswept and poorly ventilated wards. Municipal ordinances required poor women needing aid during confinement to use these institutions.

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[1]Harry Wain, A History of Preventive Medicine (Springfield, Ill.: Charles C. Thomas, 1970), p. 220; Finney, Story of Motherhood, p. 192; Williams, Obstetrics, pp. 957-58.

News of mortality could not be buried with the women; poor women often fled the hospitals,[1] or when choice of midwife or doctor was possible, pleaded pitifully to receive care from the female attendants.[2] Oliver Wendell Holmes, Sr., reported that in a private hospital in London, women were buried two in a coffin to hide the true mortality rate.[3]

Until the late nineteenth century, medical opinion differed over the nature and etiology of puerperal fever. Since it occurred most frequently in the postpartum period, most physicians regarded the fever as a specific disease such as yellow fever or small pox, related to "noxious air" or atmospheric conditions. As late as 1872, Charles Bell, an American physician, called it a blood disease which could "be inhaled from the atmosphere."[4] Other medical interpretations were interlaced with moralism. The fever became

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[1]Finney, Story of Motherhood, p. 200; Slaughter, Semmelweis, p. 4; Haggard, Devils, Drugs and Doctors, p. 80.

[2]Semmelweis wrote that the fact that lying-in patients, "dreaded the First Division [the hospital clinic staffed by medical students] can be readily demonstrated, because one must encounter heart-rending scenes, when women, wringing their hands, beg on bended knee for their release in order to seek admission in the Second Division [run by midwives] . . . ." Quoted in Slaughter, Semmelweis, p. 48.

[3]Ibid., p. 39.

[4]Charles Bell, "A New Mode of Treating Puerperal Fever," The American Journal of Obstetrics and Diseases of Women and Children 5 (August, 1872):362.

one of the "peculiar diseases" to which the fragile sex was susceptible.[1] There was a hint of personal blame in physicians' speculations, a suggestion that the fever was somehow connected to bodily constitution or moral fiber. In 1808, one doctor warned both midwives and general practitioners to be particularly vigilant when attending women of the upper class, since puerperal fever was more likely to strike "weak and delicate women, and especially those accustomed to genteel life."[2] Barker, in 1894, repeated the view that upper-class women provided the most likely targets for the fatal disease.[3] On the other hand, some physicians imagined the fever to be a symptom of lower-class degeneracy; their clinical work, they claimed, lent credence to the suggestion that unmarried women were most susceptible to the fever. If they did not specifically bring epidemic havoc, then, according to these clinicians, it was not the fault of the institutions which women of the lower class inhabited, but of the women themselves for somehow "tainting" the environment.[4]

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[1]See Rich, Of Woman Born, p. 168, for the observation of the Reverend Richard Polwhile upon Mary Wollstonecraft's death of puerperal fever.

[2]Samuel K. Jennings, The Married Lady's Companion, or Poor Man's Friend (New York: Lorenzo Dow, 1808), p. 158.

[3]Barker, Puerperal Diseases, p. 439.

[4]Leopold Putzel, "Puerperal Fever," The American Journal of Obstetrics and Diseases of Women and Children 8 (August 1875):294; Cock, Manual of Obstetrics, p. 203.

In 1795, Dr. Alexander Gorden of Scotland discovered the contagious nature of puerperal fever; it took a century, and two more scholarly theses, to persuade the medical profession to accept its responsibility for the infectious quality of puerperal fever. As early as 1773, Charles White posited rational preventive measures. Although he attributed postpartum fever to an accumulation of uterine secretions, he also blamed hospital conditions of filth and musty, dust-ridden air for igniting its swift and unrelenting spread. He admonished hospital administrators to clean and ventilate their maternity wards; as significant, he urged the isolation of afflicted patients and uterine drainage in lieu of bleeding, then the prevelent method of treatment.[1]

White's demands for ventilation and general cleanliness received increasing attention; unfortunately, his fears that bleeding simply resulted in the patient's loss of vitality were ignored until after the middle of the nineteenth century. Dr. Gorden demonstrated that cases of puerperal fever followed a distinct pattern; they occurred in women attended by the same practitioners. Although ridiculed for his thesis, Gorden, without the benefit of

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[1]Charles White, A Treatise on the Management of Pregnant and Lying-In Women, and the Means of Curing, but More Especially of Preventing the Principle Disorders (London: Edward and Charles Dilly, 1773).

clinical observations (and therefore without convincing proof), went to the root of causation: "If putrid matter be applied to the uterus, it inflames that organ and the contiguous viscera; that is it gives rise to the puerperal fever."[1]

Oliver Wendell Holmes, Sr., heard similar ridicule when he presented his essay on "The Contagiousness of Puerperal Fever" to the Boston Society for Medical Improvement in 1843. Responsibility for carrying the infection rested not with the patient, but with her attendants, said Holmes. The fault lay in uncleanliness. But Holmes was not an obstetrician, and without an arsenal of clinical observations, European physicians ignored him and the American medical elite mocked him.[2] Charles D. Meigs, the leading contemporary professor of obstetrics in the United States, responded sardonically to Holmes: "I prefer to attribute [childbed fever] to accident or Providence of which I can form a conception rather than to a contagion of which I cannot form any clear idea, at least to this particular malady."[3] Had Holmes' essay received serious attention

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[1]Alexander Gorden, A Treatise on the Epidemic of Puerperal Fever of Aberdeen (London: G. G. and J. Robinson, Paternoster Row, 1795), p. 3.

[2]Cutter and Viets, History of Midwifery, p. 129; Wain, Preventive Medicine, p. 222.

[3]Quoted in Findley, Priests of Lucina, p. 224.

instead of scorn, thousands of women's lives might have been saved. He urged the obstetrician to sever his participation in postmortem examinations of puerperal victims, and placed the watchdog responsibility on the physicians' shoulders:

> On the occurrence of a single case of puerperal fever in his practice, the physician is bound to consider the next female he attends in labour, unless several weeks at least have elapsed. . . . If within a short period, two cases of puerperal fever happen close to each other, in the practice of the same physician . . . he would do wisely to relinquish his obstetrical practice for at least one month. . . . The occurrence of three or more closely connected cases in the practice of one individual . . . is prima facie evidence that he is the vehicle of contagion.[1]

History credits Ignaz Philipp Semmelweis, born in Budapest, Hungary in 1818, with definition of the etiology of puerperal fever, based upon clinical foundations. As Assistant Professor of Midwifery and Attending Physician to Vienna's Allegemeines Krankenhaus, women's agonizing pleas for delivery by midwives puzzled Semmelweis. The hospital serviced poor parturient women with two clinics, one run by medical students and the other by midwives. This arrangement offered him the first clue in unraveling the mysteries of women's dreaded plague.

In the medically-staffed First Division, mortality from childbed fever was nearly three times as high as in the

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[1]Oliver W. Holmes, "The Contagiousness of Puerperal Fever," in Inglis, History of Medicine, p. 152.

Second or Midwives' Division.[1] These statistical revelations were merely a frustrating riddle until a close friend died of blood poisoning after suffering a small wound while conducting an autopsy. Pathological examination revealed changes matching those found in women who died of puerperal fever. The enigma disappeared. Puerperal fever was nothing more than infection; medical students were carrying cadaveric material from the dissecting table to the delivery room. It was not competence, but the fact that they did not perform autopsies, which gave midwives the better record. Although Semmelweis first traced the septic agent to cadaveric matter, a year later he recognized that the putrefaction of any organic matter would produce the disease.[2] Hence he revised and enlarged his injunction that physicians disinfect their hands. All that came into contact with the genitalia of the lying-in woman, including the linen, must be free from any association with decomposing animal life.

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[1]Semmelweis compiled and compared the mortality of the two divisions between 1841 and 1846. The First Division experienced a mortality rate of 10 percent. In the Midwives' Clinic, the rate was 3.4 percent. This divergence became more marked in 1846; puerperal mortality climbed to 11.4 percent in the students' clinic while that in the Midwives' was 2.7 percent. See Wain, History of Preventive Medicine, p. 224.

[2]Semmelweis, The Cause, Concept and Prevention of Childbed Fever, 1861, exerpts in Clendening, Source Book, pp. 607-09.

In open confession, Semmelweis acknowledged his own guilt as women's death agent. Anxious to divine the secret of puerperal death, he had traversed from autopsy to delivery. In attempting to rally the medical profession, he insisted that "however painful and depressing the recognition may be, there is no advantage in concealment; if the misfortune is not to remain permanent, the truth must be brought home to all concerned."[1] Despite the success he and his students had after employing antiseptic solution (the death rate from puerperal fever fell from 18 percent in April 1847 to 1.2 percent in July 1848), organized medicine remained recalcitrant. Ridiculed and professionally ostracized, Semmelweis became emotionally unstable. He died, ironically, from a septic infection on April 13, 1865. On the day before Semmelweis' death, Joseph Lister proclaimed his principles of antiseptic surgery.[2]

The medical establishment remained indifferent, in spite of Semmelweis' evidence and the 1867 publication of Lister's principles. In 1856, the Paris Maternité closed; when it reopened, the fever showed no signs of abatement.

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[1]Semmelweis, quoted in Inglis, History of Medicine, p. 154.

[2]Wain, History of Preventive Medicine, pp. 225-26.

Between 1860 and 1864, 1,226 of 9,886 patients died of the fever, a mortality rate of 12.4 percent.[1]

Perhaps the sectarian nature of American medicine impeded acceptance of Semmelweis' discovery. An obstetrical manual in 1853 attributed "seven eighths" of all deaths connected to childbirth to puerperal fever; the author questioned the justification of lying-in institutions, "so frequent are cases of puerperal fever . . . so fatal are they when they occur."[2] In 1874, an American doctor declared in a child-birth manual: "Nothing can be more discordant than the opinions of medical men regarding [puerperal fever's] essential nature or proper mode of treatment."[3] Writing in The American Journal of Obstetrics and Diseases of Women and Children in 1872, Dr. S. L. Jepson resignedly characterized childbed fever as "an accident," which more than any other medical fatality highlighted the physician's ultimate powerlessness.[4]

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[1]Finney, Story of Motherhood, p. 288; Slaughter, Immortal Magyar Semmelweis, p. 167.

[2]Thomas F. Cock, Manual of Obstetrics, pp. 203, 212.

[3]R. T. Trall, The Mother's Hygienic Handbook; for the Normal Development and Training of Women and Children, and the Treatment of Their Diseases with Hygienic Agencies (New York: S. R. Wells, 1874), pp. 116-17.

[4]S. L. Jepson, "Sudden Death in Puerperal Cases," The American Journal of Obstetrics and Diseases of Women and Children 5 (August 1872):192.

Dr. Gunning Bedford of New York University Hospital fully accepted the Semmelweis thesis as early as 1861, in the publication of his obstetrical textbook. This most scholarly of nineteenth-century texts announced that there was "nothing specific--nothing essential" about puerperal fever.[1] Yet, there is no indication of any medical consensus among the "regular" medical establishment. In 1875, Dr. Leopold Putzel reported puerperal fever "more prevalent in cold and damp seasons" and proportionately more frequent among primipara.[2] Nine years later, a physician writing in The American Journal of Obstetrics and Diseases of Women and Children flirtingly admitted that the septic theory "was a most attractive one."[3]

Throughout his long and influential career, Fordyce Barker, Clinical Professor of Midwifery and the Diseases of Women at Bellevue Hospital and former president of the Medical Society of New York, as well as president of the American Gynecological Society, rejected the identification of

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[1]Gunning S. Bedford, The Principles and Practice of Obstetrics (New York: Samuel S. and Wm. Wood, 1861), pp. 681-2. The text was originally published in 1855, then again in 1856, 1861, 1862, 1863, 1866, 1868, 1869, and 1876.

[2]Leopold Putzel, "Puerperal Fever," The American Journal of Obstetrics and Diseases of Women and Children 8 (August 1875):294.

[3]R. K. Kinkead, "Questions Relative to Puerperal Fever," The American Journal of Obstetrics and Diseases of Women and Children 17 (July 1884):600-01.

postpartum fever with septicemia. In the 1894 publication of his text, while conceding the fever's contagious component, he maintained, as he did in 1857, that "it is as much a distinct disease as thyphus fever and typhoid fever." His discussion of puerperal diseases lacks mention of antisepsis. Instead, he reiterated his view that childbed fever is more prevalent in the sanitary homes of the upper class than in the crowded tenements of the poor.[1]

Medical science did not accept fully the septic nature of the fever--its identity to ordinary surgical fever --until Lister and Pasteur made obstinacy embarrassing. Semmelweis' full vindication came finally in 1879, when Pasteur identified the streptococcus in the lochia (vaginal discharge) and bloodstream of a patient dying from puerperal fever. The English translation in 1880 of Robert Koch's treatise, The Cause of Wound Infections, supplemented Pasteur's discovery. Koch noted that other bacteria as well as the streptococcus caused disease. Since bacteria are found everywhere, the only prophylaxis could be careful antisepsis.

Practitioners recognized that the parturient woman was an ideal candidate for infection, since childbirth often caused lesions in the birth canal and the exposed raw uterus

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[1]Barker, Puerperal Fever Diseases, pp. 439, 476.

was identical to an open wound.[1] By the turn of the century, physicians had at least agreed to the fever's nature, hence to its prevention. Using the plural rather than the more speculative singular, Dr. I. A. McSwain definitely asserted in 1901: "We no longer look upon the fever as being a disease."[2] In the 1903 edition of perhaps the most widely-used obstetrical textbook of the period, J. Whitridge Williams declared the rule: asepsis, limited number of vaginal examinations during labor, and immediate repair of perineal lacerations.[3]

Henry Jacques Garrigues, a native of Denmark living in New York, provided the first convincing demonstration in the United States that large maternity hospitals could, with the systematic application of antiseptic technique, become lifegivers. While working as gynecologist in the German Dispensary, in 1881 he was appointed obstetric surgeon to the maternity department of Charity Hospital. It was there on Blackwell's (now Roosevelt) Island in 1883, serving the city's most destitute, that he changed American hospital care for lying-in women.

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[1]Finney, Story of Motherhood, p. 235; Haggard, Devils, Drugs and Doctors, pp. 169-71; Inglis, History of Medicine, pp. 152-52; Irving, Safe Deliverance, p. 165; Slaughter, Semmelweis, pp. 8-10, 202.

[2]S. A. McSwain, "Puerperal Fever," The American Gynecological and Obstetrical Journal 19 (September 1901): 219.

[3]Williams, Obstetrics, p. 785.

In 1886 he described his ultimate success, preceded by experimental failures, staff discouragement and criticism. Upon joining the staff, he introduced antiseptic guidelines requiring doctors and nurses to wash in a 2 percent solution of carbolic acid before and after any vaginal examination. His routine prescribed the same chemical compound for vaginal douching before delivery and twice daily thereafter for the next eight days as well as sterilization of instruments with a stronger solution of the same disinfectant. After his first six months of service, the data revealed eight deaths attributed to septicemia of the 200 women who had delivered. The rate of 4 percent, a high proportion, put Garrigues under much critical pressure.[1]

Commencing in October 1882, for the next six months he dispensed with vaginal antiseptic injections on the theory that the nurses who administered them came directly from the general wards. At the end of the period, the mortality rate was even higher. Of 192 women who had been delivered, 15 died, 9 of infection, for a septic rate of 4.6 percent. The trend continued: from April 1 to

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[1]Henry J. Garrigues, Practical Guide in Antiseptic Midwifery in Hospitals and Private Practice (Detroit: George D. Davis, 1886), pp. 12-13. See also James V. Ricci, ed., Contributions from the Department of Gynecology of the City Hospital, New York, James V. Ricci, "A Glance at the History of City Hospital and into the Lives of Its Gynecologists" (New York: New York Medical College, 1945), pp. 1-71.

October 1, 1883, there were 17 septic deaths among 237 women who delivered, or 7 percent. In November, 1883, one in five women died of one cause or another, and the septic death rate was 16 percent.[1]

Aware that toleration among the hospital administrators was running thin, Garrigues made one final effort. Charity, a large general hospital, usually housed between seventy and eighty expectant women; transfer to the separate maternity pavillions came only with the onset of labor with return to the general wards as soon after delivery as possible. Garrigues persuaded officials to revise this procedure, prescribing the containment of postpartum women in the separate pavillions for at least nine days after delivery. Garrigues prohibited all outside visiting to lying-in patients, and he barred contact with doctors attending Charity's medical and surgical wards. He substituted bichloride of mercury for carbolic acid and ordered antiseptic cleansings for the rooms, furniture and linen, as well as for patients and staff.[2]

The results were astonishing. During the three months following these revisions, not a single death occurred among the 102 parturients. From October 1, 1884

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[1]Garrigues, Practical Guide, pp. 19, 21. In November 1883, fifty-one women delivered with ten deaths.

[2]Ibid., pp. 21-24.

to October 1, 1885, among 541 women who delivered there were four deaths, a rate of 0.75 percent; in the next ten-month period, the rate was 0.78 percent, with three deaths among 384 lying in women.

With renewed confidence, Garrigues expanded the plans for hospital safety. Fresh air must be ensured through proper ventilation and water-closets should be isolated; they must have open windows and be disinfected. Instruments and laundry must be sterile, with the linen of an infected patient to be washed separately. Wards should be rotated routinely (i.e., emptied regularly and fumigated) and the sick must be isolated from the healthy, with special nurses and doctors for each.[1] The removal of afterbirth should be accomplished through Credé's method; the accoucheur's hands must never enter the woman's genital tract after delivery. Upon the birth of the infant, prompt application of silver nitrate to its eyes would prevent ophthalmia neonatorum or infant blindness.[2]

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[1]Ibid., pp. 28-32, 73-75.

[2]In 1882 Carl Sigmund Franz Credé, Professor of Obstetrics and Gynecology at Leipzig University, urged that the delivery of the afterbirth should not be hastened with the introduction of the attendant's hand into the uterus as was the custom. He maintained, instead, that uterine contractions, perhaps abetted by external manual pressure of the abdomen, would be sufficient to accomplish placental expulsion. Credé's second discovery was the prophylactic application of silver nitrate to the newly-born's eyes, destroying bacteria which might have been collected while

Major lying-in institutions copied the Garrigues' antiseptic model with the same convincing results. The re-opening of the Boston Lying-In Hospital in 1873 after sixteen years reflected the abandonment of "heroic" therapuetics of bloodletting, blistering, purgatives, and emetics. While staff acknowledged the contagious nature of childbed fever, they considered the disease self-emanating from uterine discharge unrelated to infection. Although administrators rotated wards and isolated the sick with special nurses, personnel did not adopt antisepsis. The ratio of septic deaths among the women averaged about one in twenty until 1883, when epidemic struck and one of every four women became infected. Dr. W. L. Richardson, Professor of Obstetrics at Harvard and Visiting Physician to the Boston Lying-In, read about Garrigues' work at New York Maternity and immediately ordered the use of bichloride of mercury as a bathing and douching solution for patients and scrubbing agent for the staff. Postpartum fever death rates reflected the change instantly; the ratio fell to one in sixty-two.[1]

Antisepsis evolved into asepsis; a sterile environment would make unnecessary the repeated application of

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pushing through the birth canal. These bacteria, of which the gonoccoci were the most dangerous, were a major cause of blindness.

[1]Irving, Safe Deliverance, pp. 129, 165-68.

liquid antiseptics. Progressive hospital services installed autoclaves for the sterilization of materials coming into contact with patients; instruments were boiled; and with the introduction of rubber gloves in 1903 it was possible to hope that the attendant's hands might never again become woman's death agent.[1]

As hospitals adopted aseptic preventatives, new therapies for the afflicted emerged. Through the middle of the nineteenth century, blood depletion (either through lancet or leech) and purgatives were the most common modes of treatment. In 1861, Bedford's recommended enema consisted of "half an ounce of turpentine, with the same quantity of castor oil, every six or eight hours." Blistering was not uncommon, supplemented with heavy doses of opium.[2]

The drug therapy of the "regular" physician was a mixed blessing at best. Their preoccupation with fever reduction led to the experimental use of antipyretics. Eventually doctors abandoned these drugs because of nasty side effects. They discarded aconite since it risked cardiac arrest. In the 1880s, quinine was the drug of choice.

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[1] Ibid., p. 197.

[2] Bedford, Principles and Practice of Obstetrics, pp. 95-96; see also Cock, Manual of Obstetrics, pp. 206-07; Jennings, Married Lady's Companion, pp. 91-92; T. Morton, "On Cases of Puerperal Septicemia Treated by Elimination," The American Journal of Obstetrics and Diseases of Women and Children 6 (November 1873):513-19.

Yet it too had its drawbacks, weakening the heart and pulse while causing general tension and gastric distress. Stimulants for appetite inducement were simultaneously administered with analgesics, the favorite being opium (the importation of which into the United States soared between 1860 and 1910).[1]

"Irregular" physicians, homeopaths, and hygienists, if no more effective, were at least a little kinder to fever-stricken women. They vehemently rejected blood depletion, relying instead on local treatment and mild doses of cathartic drugs. Hygienists advocated the use of cold wet sponging to relieve fever and tepid enemas to remedy abdominal distention. In 1898, Alice B. Stockham wrote: "Sweat the patient as soon as possible. Place several steaming bricks or ears of boiled corn about her . . . . If gangrene threatens, it is often arrested by the application of a yeast and charcoal poultice."[2]

By the new century, scientific developments would cure the mildly-infected woman. While Barker continued to deny the infectious etiology, hence the antiseptic treatment, of childbed fever, by 1894 he rejected therapy by "purgatives, emetic, and diuretics" as "positively

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[1]Rothstein, American Physicians, pp. 126-93.

[2]Alice B. Stockham, Toxology: A Book for Every Woman (Chicago: Alice B. Stockham and Co., 1898), p. 207; see also Trall, Mother's Hygienic Handbook, pp. 116-18.

injurious." Instead, he recommended arterial sedatives to lower the pulse, opiates to relieve pain, and cold sponging to control temperature. Yet Barker was the last stronghold. The Garrigues textbook, published in 1902, marked a significant therapeutic advance. The primary aim was to destroy any bacteria which might remain in the genital tract, but had not yet infected the tissue. Vaginal antiseptic ablution might accomplish this. Cauterization was the next indication, to seal tissue and prevent germ invasion. Enemas for internal antisepsis might then be given. To sustain a patient's strength and improve her resistance, Garrigues recommended free use of stimulants and food (within ten years blood transfusions were administered for this purpose). Narcotics could relieve pain, and cold sponging would reduce fever.[2] The final conquest of puerperal fever would come later, with the discovery of sulfanilamides, penicillin, and antibiotics.

In two centuries scientists demystified childbirth. The abnormalities of birth caused by complications of pregnancy, fetal malpresentation, pelvic deformity, or maternal exhaustion could be addressed with systematic application of knowledge. Version and forceps extraction assured that

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[1]Barker, Puerperal Diseases, pp. 492, 509.

[2]Henry J. Garrigues, A Text-Book on the Science and Art of Obstetrics (Philadelphia: J. B. Lippincott Company, 1902), p. 128.

infants and mothers need no longer be passive victims of long and battering labors. The acceptance of anesthesia for use in childbirth meant the end of women's painful endurance of operative interference.

At the turn of the century the germ theory made medicine a science, boosting the field of medical research. New discoveries narrowed the range of childbirth fatality. Patients and doctors no longer dreaded cesarean section as an awesome procedure. No one seriously doubted the etiology and prevention of puerperal fever.

In spite of this progress, which made puerperal fever virtually preventable, it remained the principal killer of women in childbirth throughout the first third of the twentieth century. In 1927, an epidemic of childbed fever closed Sloane Hospital for Women in New York City. During January and February of that year, 24 of 163 women who delivered became infected and 8 died.[1] In 1929, maternal mortality in the United States was 6.8 per 1,000 live births (in Sweden for the year it was 2.3). Childbed fever caused 40 percent of these deaths. Thus every year 7,000 women died needlessly in the United States. The fever's victims numbered many more, since by 1929, for each

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[1]B. P. Watson, "An Oubreak of Puerperal Sepsis in New York City," Journal of Obstetrics and Gynecology 16 (August 1928):178.

afflicted fatally three or more patients lived. At least 20,000 women survived, many scarred for life with some degree of invalidism.[74]

Thus while technology should ultimately have triumphed, the persistence of puerperal fever deaths bore tragic testament to the gap between knowledge and application. In a system where economic status inevitably determined the quality of health service delivery, the revolution in medical care demanded a concomitant overhaul in social awareness and response for vitality.

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[1]Haggard, Devils, Drugs and Doctors, p. 88.

CHAPTER II

MATERNITY HOSPITALS: REDEMPTION, NOT MEDICINE

> To pass from it [the New York Hospital] to the Bellevue Hospital affords a contrast somewhat startling. The one combines in its structure and administration nearly everything that medical and sanitary science has revealed for the relief of the sick. . . . But the other is a hospital for the poorest of the poor, the dregs of society, the semi-criminal, starving, unwelcome class, who suffer and die unrecognized, and to whom charity at the best is cold and mechanical.
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> --W. H. Rideing, 1878

In 1875, the International Congress of Physicians, meeting in Brussels, found an overhaul of contemporary lying-in facilities "of urgent necessity." The Congress resolved that maternity services, especially those in large institutions, be abolished. Twenty-seven years after the publication of Semmelweis' research and conclusions, this international body of physicians agreed that high mortality, especially from childbed fever, was the inevitable result of the congregation of parturient women. The group, persuaded, urged that home confinement be encouraged, and went as far as to resolve that city governments assume the costs of women's confinement in

midwives' homes.[1]

Garrigues responded in defense of the maternity institutions. In 1878, he published a survey of lying-in hospitals in New York City, in which he concluded that although antisepsis was rarely or haphazardly applied, the nature of the facilities' clientele mandated their preservation. His brief highlighted the character of organized maternity care through most of the nineteenth century in America. For the poor and the unmarried woman, for whom the hospitals were intended, Garrigues urged that non-home care was the safest alternative.[2]

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[1]Resolutions of the International Congress of Physicians, 1875, in Henry J. Garrigues, "On Lying-In Institutions Especially those in New York," reprinted from Transactions of the American Gynecological Society 2 (1878):1. Professional opposition to maternity hospitalization was not isolated to Europe. Gunning Bedford, one of America's leading obstetricians in the mid-nineteenth century, wrote in his text, The Principles and Practice of Obstetrics (New York: Samuel S. and William Wood, 1861), p. 694: "We are firm in our conviction, that if the poor were attended at their own home--defective as they may be to ordinary comforts--instead of being exposed to the infection of crowded wards, the bills of mortality would be greatly diminished."

[2]Garrigues, "On Lying-In Institutions," p. 19. Garrigues' defense of maternity hospitals took four lines. First, he argued that although infection rates were indeed higher in hospitals, mortality from other complications of pregnancy (e.g., hemorrhage, eclampsia) was lower. Second, the death rate in hospitals was higher because many cases were emergencies. Third, most hospital parturient women assumed greater risks since the majority were primipara. Finally, mortality was greater in hospitals than in the city at large because hospitals "have a less favorable class of patients. The majority

Through the nineteenth century, hospitals were primarily charitable institutions. While the secularization of the medieval hospital attenuated its religious orientation, the medical aspect of hospitalization did not predominate until the twentieth century. The function of institutional medical care was chiefly social.[1] In an era marked by the relatively low level of medical technology, it was designed to serve perceived needs for social order and morality, with its service to the art of healing and the professional goals of practitioners peripheral to this more encompassing aim. The sick poor saw hospitals as a last resort--a place to die;[2] women bearing children viewed them as refuges in destitution or houses of shame and moral restoration for the unmarried.

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of patients who seek the lying-in asylums are unmarried, and it cannot be doubted that this circumstance has a bad influence on their chances of recovery," pp. 18-25.

[1]George Rosen, From Medical Police to Social Medicine. Essays on the History of Health Care, "The Hospital: Historical Sociology of a Community Institution," (New York: Science History Publication, 1974), p. 274. Rosen depicts the hospital as an outgrowth of a particular social setting, "an organ of society," reflecting its outlook as well as changing with alterations of social philosophy.

[2]While St. Vincent's Hospital was the first hospital in New York City to provide private facilities, they were hardly utilized: "[T]he rich for a long time continued to receive medical care, including surgery at home, and the poor feared admission to the hospital as a death sentence, a way station to a pauper funeral." Rosen, "The Hospital: Historical Sociology," p. 297.

As a result, medicine remained a fragmented system, with no preventive overview. Hospital maternity care included neither prenatal nor postpartum observation, with delivery service disconnected from the total process of pregnancy and women's health.

New York City's major lying-in hospitals were located in Manhattan,[1] and through 1874, Bellevue hospital was the only city-run institution with maternity facilities.[2] Until the latter part of the century, institutional obstetrical care was a private (although frequently gratuitous) function, provided at small, specialty hospitals rather than the large voluntary hospitals which were also established during the period.[3] The exclusion of

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[1]Many hospitals had branches, often used for convalescence, in the suburban, outlying boroughs of Staten Island and Queens. The concentration of maternity facilities, all medical services, in Manhattan continued into the twentieth century. In 1927, Michael M. Davis and Mary C. Jarrett wrote: "Manhattan, with only 30 percent of the population and a declining population at that, is now the seat of 62 percent of the clinic services offered by all agencies and 50 percent of all the home visiting." A Health Inventory of New York City. A Study of Volume and Distribution of Health Service in the Five Boroughs (New York: Welfare Council of New York City, 1927), p. 43.

[2]The State administered Emigrant Hospital, on Ward's Island. Hospital administrators established lying-in wards at Charity Hospital in 1874 and at Metropolitan Hospital in 1895.

[3]After 1827, when the New York Lying-In Hospital and New York Hospital severed their ties, the latter ceased to provide obstetrical care. The annual reports of St. Luke's Hospital, established in 1858, give no

maternity care from the services of general hospitals reflected no inconsistency with demand. Upper- and middle-class women, especially, and lower-class women when they could afford to do so, continued to have their babies at home.[1]

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evidence of maternity service. See Annual Reports of St. Luke's Hospital, New York, 1869-1900 (New York: James Pott and Co.). According to the Local Visiting Committee for Bellevue and other Hospitals, organized to visit and report on conditions at charitable institutions in New York State, Catholic hospitals could not provide lying-in service because the Church prohibited nuns from attending such cases. This then meant that St. Vincent's Hospital, opened in 1849, did not provide maternity care. See Local Visiting Committee for Bellevue and Other Hospitals, To the Governors of the Society of the New York Lying-In Asylum (New York: State Charities Aid Society, 1876), p. 1. Although the Visiting Committee noted that Mount Sinai (established in 1855) admitted a small number of married women for confinement, the annual reports (except that for 1873-1874, which records the birth of eight infants in the hospital) do not suggest maternity service. Until 1877, the reports list only medical and surgical wards. In 1877, the hospital added a gynecological division. In 1898, the hospital boasted medical, surgical, gynecological, ophthalmological, otological, and pediatric departments. See Annual Reports of the Directors of the Mount Sinai Hospital, 1873-1920 (New York: Stettiner Brothers). The Presbyterian Hospital (1872) did not offer obstetrical care until the Sloane Hospital was established in 1887 and became a part of the P&S complex. See Harold Speert, The Sloane Hospital Chronicle. A History of the Department of Obstetrics and Gynecology of the Columbia-Presbyterian Medical Center (Philadelphia: F. A. Davis Co., 1963).

[1]In the United States, hospital deliveries in 1937 amounted to 37 percent of the total number of live births; in 1941, the figure rose to 51 percent; by 1946, it was 82 percent. See Nicholson J. Eastman, "Obstetrics and Gynecology" in 75 Years of Medical Progress, Louis H. Bauer, ed. (Philadelphia: Lea and Febiger, 1954), p. 90. Earlier data show that in New York City in 1915

Until the last two decades of the nineteenth century, Manhattan saw the creation of only two private institutions with the avowed, singular aim of providing maternity care. In 1799, philanthropists incorporated the Lying-In Hospital of New York, marking the first delivery service in the city. Later the same year, a lying-in ward opened at the New York City Almshouse (later to become Bellevue).

The genesis of the Lying-In Hospital lay in the response of charitable gentlemen to the yellow fever epidemic which swept the city in 1798. According to the founders, the poor bore the major brunt of the disaster; the benefactors' sympathies focused on destitute women, many of whom suddenly became widows. The hospital operated for almost two years at No. 2 Cedar Street; insufficient funds forced its discontinuance in 1800. In 1801, an agreement between the Governors of the Lying-In Hospital and the New York Hospital re-established the functions of the former as the obstetrical ward in New York Hospital. This relationship continued until 1827, after which the Society of the Lying-In Hospital remained

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only 30 percent of the deliveries were connected with hospitals; another 30 percent were conducted by midwives and another 40 percent by general practitioners or obstetricians at home. See George W. Kosmak, "Prenatal Care and Maternity Welfare from the Standpoint of the Maternity Center without Hospital Connection," New York State Journal of Medicine (August 1923):2.

dormant until 1892 when it assumed the financing of the Midwifery Dispensary.[1]

The only other institution in Manhattan designated specifically for parturient women was the Old Marion Street Maternity Hospital, organized in 1823 and incorporated in 1827 as the New York Female Asylum for Lying-In Women. The Marion Street facility grew out of the New York Female Assistance Society, organized in 1813 for the relief of the sick poor. While the Asylum never served large numbers of women, and since it was later incorporated into a more dynamic institution, its significance lay in the provision, the first of its kind, of outdoor medical care for home delivery.[2]

Four major hospitals incorporated obstetrical attendance as a part of their larger aims. The New

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[1]The Society of the Lying-In Hospital of the City of New York, Annual Report from January 1, 1922 to December 31, 1923, p. 69. In 1855, the Society instituted a program of financial aid to needy women in their homes during confinement. Although the records have been lost, it is evident that this service did not seriously interfere with the growing interest of the original endowment. See James A. Harrar, The Story of the Lying-In Hospital of the City of New York (New York: The Society of the Lying-In Hospital, 1938), pp. 11-12, 14, 18, 21, 28, 38.

[2]New York Female Assistance Society for the Relief of the Sick Poor, Seventieth Annual Report, 1883, pp. 5, 8; New York Female Assistance Society, Eighty-third Annual Report, 1896, p. 3; New York Nursery and Child's Hospital, Annual Report for the Year Ending September 30th, 1915, p. 13; James J. Walsh, History of Medicine in New York. Three Centuries of Medical Progress, 5 vols. (New York: National Americana Society, 1919), 3:825.

York Infirmary for Women and Children and the New York Medical College and Hospital for Women offered maternity care as general hospitals; however, their founders designated the hospitals primarily to serve the clinical needs of their women medical students and thus these institutions treated all the ills of women and children, with no special emphasis on obstetrics.[1] Of these four, the

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[1]Dr. Elizabeth Blackwell established a small dispensary in 1854 at Tomkins Square, after New York City's dispensaries refused her admission to practice. In 1855, the dispensary became incorporated and in 1857, it added a hospital and became known as the New York Infirmary for Women and Children. A college incorporated in 1865 and opened in 1868, offering the first "regular" college education to women in New York City. The college was closed in 1899, when educators deemed it best for women students to be connected to large university schools. The Infirmary moved to 128 Second Avenue in 1860 and to 5 Livingston Place at Stuyvesant Square in 1874. For the history of the Infirmary see The New York Infirmary. A Century of Devoted Service, 1854-1954 (New York: N. Y. Infirmary, 1954), p. 20; New York Infirmary for Women and Children, Thirty-seventh Annual Report for the Year 1890, p. 7; The Woman's Medical College of the New York Infirmary for Women and Children, Final Catalogue, 1899, pp. 7, 9; S. Josephine Baker, Fighting for Life (New York: The Macmillan Co., 1939), p. 34. As listed in the Thirty-fourth Annual Report, 1887, p. 7, the original aims of the Infirmary included (1) a hospital for poor women and children where they could receive treatment by female practitioners; (2) a clinical training program for women medical students; and (3) a training school for nurses. In 1863, Dr. Clemence Sophia Lozier established the first women's medical college in the world. In 1864, the trustees purchased a hospital building and reincorporated the college as the New York Medical College and Hospital for Women (a homeopathic institution). The hospital opened in 1869. In 1895, the college reincorporated as part of the University of the State of New York. The College and Hospital were first located at 74 East 12th Street, then moved to the west side at 54th Street, and finally, in

Nursery and Child's Hospital and the New York Infant Asylum typefied more the nineteenth-century approach to organized maternity care. Obstetrical care, which became a major service in both institutions, was initially a second thought developed only to further more important aims.

The Nursery and Child's Hospital was originally incorporated in 1854 as "The Nursery for the Children of Poor Women." As the name suggests, the Society provided care for children whose mothers worked, specifically the children of wet nurses, often forced to abandon or neglect their children. Since many of these children were feeble, in 1856 the founders added a children's hospital department, and the institution's name changed to the Nursery and Child's Hospital.[1] While a nursery for children might prevent abandonment, it did not affect the existing foundling population. To remedy this

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1898, to 101st Street and Manhattan Avenue. See Walsh, History of Medicine, 5 vols., 2:354, 552, 562; Mary S. Macy, "The Field for Women Today in Medicine," The Woman's Medical Journal 26 (March 1916):65-66. Woman's Hospital and the Infirmary for Women in Washington Heights were gynecological hospitals, without obstetric services.

[1]This was the first children's hospital in the United States. Until it opened, no hospital would admit children under twelve years of age. See Nursery and Child's Hospital, Fifty-sixth Annual Report, 1909-1910, p. 7; Nursery and Child's Hospital, Thirty-second Annual Report, 1885-1886, p. 17. The Nursery was located at 51st Street and Lexington Avenue.

situation, the Nursery opened a foundling home. With the assumption of this function, it became apparent to the administrators that child abandonment might diminish if poor, homeless, prospective mothers had a safe abode, and the staff annexed a lying-in ward in December 1865 which operated after the Civil War.[1]

The New York Infant Asylum opened in 1865. Abandoned two years later when high death rates nullified its intentions, its sponsors reorganized the facility in 1871 as a Protestant alternative to the Catholic Foundling Hospital, serving as an asylum for children to age two.[2] Like the Nursery and Child's Hospital, the Infant Asylum established a maternity division aimed not at providing safe delivery care, but "to thwart and prevent suicide, infanticide and murder."[3] This latter function grew out of the intentions of the Reverend M. R. Richmond, whose original plans for the charity emerged while visiting the

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[1]Nursery and Child's Hospital, Constitution and By-Laws (New York: E. D. Croker, 1886), p. 3; Nursery, Twelfth Annual Report, 1866, pp. 5-6; Nursery, Seventeenth Annual Report to March 1, 1871, p. 7.

[2]New York Infant Asylum, Appeal in Behalf of the New York Infant Asylum (New York: American Church Press, 1872), pp. 13-14; New York Infant Asylum, Charter and By-Laws, May, 1865 (New York: E. B. Clayton's Sons, 1865), pp. 5-7, 9-11; New York Infant Asylum, Annual Report, 1873, p. 10; New York Infant Asylum, An Appeal on Behalf of the New York Infant Asylum, 1900, pp. 3-4. After 1873, the Asylum moved from small quarters to 61st Street and Tenth Avenue.

[3]Infant Asylum, Appeal on Behalf, 1873, p. 11.

maternity wards at Bellevue Hospital; he became convinced that a more home-like atmosphere would work to elevate the character of the women and hence save children.[1]

Initially, some institutions refused to serve the unmarried pregnant woman, but since "respectable" married women consistently avoided hospital care unless destitute, most facilities opened services to the unwed.[2] The State chartered the New York Asylum for Lying-In Women to admit only "reputable females." In 1851, the policy remained intact, with a thorough character evaluated required for admission. Blithely, the annual report for that year declared that "immorals" could go to Bellevue. In order to attract more patients, however (the yearly average of those confined in the Asylum was about 120 women), a wet nurse employment service became an important feature of the institution.[3] Of more significance was the so-called "outdoor" division, with marriage not a condition for attendance. (Outdoor facilities represent the equivalent

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[1]Infant Asylum, Appeal on Behalf, 1900, p. 4; Walsh, History of Medicine, 5 vols., 3:827.

[2]Boston Lying-In Hospital, which was established in 1832, refused to change its policy regarding unmarried women. In 1856, lack of patients forced it to close for sixteen years. See Frederick C. Irving, Safe Deliverance (Boston: Houghton Mifflin Co., 1942), p. 123.

[3]New York Asylum for Lying-In Women, Fifth Annual Report of the Managers, 1828, p. 13; Asylum for Lying-In Women, Twenty-eighth Annual Report, 1851, pp. 5, 6; Asylum for Lying-In Women, Forty-fourth Annual Report, 1867, p. 4.

of today's out-patient, or ambulatory clinics; they also serviced patients at home.) The outdoor division treated a yearly average of 399 patients between 1852 and 1875.[1] Lying-in homes could not be self-sustaining if dependent only upon the married woman.

The original Constitution of the Nursery and Child's Hospital required that a working mother bring "a certification of good character" and proof of employment, and mandated that wet nurses show their marriage certificates.[2] Yet once the objects of the institution expanded beyond child care to the larger effort to prevent maternal abandonment, the unwed mother became linked inextricably to the facility. Thus the twenty-first annual report shows that 65 percent of the 226 children born there in 1874-75 were illegitimate.[3]

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[1]Garrigues, "On Lying-In Institutions," p. 26. Citing the 1876 annual report of the New York Asylum for Lying-In Women, Garrigues noted that since its foundation, the Asylum had cared for 4,134 patients while it had delivered 15,222 women in their homes.

[2]Nursery and Child's Hospital, Constitution, 1854, pp. 13, 15.

[3]Nursery and Child's Hospital, Twenty-first Annual Report, March 1875, p. 23. Like the Nursery, other urban maternity hospitals catered to the single mother. See, for example, Annual Reports of the Maternity Hospital in Philadelphia. According to its 1915 report, of the 4,020 women delivered since its establishment in February, 1873, 3,364 women were unmarried. Maternity hospital, Annual Report, 1915, p. 5. This was true also of the Brooklyn Homeopathic Maternity, founded in 1871.

Physicians working for the New York Infant Asylum estimated that in 1871 in New York City, between 2,500 and 3,000 illegitimate births occurred.[1] According to hospital administrators, many unwed mothers, driven by despair and shame, either killed or deserted their infants. The Hospital admitted homeless mothers to save them from "moral ruin," as the founders created lying-in wards to prevent "child murder" and abortion.[2]

Hospital officials at the Nursery and the Infant Asylum justified maternity work with the unmarried woman as the only humane alternative for the infant. If not abandoned or destroyed, illegitimate children often landed in baby farms, private homes where they were "hand-fed, with a distinct understanding to all parties that such infants would not long survive." These infants usually died of starvation and physical abuse. When abandoned and found alive, the city received them at the foundling hospital (Infants' Hospital) on Blackwell's Island, where most died in the first few weeks of life. The final alternative, hardly palatable for Protestants, was placement in the Catholic foundling hospital, already crowded

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[1]Infant Asylum, Appeal on Behalf, 1873, p. 11.

[2]Infant Asylum, Appeal on Behalf, 1873, Nursery, Twelfth Annual Report, 1866, p. 6; New York Infant Asylum, Eighth Annual Report, 1880, p. 8.

"to excess."[1]

Having taken in the unmarried mother, albeit for her child's sake and not hers, hospital spokesmen became her champions against public charges that aid to the unwed mother merely sanctioned and fostered illegitimacy. A romantic view of pregnancy as the great neutralizer of even the most unenviable status in life intertwined with the defense. The most stoic of women are "at this period extremely susceptible, and may be rescued from an impending life of crime, if placed with their children under the home-like discipline of a well-ordered charity."[2] If encouraged to stay with her child, the theory went, she developed strong and binding love, sure to foster community cohesion and tranquility.

Realization came that infant survival depended in large measure on maternal nourishment.[3] The recognition of the centrality of the mother subtly shifted the emphasis of the Nursery and the Infant Asylum from homes for abandoned children to institutions striving to attract the women before birth, with the goal of keeping mother and

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[1]Infant Asylum, Appeal on Behalf, 1873, pp. 12-13.

[2]Ibid., pp. 16-17.

[3]Ibid., pp. 17-18; Nursery and Child's Hospital, Twenty-seventh Annual Report, March 1881, p. 11.

child together. Nursing was not the sole basis necessitating mother's care; as early as 1874, the directors of the Infant Asylum knew that children fondled less and responded to more slowly did not thrive as did children who received the "little attentions which maternal love alone" carried.[1]

By 1881, the Infant Asylum refused to admit infants without their mothers. The 1886 house rules forbid the mother to leave the institution until the child was three months old. If the woman chose to leave then, rules prescribed that she must take the child with her. If, instead, she stayed in the institution a year after confinement, nursing her child and preferably one other, she could leave the child in the Asylum while she went out to work.

Hospital administrators expressed confidence that even a three-month period would forestall maternal desertion.[2] Provisions in the City Charter, which granted payments to the institution only for women who remained more than two months reinforced these rules; funding would continue a year after delivery, provided that the mother

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[1]New York Infant Asylum, Annual Report, January 20, 1874, p. 27.

[2]New York Infant Asylum, Ninth Annual Report, January 18, 1881, p. 13; Infant Asylum, Fourteenth Annual Report, January 19, 1886, p. 40; Nursery and Child's Hospital, Fiftieth Annual Report, 1903, p. 7.

continued to nurse: "The provision have for their object, the cultivation of that maternal affection, which shall lead the mother to keep the child with her, and to work for its support, after she leaves the institution."[1] While the mother saved the child, hospital spokesmen reasoned, the mother's salvation came through the infant. The child's innocence would provoke courage and purity in the woman. "The child becomes, as it were, guardian of the soul of the mother."[2]

Hospital administrators' public expressions of sympathy toward unmarried women meshed with the thrust of the nineteenth-century purity crusade--that women bore the brunt of the double standard. As long as the "average man is not held directly answerable for his moral conduct . . . the necessity of lying-in asylums will exist."[3] Unless men and women suffer equally for their sin, pain belonged to neither party. The trustees of the Nursery regarded it "a privilege" to comfort and "shelter . . . a penitent mother and her helpless infant."[4] So adamant

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[1]New York Infant Asylum, Twenty-eighth Annual Report, for the Year 1899, pp. 10-11.

[2]Nursery and Child's Hospital, Nineteenth Annual Report, 1873, p. 23.

[3]New York Infant Asylum, Sixteenth Annual Report, Report of the Ladies' Committee, January 17, 1888, p. 35.

[4]Nursery and Child's Hospital, Thirty-second Annual Report January 1, 1886, p. 21.

was the Ladies' Committee of the Asylum's Lying-In Department that its members ignored distinctions between the acceptable and unacceptable sinner:

> Maternity and shame should never be interlinked, but since our imperfect civilization admits to such a state of semi-barbarism, since neither civil or divine law has regulated or sufficiently enlightened the world to prevent this class of injustice and crime, it is more and more apparent that even unworthy women should be protected from censure and wretchedness during pregnancy.[1]

The theme recurred that these women were simply "injured victims of deception and fraud."[2] Betrayal, followed by desertion, was the perceived road to illegitimacy. Stories of poor girls lured away by men, "moral lepers," with promises of wealth, abound in the annual reports of these institutions.[3] Staff members expressed unequivocal views:

> The MOTHERS represent every grade of society, and every degree of intelligence. The illegitimate child is generally the first-born of the mother, who, with rare exceptions, is the victim of seduction under promise of marriage. She has fallen, while her motives are yet

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[1]Infant Asylum, Sixteenth Annual Report, Report of the Ladies' Committee, p. 35.

[2]New York Infant Asylum, Fourth Annual Report, January 18, 1876, p. 14.

[3]For examples, see Nursery and Child's Hospital, Twelfth Annual Report, p. 7; Maternity Hospital, Annual Report, 1915 (Philadelphia: Press of Patterson and White Co., 1915), p. 3; Brooklyn Maternity, Fourth Annual Report, October, 1874 (New York: E. B. Tripp, 1875), p. 14.

> innocent, through the atrocious deception practised upon her affections.[1]

The principal goals of these specialty hospitals remained moralistic, not medical. Workers saw the redemption of the unwed mother, with its concomitant aims, the prevention of prostitution and infanticide, as more important than the safe delivery of the child and healthy recovery for the woman. Staff physicians ignored prenatal care. The institutions did not welcome women earlier than four weeks before delivery, although hospitals asked them to remain a year afterwards for the sake of their infants and to "earn good characters." One institution "recommend[ed] that waiting women should not, as a rule, be received for any longer period than is absolutely necessary before confinement."[2] While hospital staff members often manifested genuine empathy for the unwed mother, perhaps bordering on militant feminism, they never shook their sense of moral rectitude. Although maternity institutions enveloped first sinners warmly, hospitals closed their doors to second offenders.[3] The perimeters of

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[1] Appeal on Behalf, 1873, p. 11.

[2] Nursery, Nineteenth Annual Report, 1873, pp. 22-23; Infant Asylum, Ninth Annual Report 1881, p. 20.

[3] Infant Asylum, Eighth Annual Report, 1880, p. 62; Infant Asylum, Appeal on Behalf, 1900, p. 1; Brooklyn Maternity, Eighth Annual Report, January 1, 1879, p. 139; Philadelphia Maternity Hospital, Annual Report, 1915, p. 4.

nineteenth-century morality would only extend so far. Moral didacticism would prevail; hospital administrators forgot an infant's innocence if mother had not learned her lesson. Perhaps women bearing a second illegitimate child revealed that sex, not deception, was the root of illegal intimacy. The Nursery and Child's Hospital staunchly refused "those who have not repented, and have fallen a second time"; staff members remained in "constant vigilance that no evil association can contaminate those who we hope to restore to a virtuous life."[1]

In spite of the solicitude, the Nursery and Child's Hospital and the Infant Asylum retained qualities of a reformatory, with rigid internal rules and patterns. Women were to be reminded "not . . . in words" that "any undue levity, or the use of evil words, must be considered as showing unworthiness of the refuge afforded."[2] The Nursery expected each woman to nurse her own child and another's; if a woman lost her child and still desired a wet nurse position, the institution's rules required her to suckle two children before discharge. Rules stipulated that women participate in the chores of the institution--washing, ironing, and cleaning. (Advice

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[1]Nursery and Child's Hospital, Twenty-sixth Annual Report, 1880, pp. 6-7.

[2]Nursery, Annual Report, 1886, p. 26.

literature addressed to middle-class women during the period forbid this kind of work for pregnant and post-partum women.) In many respects, these hospitals involved themselves more in character building than in medical assistance. Behavior was the crucial criterion winning aid and recommendation in obtaining employment.[1]

Through the nineteenth century, the Department of Charities and Correction (which ran New York City's public institutions) operated only two hospitals, Bellevue and Charity, offering obstetrical services. Bellevue, the larger with approximately 1,200 beds, treated between 7,700 and 9,000 patients annually and delivered between 400 and 500 women.[2] The oldest hospital in the United States, its remote history dates back to 1658 when the West India Company established an infirmary attached to the first almshouse in New Amsterdam. Municipal authorities opened a lying-in ward in 1799 in the Public Workhouse and House of Correction, now expanded for the third time. In 1811, the city purchased land in the "Belle Vue"

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[1]Nursery, Constitution, By-Laws, and Regulations (New York: Billen and Brothers, 1854), p. 15.

[2]Department of Public Charities and Correction, Twenty-third Annual Report for the Year 1882; Garrigues, "On Lying-In Institutions," p. 26; John Duffy, A History of Public Health in New York City: 1866-1966 (New York: Russell Sage Foundation, 1974), p. 179; Charles Rosenberg, "The Practice of Medicine in New York a Century Ago," Bulletin of the History of Medicine 41 (May-June 1967): 238-39.

section of Manhattan where it built a new workhouse, morgue and two hospital pavilions, with the complex known as the Bellevue Establishment. When the city transferred the almshouse to Blackwell's Island in 1848, the facility gained independent status and became known as Bellevue Hospital.[1]

Louisa Lee Schuyler, a member of one of New York City's "first families" who had been active in the U.S. Sanitary Commission, subsequently founded the State Charities Aid Association, a nonpartisan, non-sectarian group. Notwithstanding its name, the Association operated without state aid; its mission was to improve charitable institutions in New York. A local branch, the Bellevue Hospital Visiting Committee, consisted of 60 women, with Mrs. Joseph Hobson serving as chairwoman of a subcommittee to oversee the surgical wards for women.[2]

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[1]Public Welfare Committee, Humanizing the Greater City's Charity. The Work of the Department of Public Charities of the City of New York (New York: Public Welfare Committee, 1917), p. 57; Walsh, History of Medicine 5 vols., 2:475-76; Page Cooper, The Bellevue Story (New York: Thomas Y. Crowell Co., 1948), pp. 8, 10, 23-24, 26; Claude Edwin Heaton, "Obstetrics at the New York Almshouse and at Bellevue Hospital," p. 39; Don Gold, Bellevue. A Documentary of a Large Metropolitan Hospital (New York: Harper and Row, 1975), pp. 11-12; John Starr, Hospital City (New York: Crown Publishers, 1957), pp. 8-15; Mary Risley, House of Healing. The Story of the Hospital (Garden City, New York: Doubleday and Co., 1961), p. 216.

[2]Cooper, The Bellevue Story, pp. 85-86.

On an inspection, Mrs. Hobson found no dishes, knives or forks; rats cleared away food scraps, and the cook brewed coffee and soup in the same pot. In the laundry, a "feeble old man was poking a kettle with a stick," trying to do the laundry for the whole hospital without soap, absent for six weeks because the appropriation had been exhausted. The creation of the Bellevue Hospital Training School for Nurses followed on May 1, 1873, with Mrs. Hobson's report instrumental.[1]

Before the establishment of the Training School, Bellevue's "nursing" staff consisted of so-called "ten-day women," female offenders serving short sentences, brought each day from Blackwell's Island after they had been dried out and were sober. The hospital had no night nurses, simply three watchmen on duty. Even by 1874, no professional nurses worked at Bellevue's obstetrical wards. The hospital medical board refused at first to provide a nursing staff, but when the visiting committee threatened a public scandal, in May 1874, the medical board finally invited the Training School to staff the three wards.[2]

Then, a new outbreak of puerperal fever struck, and the visiting committee investigated. When the women's

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[1]Ibid., p. 86.

[2]Starr, Hospital City, p. 120.

group gave the medical board 24 hours to remove the lying-in wards from the surgical service, again threatening to go to the press, the board instead closed its obstetrical service and moved the patients affected to Charity Hospital on Blackwell's Island.[1]

The epidemic of puerperal fever at Bellevue took the life of one of every six women confined; between January 1, 1874 and June 11, 1874, 31 of the 166 patients confined in Bellevue's wards died. Staff efforts to control the contagion ignored the physical organization of the wards, probably--after uncleanliness--the key factor causing cross-infection. Maternity wards sat directly above the surgical services, connected to the medical unit; house rules did not prohibit physicians working in general surgery from attending lying-in patients. Without such reorganization all attempts to stymie the fever necessarily failed, and the city finally closed the wards and transferred lying-in services to Charity Hospital on Blackwell's Island.[2]

The origins of Charity Hospital can be traced to 1832, when the city erected a hospital atop the

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[1]Ibid., p. 121.

[2]William T. Lusk, "The Genesis of an Epidemic of Puerperal Fever," The American Journal of Obstetrics and Diseases of Women and Children 8 (November 1875):398; see also Irving, Safe Deliverance, p. 161.

recently-constructed prison on Blackwell's Island.[1] Not without reason, authorities called the facility Penitentiary Hospital. In an effort to disconnect the hospital from unsavory associations, city officials renamed it Island Hospital in 1857. In 1866 they changed the name to Charity Hospital, and in 1892 to City Hospital.

In 1860, after a fire destroyed the original structure, the city constructed a new central building with outlying wooden pavilions for distinct specialty services.[2] Bellevue first housed its maternity patients in one of these pavilions in 1874.[3]

Charity had a bed capacity of 1,000 and accommodated about 7,000 patients a year, all without charge.[4] Annual confinements ranged between 400 and 550.[5]

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[1]The city purchased the island from James Blackwell in 1828. See James V. Ricci, gen. ed., Contributions from the Department of Gynaecology of the City Hospital, New York, Ricci, "A Glance into the History of The City Hospital and into the Lives of Its Gynaecologist and Obstetricians" (New York: New York Medical College, City Hospital Division, 1945), p. 1.

[2]Ibid., pp. 3-4; Walsh, History of Medicine, 5 vols., 3:728-29; Public Welfare Committee, Humanizing the City's Charity, p. 57.

[3]Department of Public Charities and Correction, Twenty-eighth Annual Report, 1891, p. 3.

[4]Department of Public Charities and Correction, Twenty-third Annual Report, 1882; Duffy, History of Public Health, p. 179; Rosenberg, in "Medicine in N.Y. a Century Ago," set the figure at 7,574.

[5]From October 1882 to October 1883, Charity delivered 429 women; between October 1883 and October 1884,

Apparently, maternity patients found conditions no better on the Island than at Bellevue, at least until the hospital adopted Garrigues' methods of antisepsis and constructed new maternity pavilions in 1888. Before then, maternity patients found themselves crowded into the general wards. Since the original pavilions could not house all parturient cases (about 50 new cases per month, but as many as 100 at any time), female wards housed an eclectic group without rational subdivision: "The beds stand very near one another in the main building; in the large wards, not only on the sides of the room, but also in groups in the middle."[1]

Once Garrigues began working at Charity, he reported mortality figures of 8 percent for the six months between October 1, 1882 and April 1, 1883; mortality remained stationary in the next six-month period.[2] It is a reasonable assumption that earlier mortality rates were no lower. Moreover, the public hospital patient delivered her baby under the eyes of professors and medical students hungry for clinical observation. The 1902 annual report

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there were 505 deliveries and during the next 12 months there were 541 confinements. See Henry J. Garrigues, Practical Guide in Midwifery in Hospitals and Private Practice (Detroit: George S. Davis, 1886), pp. 19, 21, 28-30, 31.

[1]Garrigues, "On Lying-In Institutions," p. 46.

[2]Garrigues, Antiseptic Midwifery, pp. 19, 21.

of the New York Infirmary for Women and Children underscored a major advantage of a small maternity hospital for poor women who could not afford proper home attendance. Private hospitals, which served pedagogic needs less obviously, "saved the poor patient from being looked upon exclusively as material for study."[1]

Bellevue and then Charity's maternity clientele presented a farrago of the city's most destitute--even more impecunious than private hospital patients. Although mortality statistics were hardly ideal, the Commissioners of Public Charity expressed satisfaction at hospital results, in view of the kind of patients which public hospitals attracted:

> No department of the institution [Charity] reflects more credit upon its management than the Maternity Wards. When it is remembered that the class of patients admitted here include many suffering from advanced stages of pulmonary and venereal diseases; that others are transferred from the work-house, sent thither for vagrancy and debauchery; that some are mere wrecks of dissipation, whose constitutions are not able to withstand the extra strain incident upon motherhood; that our doors are open to all, regardless of their history or physical conditions, and when it is also remembered that the service has in large part been carried on in the very wards of the Hospital where its proximity to disease renders it particularly hazardous, the results . . . are particularly gratifying.[2]

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[1]New York Infirmary for Women and Children, Forty-ninth Annual Report, 1902, pp. 7-6.

[2]Commissioners of Public Charities and Correction, Twenty-first Annual Report for the Year 1880 (New York: Asylum for the Insane, 1880), p. 32.

Similarly, Dr. William R. Gillette, a physician to Bellevue and then Charity's maternity wards, cautioned his audience to hesitate before criticizing Charity too severely:

> We must bear in mind that its inmates represent the very lowest of the poverty-stricken. . . . Hardly a patient comes to us who is not cast down in mind or body. . . . Thus forty-five per-cent of our inmates last year were unmarried women . . . or prostitutes suffering with the venereal disease. . . . We are obliged to receive all who come. . . . Of 613 patients under obstetric observation, 182 were unmarried primiparae and another 75 were unwed multiparae--mostly prostitutes.[1]

The transportation of expectant mothers across the river posed the gravest problem after the abandonment of maternity service at Bellevue, especially aggravated by the kind of women who sought public hospital delivery assistance. Single women often did not seek hospital aid until labor began. In order to alleviate the problem, the Local Visiting Committee for Bellevue and Other Hospitals pleaded with the Governors of the Society of the New York Lying-In Hospital to release unexpended income to open an asylum for what the Committee called "street cases."[2]

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[1]William R. Gillette, "Report of Lying-In Service of the New York Charity Hospital for the Year 1875," The American Journal of Obstetrics and Diseases of Women and Children 9 (August 1876):452-53.

[2]Local Visiting Committee for Bellevue and Other Hospitals, To the Governors of the Society of the New York

Charity received about fifteen so-called "homeless women" a month, women already in labor who had taken themselves to police stations or been spotted by passers-by. Once discovered, a city agent took them to the boat landing at 26th Street and the East River, where they often waited all night for the next ferry to the Island (the ferry ran only twice a day--at 6:30 a.m. and again in mid-afternoon). If a patient was brought in at night, as was often the case, according to a report of the Bellevue student nurses, the woman stayed in a waiting cabin boat. When the ferry was due to depart, staff transferred the patient from the stationary boat to the transporting one. If the woman did not give birth on the carrier boat itself, the report alleged, the rules required that she be removed from the boat upon its arrival on the Island, regardless of her condition.

> In two cases the child was partly born when the boat reached the wharf, and in this moment of extremest pain and danger, these women were

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Lying-In Asylum, October 30, 1876 (New York: State Charities Aid Society), pp. 1-2. Through the summer of 1876, the Training School for Nurses at Bellevue provided nurses to attend these women on the boat traveling to the Island. The School, however, would have to terminate service in winter for fear of jeopardizing the nurses' health: "The consequence of the withdrawal of the Training School for Nurses," the Committee claimed, "is that the patients will probably be left to the attendance of some ignorant woman, possibly from the workhouse, who, having been committed for intemperance, is unable to obtain employment elsewhere." Ibid., p. 2.

> moved from the boat and carried up to the Hospital, on open stretchers, by workhouse men.[1]

During the winter, conditions on the boat deteriorated; heat was hardly sufficient while weather conditions prolonged the crossing. Other than a bed, the boat carried no provisions for delivery, not even "stimulants . . . owing to the intemperate habits of the employees."[2]

The Society of the New York Lying-In Hospital never furnished an institution for these women. The city, however belatedly, made some adjustments. Since the Local Visiting Committee had aroused public attention to the myriad complications and dangers with the closing of Bellevue's maternity wards, in 1877 the city converted an old fire engine house at 26th Street between Second and Third Avenues to an Emergency Hospital for acute obstetrical cases.[3] Ferry service from East 53rd Street to the Island, established in 1911, made travel more direct. Also in 1911, the city opened an emergency relief station, or Reception Hospital, at 70th Street and the East River for twenty-four-hour emergency treatment. In

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[1]Ibid., Report of the Bellevue School for Nurses, p. 3.

[2]Ibid.

[3]The Emergency Hospital had only six beds. It continued to operate until November 1908, when Bellevue opened its A & B Building and resumed obstetrical service. See Heaton; "Obstetrics at the New York Almshouse and at Bellevue," pp. 46-47.

that year, Charity and Metropolitan Hospitals established their first ambulance service.[1]

But the difficulty of transportation continued to plague Charity's effectiveness, as the hospital could not shed its unsavory reputation. Acute cases came only when surplus at Bellevue forced patients' removal, or from the workhouse or the Almshouse on the Island.[2] The decline of medical moralism revamped maternity care into a medical specialty and new institutions were created. By the mid 1890s, Charity's decline appeared irreversible.

Because of the scattered nature of the data, and the general paucity of inclusive statistics, no universal numerical generalizations can be stated with certainty. Nevertheless, upon the available information several reasonable inferences may be drawn regarding the limited hospital beds available to parturient women through most of the nineteenth century.

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[1]Bellevue established an ambulance service in 1869. Transportation to Charity eased when the Queensboro Bridge (built in 1909) permitted access to the Island in 1920. In that year, too, the bridge elevator replaced Reception Hospital. In 1922 a City Hospital dispensary and out-practice department opened at 220 East 59th Street; in 1939, the dispensary moved to 81st Street and East End Avenue. See Ricci, "History of The City Hospital," p. 466; Public Welfare Committee, Humanizing the City's Charity, p. 61.

[2]Ricci, "History of the City Hospital," p. 60.

In his survey of lying-in hospitals in New York City in 1878, Garrigues listed the Lying-In Asylum, the Infant Asylum, the Infirmary for Women and Children and the Nursery and Child's Hospital as the only private institutions in the city. He calculated that yearly confinements in any one of these hospitals never exceeded 150.[1] Conceding that Garrigues may have overlooked small maternity services, the total number of women receiving hospital obstetrical aid, at its very maximum, remained relatively insignificant.

Garrigues, for instance, did not include the New York Medical College and Hospital for Women. Perhaps he intended this omission, for the hospital made negligible contribution to maternity care throughout the century. Although the 1882 annual report of the Medical College and Hospital for Women does not provide information on the hospital's maternity division, it offers cumulative data for the preceding year, showing a total of seventy-eight patients treated with sixteen the largest number at any one time. The yearly number of patients increased to 145 in 1884, 205 in 1886, 201 in 1888, 190 in 1891 and 253 in 1894, but the total number of obstetric patients remained proportionally small. The annual reports of 1888, 1890 and 1892 list obstetrical data separately, and show but

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[1]Garrigues, "On Lying-In Institutions," p. 26.

thirty, forty and thirty maternity patients for those years respectively.[1]

Indeed, Garrigues' figures are even somewhat inflated. The New York Asylum for Lying-In Women confined 5,542 women from its establishment in 1823 to 1892. This represents a yearly average of eighty.[2]

Until a new hospital was completed in 1899, the New York Infirmary for Women and Children had 35 beds, with only thirteen beds reserved for obstetrical use.[3] (Even in the new building of 115 beds, the building provided only 35 bassinets for the new born.)[4] The Infirmary

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[1]Annual Reports of the Hospital of the New York Medical College and Hospital for Women, 1882-1894. The medical division was the hospital's largest, followed by the gynecological, then the obstetrical and surgical divisions. The numerical sub-divisions of the 1888 annual report typify the kinds of treatment over the years studied. In 1888, the hospital treated 103 patients in its medical wards, 47 in its gynecological wards, 30 in its obstetrical ward and 21 in its surgical wards. Rightly, Garrigues does not mention the Woman's Hospital in his lying-in survey. The hospital, which Dr. J. Marion Sims established in 1855, specialized in gynecological diseases and surgery and did not take maternity patients until 1910. See Walsh, History of Medicine, 5 vols., 3:834.

[2]New York Nursery and Child's Hospital, Annual Report for the Year Ending September 30, 1915, p. 14, quoting the Sixty-ninth Annual Report of the Marion Street Hospital. Available annual reports from the institution itself show 29 confinements in 1828, 139 in 1851, 104 in 1867 and 80 in 1881. See Annual Reports of the New York Asylum for Lying-In Women, 1828, 1851, 1867, 1881.

[3]Garrigues, "On Lying-In Institutions, p. 34.

[4]New York Infirmary for Women and Children,

began to receive lying-in women in 1858 and between then and 1876, hospital physicians delivered 1,350 women, a yearly average of approximately 71.[1]

Likewise, annual totals for maternity cases in the Nursery and Child's Hospital and the Infant Asylum often showed less than Garrigues' general figure of 150. The tenth annual report of the Nursery cites seventy-two deliveries; the twelfth counted only forty.[2] Between 1867 and 1876, services increased, with a yearly average of 148 lying-in patients.[3] Available data demonstrate that until 1876 the number of births at the Infant Asylum did not exceed seventy-five. Between 1879 and 1882 annual deliveries ranged between 108 and 168; in 1884, 194 women gave birth in the institution.[4]

Historical Mural of the New York Infirmary (New York: The Infirmary, 1958), p. 4.

[1]Garrigues, "On Lying-In Institutions," p. 37.

[2]Nursery, Tenth Annual Report, 1864, p. 6; Nursery, Twelfth Annual Report, 1866, p. 3.

[3]Garrigues, "On Lying-In Institutions," p. 39. Between 1867 and 1876, he reported 1,479 confinements.

[4]Annual Reports of the New York Infant Asylum, 1873, 1874, 1875, 1876, 1877, 1880, 1881, 1883, 1884. After 1884, the Infant Asylum reports merely state the total number of women in the hospital, without specifying which received obstetrical care. The exception is the report of 1900, which shows 184 women admitted in 1899 for confinement. See Infant Asylum, Appeal on Behalf, 1900, p. 8. Garrigues does not discuss the New York Lying-In Hospital because it ceased active service in

Therefore, based upon Garrigues' tallies, and adding 500 possible confinements from scattered services throughout the city and another 500 for Charity, the number of women in New York City receiving institutional maternity care was approximately 1,620 a year.

Nineteenth-century hospital construction followed two architectural models. Architects built hospitals as a series of pavilions, housing separate specialties, or they followed a block design.[1] While theoretically the series design offered better sanitation, with isolation of the sick, infected and dead, more desirable ventilation and separation of kitchen and laundry areas, New York

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1827. In twenty-six active years, it cared for between twenty and thirty women a year. No records exist of the number of women who received financial aid from the Society during confinement. See Society of the New York Hospital, 1971 Annual Report of the Society of the New York Hospital, p. 27. In the years from 1881 to 1886, annual births at Charity totalled 428, 429, 505, 541 and 472. See Department of Public Charities and Correction, Annual Reports of the Department, 1881, 1882, 1883, 1884, 1885, 1886.

[1]See The Society of the Lying-In Hospital of the City of New York, Annual Report, 1897, pp. 18-19, and 46-54 for the plans of the proposed hospital building; New York Infant Asylum, Twenty-ninth Annual Report, October 1, 1899 to October 1, 1900, pp. 10-11. Plans at the Asylum for the new building included separate buildings for patients and staff as well as a one-story quarantine structure. In the block form of construction, wards formed the heart of the building, and served themselves as passages from one part of the building to another. In contrast, the pavilion scheme of design involved long, narrow buildings, attached to common corridors only at their ends. See Risley, House of Healing, pp. 222-23.

City real estate prices necessitated block construction. Operating under this major constraint, hospital planners did their best, often constructing open solaria on the roof and situating septic and mortuary wards downstairs, while housing patients on the upper floors to give them the benefits of increased sunlight and air. After Garrigues' reforms at Charity, maternity hospitals often created special nursing stations for nurses treating puerperal fever victims; hospitals also established separate laundries and kitchens for this purpose.

Until Garrigues' success with antiseptic midwifery in 1883, laxity marked maternity hospitals' use of antiseptics. Preventive application could not be found in New York City. Instead, scattered antiseptic methods included intrauterine injections in infected women, hospital requirements that attendants wash their hands after delivering "suspicious" patients, or a policy of hanging sheets dipped in antiseptic solution over the entrance to the recovery room.[1]

Despite the Infant Asylum's regular efforts to rotate and fumigate vacant wards, puerperal fever struck periodically. Between 1865 and 1878, the maternity closed twice when efforts to extinguish the fever failed. Again,

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[1]See descriptions of these methods in Garrigues, "On Lying-In Institutions," pp. 36, 39.

the staff temporarily closed wards in 1884.[1] Since rotation and disinfection, practiced almost universally, could not be fully effective until the adoption of antiseptics, ward closings followed, typically and often inevitably.[2]

Once house doctors utilized systematic antisepsis, lying-in hospitals often posed fewer risks than home delivery. While nineteenth-century hospital obstetrical service proved fragmented, often moralistic, and unimpressive when tested against the numbers it actually affected, by the turn of the century hospitals offered the pregnant woman better care than most private practitioners. Whatever else these hospitals were, they presented centralized enclaves which allowed doctors to combine their resources and mature collectively from individual mistakes.

Private physicians generally had poor training, without clinical experience, and practiced under no supervision. Yet they delivered most middle-class babies.

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[1] Infant Asylum, Seventh Annual Report, 1879, p. 16; Infant Asylum, Thirteenth Annual Report, 1885, p. 31.

[2] Infant Asylum, Sixth Annual Report, 1878, p. 19; Infant Asylum, Twenty-ninth Annual Report, 1899-1900, p. 10; Nursery, Twenty-second Annual Report, 1876, p. 28; James W. McLane, "The Sloane Maternity Hospital. Report on the First Series of One Thousand Successive Confinements from January 1st, 1888, to October 1st, 1890," The American Journal of Obstetrics and Diseases of Women and Children 24 (April 1891):386-87.

According to Garrigues, few private practitioners employed antiseptics, claiming the practice too expensive vis-a-vis their fees; country doctors insisted that fresh air was sufficient. Practitioners unaffiliated with hospitals often employed makeshift or "imaginary" antiseptics, such as vaseline or carbolized soap. Observers recognized that mortality from cesarean section was greater in private practice than in the city's hospitals, and that puerperal fever fatalities were twice as great in homes than in the hospitals.[1] Samuel Gross, a leading American surgeon whose 1859 text remained a college standard for decades, spoke of

> . . . a medical gentleman, at one time largely engaged in obstetric practice in this city [Philadelphia], [who] lost in the course of a few months upwards of thirty women from having carried the virus [Gross still considered puerperal fever a specific disease] from one house to another.[2]

When the public saw increasingly that hospitals in fact offered medical safety and discoveries created

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[1]Garrigues, Antiseptic Midwifery, p. 43; Henry J. Garrigues, "The Improved Cesarean Section," reprinted from The American Journal of Medical Sciences (May 1888): 15; Henry J. Garrigues, A Text-Book of the Science and Art of Obstetrics (Philadelphia: J. B. Lippincott Co., 1902), p. 213.

[2]Samuel D. Gross, "The Factors of Disease and Death after Injuries, Parturition, and Surgical Operations," 1859, in Gert H. Brieger, ed., Medical America in the Nineteenth Century. Readings from the Literature (Baltimore: The Johns Hopkins Press, 1972), p. 192.

technology that hospitals alone could afford to supply, and as medical education became linked inextricably to hospital surroundings, the institutions' growth spiraled almost unchecked. As the middle and upper classes became more willing to use hospitals, patient profiles and rate policies changed.

The most significant trend in hospital care was not merely the decline of moralism, but the drift toward privatism. Historically, when private hospitals determined that given patients could afford to pay for all or some portion of their care the facilities required remuneration. The maternity ward operated by the Society of the Lying-In Hospital at the New York Hospital charged all women who were not literally indigent $4.00 for a maximum stay of four weeks.[1] When the Nursery and Child's Hospital managed a nursery for working mothers, it billed 6 percent of their wages for caring for one child, another 5 percent for a second child, and 4 percent for a third.[2] Once the nursery staff created lying-in facilities, the hospital charged a $25.00 fee for confinement; a woman entering prior to delivery paid board of $5.00 a week in advance. This scheme assumed simple maternity care, in which the hospital discharged patients within several days

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[1]Harrar, Story of the Lying-In Hospital, p. 22.

[2]Nursery, Constitution, 1854, p. 13.

of delivery. On the other hand, the hospital required the majority of charity patients to remain in the institution three months after delivery, nursing two children.[1] In one way or another the poor paid.

The City and State of New York accepted some responsibility in hospital financing. By mid-century, the Legislature appropriated $1,000 a year to each dispensary.[2] Where institutions functioned as orphan or foundling asylums, city and county tax funds paid a portion of costs. Lobbying efforts of the Infant Asylum sought passage of a bill (opposed, incidently, by the Commissioners of Charity) "requiring the city to pay a per capita allowance for the maintenance of the destitute children committed" to the Infant Asylum's care.[3] An amended proposal finally passed, providing the Asylum with a weekly sum for infants under eighteen months and a monthly sum for older children, not exceeding the "lowest" costs of care (measured by costs for the preceding fiscal year), for public custody of infants and children on Randall's Island.[4] The Nursery and Child's Hospital, the Catholic

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[1]Nursery, Constitution, 1886, p. 7; Nursery, Twentieth Annual Report, 1874, p. 8.

[2]Walsh, History of Medicine, 5 vols., 1:316.

[3]Infant Asylum, Appeal on Behalf, 1900, p. 4.

[4]Infant Asylum, Charter and By-Laws of the New York Infant Asylum (New York: E. B. Clayton's Sons,

Foundling Asylum and the Infirmary for Women and Children won coverage, on the same basis, under the modified bill.[1]

Yet at the bottom line, the institutions relied primarily upon endowments and private subscriptions to support themselves. (This arrangement persists to the present, setting a pattern of private financial domination.) Patron control--the power of private donors to set institutional rules, appoint administrators and determine admissions policy[2]--has served to thwart attempts at public control, centralization and the effort for regionalization and distribution of services.[3]

Money came also from full and part-paying patients. Again, until the last fifth of the century, most hospital

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1865), p. 13; Infant Asylum, Charter and By-Laws of the New York Infant Asylum (New York: Evening Post Steam Press, 1873), p. 8. Randall's Island housed a hospital for infants under 18 months and a nursery for children 18 months and older.

[1]Infant Asylum, Appeal on Behalf, 1900, pp. 5-6.

[2]For instance, in 1828, if a subscriber gave $3.00 to the New York Asylum for Lying-In Women he could recommend one patient in the year; if he gave $5.00 he could choose two. If, however, he became a life-member, with a donation of $25.00, every year he would enjoy the right to appoint a patient; if he gave $40.00, the yearly privilege was extended to two patients, with three permitted if a subscriber donated $50.00. See New York Asylum for Lying-In Women, Fifth Annual Report of the Managers, 1828, p. 14.

[3]For a modern treatment of this issue, see Robert M. Cunningham, Jr., Governing Hospitals: Trustees and the New Accountabilities (Chicago: The American Hospital Association, 1976).

patients were necessarily non-paying. Toward the end of the century and continuing into the twentieth, as hospitals felt heavier financial strains they depended increasingly upon private or at least partially-paying patients. In return, hospitals offered distinct services, according to the financial categorization of patients.[1]

The evolution of payment policy at the New York Infirmary for Women and Children demonstrates the pattern. In 1876, the hospital classed most patients as charity cases, although those who could afford to paid $16.00 for confinement.[2] Perhaps it was merely inflation which increased the cost of maternity hospitalization in 1886 to $5.00 a week and $25.00 in advance, but an articulated need for funds motivated hospital administrators to grant special privileges to paying patients. They would be permitted to enter the hospital a full month before their expected delivery, while the facility admitted free

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[1]One example of the increasing dependence on paying patients can be seen through a review of the annual reports of the Hospital of the New York Medical College and Hospital for Women. The 1882 report (p. 8) listed 22 free patients, 9 full-paying patients and 47 part-paying patients. In the report for 1884 (p. 7), there were 82 free, 22 paying and 35 part-paying patients. In the 1886 report (p. 9), the breakdown reads 140, 22 and 42 respectively. In 1892, the number of paying patients finally exceeded those receiving free services, with 64 free, 49 paying and 49 part-paying patients. See the 1892 Annual Report, p. 8.

[2]Garrigues, "On Lying-In Hospitals," p. 35.

patients only at the time of labor (this policy virtually eliminated any opportunity for prenatal observation). Hospitals' financial reliance on paying patients meant that they rationally reserved bed priority for those who could contribute. Instead of maintaining free beds in perpetuity, the Infirmary accepted free patients into its wards only "as far as there are vacant beds."[1] In 1895, the weekly charge for obstetric patients rose to $7.00 per week, with additional charges varying with the type of room chosen. Also by 1895, a wary Infirmary scrutinized closely those it provided with free services. Infirmary rules now insisted that "applicants for free beds must be suitably certified as unable to pay hospital rates, and as worthy objects of charity."[2]

Private hospitals grew accustomed to partial public reimbursement for care of "homeless" or destitute women. The Infant Asylum received $25.00 per patient from the New York County treasury for obstetrical care of needy mothers. Public funding continued if a woman remained in the Asylum for a year, suckling her own and another's infant.[3] But increasing operating costs as well

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[1]New York Infirmary for Women and Children, Thirty-fourth Annual Report for the Year Ending 1887, p. 8.

[2]New York Infirmary for Women and Children, Forty-third Annual Report for the Year Ending 1896, p. 7.

[3]Infant Asylum, Charter, 1873, p. 9.

as more restrictive public financing caused financial difficulties among virtually all institutions providing obstetrical service and accelerated the trend toward privatization.

Along with reducing the number of free-patient space, hospitals sought solution of money troubles through consolidation. This movement began toward the end of the nineteenth century and continued into the twentieth. In the 1891 annual report of the New York Asylum for Lying-In Women, the managers first complained "for lack of money," and in 1899 the hospital merged with the Infant Asylum.[1] But the Infant Asylum itself was hardly immune to pressures of increasing costs and the rising public expectations of hospital services. Both it and the Nursery and Child's Hospital closed country branches for insufficient funds.[2] Negotiations for consolidation between their boards began in 1906; by 1910 they completed the transaction, combining the two into the New York Nursery and Child's Hospital.[3]

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[1]New York Asylum for Lying-In Women, Sixty-eighth Annual Report of the Managers, 1891, p. 5.

[2]Infant Asylum, Thirtieth Annual Report, 1902, p. 10; Nursery and Child's Hospital, Fifty-second Annual Report, 1905-1906, p. 7.

[3]Nursery and Child's Hospital, Fifty-sixth Annual Report, 1909-1910, p. 11; New York Infant Asylum, Thirty-fifth and Thirty-seventh Annual Reports, October 1905 to October 1907, p. 9.

A change in policy in the Comptroller's Office of the Department of Charities in 1900 contributed significantly to mounting hospital deficits. New requirements cut per capita allowances, by narrowing patient qualifications for public-funding approval. Private hospitals continued to receive city payments for inmates who were "properly public charges"; hospitals would be reimbursed, per diem, 60 cents for medical cases and 80 cents for surgical patients, with the city to pay a lump sum of $18.00 for each obstetrical patient.[1] But now, regulations required hospitals to conduct painstaking investigation before admitting patients of questionable income capacity, for the rules set firm guidelines for reimbursement. The city might refuse to fund if Public Charities' agents found a patient to be a non-resident or if he or she were unknown at the address supplied; city rejection would come, too, if agents demonstrated a patient able to pay or if hospital authorities simply failed to submit sufficient patient histories.

The most devastating new stipulation, particularly for poor pregnant women, provided that the city would pay for emergency treatment only.[2] This requirement acted to

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[1]"Private Hospitals. Quarterly Report of Cases Approved and Disapproved by the Department of Charities," Charities 6 (January 19, 1901):56.

[2]Ibid.

preclude poor women from whatever prenatal care hospitals might provide. The new policy had direct impact on free hospital service. Administrators of the New York Nursery and Child's Hospital protested that the change made it necessary that charity "patients . . . be delivered within forty-eight hours after admission."[1]

Tight city accounting struck the Brooklyn Maternity Hospital. Incorporated in 1871 as the Homeopathic Lying-In Hospital, the founders changed the name in 1873 to the Brooklyn Homeopathic Maternity, or simply the Brooklyn Maternity.[2] The facility engaged primarily in free maternity work, but in 1911 circumstances compelled it to add a general hospital. This annexation,

> . . . brought about by no special desire . . . of our own, but by . . . the fact that the financial condition of the State and City have undergone a radical change, so affecting our income that an alteration in the character of our work is its natural consequence,

prompted another name change, to the Prospects Heights Hospital and Brooklyn Maternity.[3]

Prospect Heights' board recognized that a general hospital could draw money from private patients, and so

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[1]N.Y. Nursery and Child's Hospital, Annual Report for the Year Ending September 30, 1913, p. 8.

[2]Prospect Heights Hospital and Brooklyn Maternity, Fiftieth Annual Report, November 1, 1920, p. 3.

[3]Prospect Heights Hospital and Brooklyn Maternity, Thirty-first Annual Report, November 1, 1901, p. 8.

it did. Patients paid from $15.00 to $35.00 a week. Most of the new-found income came from the medical and surgical divisions, but lying-in patients would pay, when able, $25.00 for confinement. Administrators did not abolish free maternity service, but charity cases now faced the visiting committee's thorough screening.[1] Furthermore, hospital regulations required free maternity patients to bind themselves to the hospital for three months after confinement, caring for their own infant and one other.[2] Free medical care carried with it a form of indenture.

Ironically, as hospital administrators coped with tightened revenues and resolved their problems by catering to a wealthier group, they moved concurrently toward greater social awareness--a consciousness of a social rather than moral, linkage to illness. Hospitals gradually expanded and enlarged outdoor services, to compensate for the diminished services offered to the poor in indoor departments.

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[1]Prospect Heights Hospital and Brooklyn Maternity, Thirty-third Annual Report, November 1, 1903, p. 25. See also the hospital's Thirty-fourth Annual Report 1903, p. 9, and the Forty-second Annual Report 1911, pp. 3, 4.

[2]Prospect Heights Hospital and Brooklyn Maternity, Thirty-fourth Annual Report, 1903, p. 28.

Although the New York Asylum for Lying-In Women established the first outdoor obstetrical service in 1830, credit for the creation of a multiservice diagnostic and therapeutic home capacity belongs to the New York Infirmary for Women and Children. The Infirmary's outpractice department opened in 1853 and operated intermittently through 1879, when the work was suspended for lack of funds.[1] After the Infirmary resumed its program permanently in 1881, the records illustrate a clear appreciation of the social and economic ramifications involved in medical practice.[2] Reports of the outdoor department reflected housing and sanitation conditions of the tenement population within the Infirmary's district. Staff members became advocates for tenement reform.

While the out-patient staff inveighed against tenement-house manufacturing, where personnel observed families engaged in manufacturing cigars with children ill with diphtheria, where "both parents attended to the children; they would syringe the nose of each child and, without washing their hands, return to their cigars," they did not assign blame to those who so blatantly violated

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[1]Annie S. Daniel, Report of the Out-Practice of the New York Infirmary for Women and Children, 1853-1879 and 1881-1891 (New York: Trow Directory, Printing and Bookbinding, 1891), p. 1.

[2]Records of the Infirmary's out-practice department prior to 1881 have been lost. Ibid.

Board of Health prohibitions.

> When we consider that stopping this work means no food and no roof over their heads, the fact that disease may be carried by their work can not be expected to impress the people.

The Infirmary's inspectors were not content with mere adherence to sanitary laws, maintaining that there could be no model tenements "until each family has plenty of room, fresh air, and a bathroom; till each family is separated from its neighbor and conversation in one apartment cannot be heard by every other family on the same floor."[1] For the hospital visiting staff, these conditions, rather than patients' private habits, weighed heavily against the capacity of medicine to restore health.[2]

Earlier hospital workers displayed a bogus sense of optimism. At the close of the century, the stasis of poor people's lives impressed them increasingly. Infirmary outdoor personnel worked with the same families for six consecutive years and recognized that "few" had "materially bettered their condition."[3] Staff members utilized economic analysis, rather than individual

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[1]Daniel, Report of the Out-Practice, pp. 4, 6.

[2]New York Infirmary, Thirty-fourth Annual Report, 1887, p. 32.

[3]Ibid.

fault-finding. The 1889 Infirmary out-practice report calculated that a decent two-room apartment generally cost $10.00 a month. With weekly wages for two rarely exceeding $10.00, district residents had difficulty finding even minimally adequate housing.[1] In 1891, the department's report asserted definitively, that

> . . . people are sick because of insufficient food and clothing and unsanitary surroundings, and these conditions exist because the people are poor. They are often poor because they have no work.[2]

The Infirmary's staff and health workers elsewhere no longer viewed morality and health as intertwined, or even as something personal. For a new generation of hospital workers, health and living conditions were inseparable.[3] The end of the 1880s established the intellectual foundation for hospital social service work which would flourish in the twentieth century.

By the late nineteenth century, new maternity hospitals opened, solely to provide safe obstetrical care. Sloane Hospital for Women originated in 1884, when William Henry Vanderbilt donated land at Tenth Avenue and 59th Street and a building fund to the College of Physicians

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[1]New York Infirmary, Thirty-sixth Annual Report, 1889, p. 32.

[2]Daniel, Report of the Out-Practice, p. 10.

[3]Ibid., pp. 2, 4, 6.

and Surgeons. Within a year, his daughter and son-in-law, Mr. and Mrs. William D. Sloane, funded and endowed the building of a lying-in hospital, which opened on January 1, 1888.[1] Administrators no longer felt compelled to justify maternity care in lofty, idealistic terms; safe delivery and clinical training for medical students in obstetrics were reason enough. An increased willingness of women to use hospitals for childbirth followed definitive medical maternity service. In 1888 Sloane confined 241 women; in 1892, the number rose to 735.[2]

The development of new maternity hospitals grew out of the emerging trend in medical education which demanded bedside instruction.[3] The New York Lying-In Hospital owed its resuscitation to this need. The genesis lay in the decision of two Americans studying medicine in

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[1]Speert, Sloane Hospital Chronicle, pp. 3, 86; McLane, "Sloane Maternity Hospital," p. 385.

[2]Speert, Sloane Hospital Chronicle, pp. 108-09.

[3]The decade between 1900 and 1910 saw unprecedented hospital growth, with the establishment of 1,651 new hospitals. Before 1900, there were 2,419 hospitals in the United States. Between 1910 and 1918, another 1,584 hospitals opened their doors, with yet 677 more, between 1919 and 1923. By 1924, there were 6,830 hospitals in the country, with a bed capacity of 755,722. See "Hospital Service in the United States. Third Presentation of Hospital Data by the Council on Medical Education and Hospitals of the A.M.A.," Journal of the American Medical Association 82 (January 12, 1924):118-27.

Germany,[1] who determined that upon their return to the United States they would establish a dispensary for clinical training in obstetrics. In January 1890, they opened the Midwifery Dispensary at 312 Broome Street, with four attending and four consulting physicians. The dispensary provided medical service without charge, with the intention of attracting women away from midwives.

Results did not disappoint the founders. During the first year of operation, doctors delivered 199 women in their homes; the next year the service attended 955 women, and in the third year, aid extended to 2,583 women.[2] This expansion occurred because in August 1892 the Society of the Lying-In Hospital, which had accumulated a fund of almost $300,000 over its years of inactivity, absorbed the dispensary.[3] Two years later the Society purchased a hospital building on 17th Street and Second Avenue; it opened in November 1894 with bed space for thirty-two patients. In 1902, J. Pierpont Morgan's donation allowed the Society to build a large, fully-equipped maternity hospital with 168 beds.[4]

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[1]James W. Markoe and Samuel W. Lambert.

[2]Harrar, Story of the Lying-In Hospital, pp. 28, 30, 32, 36.

[3]Ibid., pp. 37, 38.

[4]Ibid., pp. 38, 40, 42, 44.

Gradually, both maternity and general hospitals, the old and the new, became teaching institutions.[1] To counteract the increasing privatization within, most institutions offered outdoor services (often combined with social service work) which provided thorough statistical recording and analysis as well as home medical care.[2] In early twentieth-century cities, outdoor programs primarily served immigrants. The home-service application card of the Lying-In Hospital, for example, presents

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[1]Large institutions did not monopolize medical training program. By the twentieth century, a hospital's prestige depended upon its attraction to medical students and interns. Even as small an institution as the Manhattan Maternity Hospital and Dispensary, opened in February 1905 with a thirty-five bed capacity, offered opportunity for clinical training to students and young doctors alike. See Walsh, History of Medicine, 5 vols., 3:851-52; Manhattan Maternity and Dispensary, First Annual Report for the Year Ending September 30th, 1905, p. 30; Manhattan Maternity and Dispensary, Second Annual Report for the Year Ending September 30th, 1906, p. 47. Teaching also provided added income. For example, in 1902 the Lying-In Hospital received $5,000 in student fees of a total income of $30,000. See the Society of the Lying-In Hospital, Circular Letter on the Activities of the Lying-In Hospital (New York: Society of the Lying-In Hospital, 1902), p. 2.

[2]According to the medical board's report in the 1916 annual report of the New York Nursery and Child's Hospital, "almost entirely the Hospital now goes to the homes of these [poor] women instead of having them come to the Hospital," p. 18. Outdoor serivce can also be viewed as part of obstetricians' response to competition with the midwife. The 1906 and 1907 annual report of the New York Infant Asylum asserted that through outdoor service, the poor "are saved from the physical injuries so often resulting from the ignorance of midwives," p. 11.

instructions in English, Italian, German and Yiddish.[1] The detailed reports of these departments offer a remarkable social breakdown of district clientele. Reports contain data on numbers treated, reasons for treatment, nativity of patients, civil condition, age, type of housing, monthly rent, occupation of husband, and weekly income.[2]

Data from the 1898 report of the outdoor division of the Lying-In Hospital demonstrate that in the period of six years and three months to April 1, 1896, the hospital confined 10,233 women in their homes, with 9,457 living children, 359 stillbirths and 417 abortions. Of this total, 6,885 of the patients reported Russia as their place of birth. United States natives made up the next largest group, 910, followed by 751 patients of Austrian nativity, 422 German-born patients, 342 from Ireland and 257 from Poland. One hundred seventy-four claimed Hungarian nativity, with 138 from Rumania, 123 English

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[1]Society of the Lying-In Hospital Medical Report of the Society of the Lying-In Hospital of the City of New York (New York: D. Appleton and Co., 1897), p. 23.

[2]See Annual Reports of the Society of the Lying-In Hospital of the City of New York, 1892-1925. The reports of the out-practice department of the New York Infirmary for Women and Children in the annual reports after 1881 also provide data on these topics, e.g., length of time in the United States; reasons for unemployment; means of support when not earning; number of rooms for each family; condition of rooms, of halls; etc.

and the rest scattered. In contrast to the nature of maternity care fifty years earlier, the report showed 10,182 married, with only eight single and the remainder widowed or unknown. In a sample of 524 cases, the largest grouping (comprising 216 people) paid rents of between $7.00 and $8.00 per month. The largest occupational group consisted of 236 tailors. Out of 400 cases, 306 breadwinners earned a maximum of $8.00 per week.[1]

The visiting staff encountered scenes such as No. 156 Attorney Street, where a woman:

> Had been confined three days; had no food for herself and no milk for her baby. Her neighbor had cleaned for her, but was away at work all day. Husband abandoned her some months before. She had a two-year old boy attending a nursery. Quite destitute. . . . She had a diet ticket but no one to fetch the food. I gave her some immediate necessaries and left scrub woman to fetch food from Broome Street. I left her 50 cents and a sheet. She would not go to a "Home."[2]

And at 84 Ridge Street:

> Patient had but a few rags to cover herself and baby lying on a mattress without a sheet. Husband a peddler staying at home to take care of

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[1]The Society of the Lying-In Hospital of the City of New York, Annual Report for the 100th Year, October 1st, 1897 to September 30th, 1898, pp. 92-95. In contrast to the ethnic composition of the Lying-In Hospital patients, backgrounds at the New York Infirmary were predominantly Italian, followed by German, Irish and Russian.

[2]Society of the Lying-In Hospital, Annual Report, 1897-1898, p. 112. The Society had established a Diet Kitchen in January 1891 at No. 314 Broome Street.

> wife, whom he seemed fond of. Two little children running around in rags. A loaf of black bread on the table and nothing else to eat. They were most thankful for the assistance of scrub-woman, who will go every day for a while till patient is strong. . . . They had not a cent, and during my visit collector came for the rent. I left 2 sheets, tin of milk, oatmeal and 25 cents on my first visit.[1]

The examples repeat themselves: stories of a family dispossessed, of poor neighbors aiding each other, and the woman, weak and emaciated from delivery, who "begged for something for the children to eat and said she required no food for herself."[2]

Private physicians and organized medicine did not accept private hospitals' adjustments to increasing costs and traditions of free medicine uncritically. At the turn of the century, they claimed that free medical work had a "pauperizing" effect upon recipients and also competed unjustly with private practices, deflecting income which the physicians claimed they properly deserved. When the managers of the New York Lying-In Hospital sought financial aid to build a new and enlarged building, for example, private physicians charged "dispensary abuse." General practitioners showed particular sensitivity to the expansion of maternity facilities, since institutional care interfered with a lucrative

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[1]Ibid., p. 113.

[2]Ibid.

aspect of practice. Indeed, they resented the implication that obstetrics required any special expertise or setting. Although the Lying-In Hospital succeeded in securing funds through the $1,350,000 Morgan donation and the Society opened a new hospital in 1902,[1] the arguments urged for expansion are relevant to the future development of obstetrical hospital service.

The proponents of increased lying-in facilities dismissed their opponents' implications that charity work was exploited. Reviewing the socioeconomic characteristics of their patients, where the average rent was $8.00 monthly and the average weekly wage $7.00, the medical board of the Lying-In Hospital concluded that this income allowed for no preparation for illness.[2] The poverty and want in the district convinced the board "how utterly impossible it is for these people to save anything for medical attendance."[3] With daily wages averaging a dollar and median monthly rent $8.00, the medical board calculated that this left families sixty cents a day to feed and

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[1]Harrar, Story of the Lying-In Hospital, pp. 44, 46; Letter from J. P. Morgan to Dr. James Markoe, April 1894, Scrap Book, Society of the Lying-In Hospital of New York, Manuscript Collection of the New York Academy of Medicine.

[2]Society of the Lying-In Hospital, Annual Report for the Ninety-ninth Year, 1896-1897, pp. 11, 17.

[3]Society of the Lying-In Hospital, Annual Report, 1897-1898, p. 13.

provide for themselves.[1]

The Lying-In Hospital spokesman's response was meant to awaken even the general practitioners who were jealously guarding their turf against encroachments of new specialists. According to organized maternity advocates, the charge that maternity hospitals incubated puerperal fever was anachronistic, as was the argument that they abetted illegitimacy.[2] To the claim that there were presently enough maternity beds, hospital administrators replied at length.

The Society of the Lying-In Hospital estimated that in each year in Manhattan alone, as many as 25,000 women depended upon charity for attendance in confinement.[3] The Department of Charities provided inadequately for such need, with accommodations of only fifty-six beds for childbirth--fifty on Blackwell's Island at City and Metropolitan Hospitals and six at Emergency Hospital.[4] When criticized for accepting Morgan's gift, the Society responded:

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[1]Ibid., p. 11.

[2]Ibid., p. 17.

[3]They based their figures on a Health Board report as well as the demand for services at the Lying-In Hospital. In 1902, the Hospital had 3,757 applications for aid during confinement. See Society of the Lying-In Hospital, Circular Letter, p. 2.

[4]Ibid.

> It may not be generally known that the Sloane Maternity Hospital, the Emergency Hospital, Maternity [City] Hospital, the 86th Street Hospital, the Nursery and Child's Hospital, the Infant Asylum, the Marion Street Maternity Hospital, the Foundling Asylum, the Mother's and Babies' Hospital, the Women's Infirmary, the Homeopath [Metropolitan] Hospital, the Hahneman Hospital, and the Society of the Lying-In Hospital, thirteen in all, are the only institutions in the city where cases of childbirth are received, and have for this purpose a capacity of less than 600 beds all told, only 123 of which are used to educate the student, while Paris gives nearly eight times that number for that alone.[1]

The notion that the hospital was the instrument in the destruction of the midwife posed the ultimate argument in favor of new hospital obstetrical departments, apparently having the most sway, if only by its repetition through the first three decades of the century. Hospital proponents pointed to the ludicrous inconsistency and illogic of local physicians, who, without offering a substitute, cried simultaneously for the abolition of hospitals and midwives. The Lying-In staff called this dual effort unrealistic, in view of the "unhappy" fact that midwives reported almost half of New York City's births for the year ending October 1, 1898.[2] Defenders saw the maternity hospital in competition with the midwife

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[1]Society of the Lying-In Hospital, Annual Report, 1896-1897, p. 10.

[2]Society of the Lying-In Hospital, Annual Report, 1897-1898, p. 10.

and not the private physician:

> The majority of our patients would not be treated by a physician if they did not come to us. They cannot afford to pay anything for their confinement and subsequent care. Midwives accept a small fee and live in the house throughout the lying-in period. This Society . . . is the rival of the midwives and not the physicians.[1]

This final argument seemed to have greatest appeal. It played directly into the status drives of obstetricians seeking to establish themselves as a medical specialty on a par with surgery and medicine. Prestige dictated disassociation from the midwife--a common woman. Interestingly, the appeal posed no threat to the generalist, while at the same time it locked obstetrical specialists into a hospital framework which would eventually cut childbirth from the duties of the general physician.

Hospital advocates increasingly underplayed the appeals of the Lying-In Hospital on behalf of free work, as hospital expansion in the twentieth century practically became commensurate with private care and the affiliation of private practitioners with hospitals.

Since the last fifth of the nineteenth century, hospital free work rested on a shaky basis. Attacked from the outside for unnecessary dole distribution, hospital administrators became defensive, and exaggerated fears of

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[1]Ibid., p. 9.

fraud hampered their work. Both the New York Infirmary and the Nursery and Child's Hospital used the services of the Charity Organization Society, whose powers of discrimination they trusted, to filter out unworthy objects of charity.[1] Increasingly, hospitals ceased free service or reduced it significantly. Although the New York Nursery and Child's Hospital continued to reserve "a number" of free beds, it blamed the rulings of the Department of Public Charities for "a falling off [of free services] from former years. . . . The free work is limited on account of the lack of hospital funds available for the purpose."[2] Undoubtedly, the more rigid city grant requirements played a role in hospital privatization, but so did the growing request for private accommodations, "so great," the Nursery asserted, "that additional private rooms and wards are urgently demanded."[3] By 1925, the

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[1]New York Infirmary for Women and Children, Forty-sixth Annual Report, 1899, p. 11; Nursery and Child's Hospital, Thirty-first Annual Report, 1885, p. 8.

[2]Nursery and Child's Hospital, Annual Report for the Year Ending September 30th, 1912, p. 24. In 1900, the Woman's Hospital added more private rooms "to make the hospital financially self-supporting." See James P. Marr, Pioneer Surgeons of the Woman's Hospital. The Lives of Sims, Emmet, Peaslee and Thomas (Philadelphia: F. A. Davis Co., 1957), p. 95.

[3]Nursery and Child's Hospital, Annual Report, 1912, p. 24; the Annual Report for the Year Ending September 30, 1916 includes an appeal for funds so that more private facilities can be built, 18.

Nursery had made a complete circle:

> Believing that the well-to-do are as much entitled to this protection [good maternity care] as the poor, we have gradually developed the largest private maternity service in the City, where our staff and some fifty outside obstetricians bring their patients. This service not only pays for itself, but also for one-third of the free care.[1]

Since the free care of the nineteenth century had never been based on any analysis or rationale involving human rights, administrators found it all too easy to rationalize a pay policy without afterthought concerning its effects.

The annual reports of the New York Infirmary reflect the diminution of outdoor services and indoor free treatment. From 1887 until 1899, patients treated in the outdoor division substantially exceeded those cared for within the hospital itself. For example, between 1888 and 1889, the Infirmary treated a total of 342 patients while the outdoor department treated 768; in 1892-1893, the ratio became even greater, with 222 patients treated indoors and 1,167 cared for outside the hospital; in 1895-1896, the division was 752 to 1,299 and in 1898-1899 it was 893 to 1,618. In the 1900 annual report, the pattern continued, with 1,073 cared for in the hospital and 1,476 outside. This balance continued until 1913 when

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[1]New York Nursery and Child's Hospital, 103rd Annual Report for the Year Ending December 31, 1925, p. 11.

the hospital began receiving more patients than the outdoor department. In 1913 and 1914 the Infirmary cared for a total of 2,445 patients while the outdoor division cared for 1,083 people. Throughout the 1920s outdoor services became less and less available, and in 1930, the hospital treated 2,418 people while the outdoor department received only 660 patients.[1]

This reversal signified qualitative alteration as well as quantitative change. Poor women in childbirth had four options available. They might plan and save for hospital birth attendance or could be subject to scrutinizing examination in order to qualify for limited free-bed space. A woman could hire a midwife (but by the 1920s, consumers found midwives less available, with those who remained poorly trained) or she might go to public hospitals designated for "the poor."

Like the Infirmary, the New York Nursery and Child's Hospital cut back on home services. By 1919, doctors attended over twice as many women in the hospital,[2] but until 1923, home deliveries amounted to at least 550

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[1]See Annual Reports of the New York Infirmary for Women and Children, 1887-1930.

[2]New York Nursery and Child's Hospital, Annual Report, 1920, p. 20. The report shows that in 1919, the hospital delivered 1,370 women, while the home service confined 560; in 1920, the figures were respectively 1,771 for hospital and 662 in home delivery service.

a year.[1] In the fiscal year 1923-1924, the drop began, with only 444 women confined at home; between 1924 and 1925, merely 387 women received home birth attendance while house physicians delivered 750 women in the Nursery's wards and 239 in the private wards, and the attending and courtesy staff delivered 851 women privately in the hospital. In 1928-1929, the outdoor department attended 217 home confinements, and in 1929-1930, in the midst of the depression, the department treated only 185 women at home.[2]

The Nursery's revenue sources reflected the increased dependence on private patients. While money contributed by the City of New York remained stationary for many years, income from private patients increased steadily. In 1915, the city provided $102,580.50 while private patient fees brought in $15,549.90. In 1916, the city's funding amounted to $102,608.82, while money from private patients jumped to $20,829.13. In 1917, the city granted $105,585.46 to the Nursery; paying patients provided $43,066.37 of the Nursery's income. In that year,

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[1]The Nursery's 1923 annual report shows 272 home deliveries.

[2]New York Nursery and Child's Hospital, Annual Report, 1924, p. 5; Nursery, Annual Report, 1925, p. 26; Nursery, Annual Report, 1929, p. 7; Nursery, Annual Report, 1930, p. 8. The annual reports of 1926, 1927 and 1928 give home birth totals of 307, 321 and 266 respectively.

the annual report listed 171 part-paying patients and 1,139 private patients, increases over the previous year of 94 and 619 respectively. In 1918, the city increased its funding by only $1,999.68, while private revenues climbed to $83,579.80. By 1922, the institution received more income from private patients ($223,376.95) than it did from the city, which in that year gave the hospital $102,858.49.[1]

Thus while maternity hospitals retreated from saving souls and concentrated on preserving lives--with the establishment, for example, of laboratories to study toxemia, fully equipped delivery rooms, and undergraduate and post-graduate training,[2]--they also became stratified, offering special privileges and comforts to patients with money. At the Nursery, paying patients might choose

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[1]Nursery and Child's Hospital, Annual Report, 1915, p. 13; Nursery, Annual Report, 1916, p. 28; Nursery, Annual Report, 1917, p. 21; Nursery, Annual Report, 1918, p. 32; The city payments that year totaled $107,363.14. Nursery, Annual Report, 1922, p. 16. Like the Nursery, Sloane Hospital's original charter stipulated free indoor treatment. In 1897, the hospital changed its policy, requiring all who could afford to pay do so. By World War I, financial difficulties plagued the hospital. By 1925, all ward obstetrical patients paid a fixed rate of $50.00 (or at least some part of the sum). In 1928, the obstetrical ward rate rose to $60.00. See Speert, Sloane Hospital Chronicle, pp. 105, 125, 177.

[2]New York Nursery and Child's Hospital, 106th Annual Report for the Year Ending December 31, 1928, p. 26.

their own doctor, had separate delivery rooms and infant nurseries, enjoyed unrestricted visiting hours, and could employ special nurses. Patients of moderate means, who paid partially for their care, had less generous visiting privileges and stayed in relatively large wards less advantageously situated in the hospital.[1]

Dependence upon private donations and patient fees posed uncertainties, and in the 1920s the hospitals again faced financial crisis. At the end of the First World War, the New York Infirmary found itself in difficult economic circumstances and the hospital shut its doors for two years, beginning in March 1918. Closing did not resolve budgetary problems and the hospital seriously considered merger with the Columbia University Presbyterian Hospital Medical Center. The consolidation agreement, as approved by Columbia, would have eliminated the Infirmary's independent status. Only a general outcry by women physicians--organized by the Medical Women's Association--prevented the merger. Female doctors, upset with the earlier closing of the Woman's Hospital in 1923, viewed the impending consolidation as a blow to women in the medical profession.[2]

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[1]New York Nursery and Child's Hospital, 105th Annual Report for the Year Ending December 31, 1927, p. 8.

[2]New York Infirmary for Women and Children, An Appeal for the Trustees of the New York Infrimary for

Financial exigencies forced both the New York Lying-In Hospital and the New York Nursery and Child's Hospital to merge with New York Hospital. As early as 1922, the Lying-In Hospital experienced financial insecurity. In 1928, the presidents of New York Hospital and the Lying-In Hospital agreed that the latter would become the obstetrical division of the new New York Hospital Medical Center; in 1932, the Lying-In Hospital moved to fresh quarters in the new hospital buildings at 70th Street and the East River.[2]

Any diminution of private-patient enrollment threatened the Nursery's existence. In 1929, the Nursery registered 1,555 private patients but in 1930 the number fell to 1,313. In 1931, 250 fewer private patients entered the hospital. This meant that the facility ran

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Women and Children (New York: The Infirmary, 1918), p. 1; New York Infirmary, A Century of Devoted Service, p. 33; "Shall the Identity of the New York Infirmary for Women and Children Established by Doctors Elizabeth and Emily Blackwell in 1857 Be Lost?" Medical Woman's Journal 33 (April 1926):111; "The New York Infirmary," Quarterly Bulletin of the Medical Women's National Association (January 1927):7; Bernice Griswald, "The New York Infirmary for Women and Children," Medical Woman's Journal 36 (November 1929):289.

[2]Society of the Lying-In Hospital, Annual Reports for the 124th and 125th Years, January 1, 1922 to December 31, 1923, p. 617; Society of the Lying-In Hospital, Annual Report for the 128th Year, 1926, p. 6; Society of the Lying-In Hospital, Annual Report for the 130th Year, 1928, pp. 6-8; Harrar, Story of the Lying-In Hospital, pp. 62, 64, 70.

a deficit of $83,362.07, notwithstanding the city's contribution, and "that our revenue from those who can afford to pay has been approximately $56,000 less this year."[1] In December, 1934, the Nursery transferred its maternity work and all of its responsibilities, assets, endowments, properties and liabilities to the New York Hospital.[2]

The emergent twentieth-century hospital, although unlikely to manifest a philosophy of health rights, demonstrated a strong medical orientation. Hospitals depended upon private money and, in an environment in which no one demanded government intervention and funding, competed for the favor of private philanthropy. Money sources, in turn, dominated hospital policy and administration.

The system necessarily posed the question whether quality medical care could be provided privately, in the absence of reliable public funding and a rational distribution of services. A two-tiered system of care resulted from this dilemma, of course, with economic status the principal determinant. Out-patient clinics for the poor replaced hospital home service; hospitals established

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[1]New York Nursery and Child's Hospital, 108th Annual Report, 1930, p. 4.

[2]Nursery, Annual Report, 1931, p. 4; Nursery, Annual Report, 1934, p. 2.

wards for part-paying patients, making private and more comfortable facilities available to the wealthy.

CHAPTER III

THE PREOCCUPATION OF PREGNANCY

> If every woman were properly qualified, and would faithfully perform her duty in bringing up her children, their virtuous affectations might be so confirmed, their disposition to vice so effectively subdued, that, the greatest revolution in morals and health of the world, would be the consequence.
>
> --Samuel K. Jennings, 1808

> Sandra Shapiro is such a good mother. She says
> That if she takes her children on nice wholesome
> family outings like picnics and bike rides,
> They won't smoke pot. And she says
> That if she buys her children jigsaw puzzles and
> coloring books instead of machine guns and
> cowboy guns and deathray guns,
> They won't invade Indochina. And she says
> That if she teaches her children (firmly and
> fearlessly and uncompromisingly) to always
> follow the dictates of their conscience but
> not yet,
> They'll thank her someday for being
> Such a good mother.
>
> --Judith Viorst
> Sandra Shapiro is Such a Good Mother, 1971

The popular literature of the late nineteenth and early twentieth centuries reflects numerous efforts addressed to women's peculiar biological and socializing functions. The many manuals, written by both lay and medical practitioners of the various nineteenth-century medical sects and indicating an almost obsessive attention,

suggest a wide audience to have warranted their publication. Certainly, the literature is significant to any serious investigation of medical-social relationships between the sexes in the later part of the nineteenth century and continuing into the first quarter of the twentieth (when, incidentally, this kind of advice literature began to decline).

Topically, authors began their descriptions of women's physical journey with pubescent entrance to womanhood, then devoted substantial attention to the physiology of pregnancy, including gratuitous advice to expectant mothers and prospective infant-rearers. Biological description and health counsel continued through woman's complete nurturing cycle, winding down with a consistent and stereotypical portrayal of what was depicted as her less expansive and quiescent stage of maturation beyond menopause. The early twentieth century contribution to the genre gave slightly less emphasis to puberty and considerably more attention to woman's caretaking role. The uneducated advisor had increasingly fewer publication possibilities; the "trained" expert, either in medicine or psychology, assumed literary preeminence.

This literature, if not purposefully normative, unquestionably predicated itself on the assumption that

women's destinies lay in fulfilling a divinely-created and distinctly separate function. Perhaps with the completion of middle-class women's divorce from productive, pecuinary labor, made final by the availability of cheap immigrant workers, a new "home industry," centered around women's maternal capacities, had to be justified. These authors, each in his or her own way, sought to convey the sense that women's lives were incomplete without motherhood. A happy marriage without maternity was inconceivable--a contradiction in terms.[1] The "four walls"[2] of the home bounded woman's sphere; yet this offered opportunity, not restriction. Here her latent capacities unfolded; she would "become calmer and more tranquil" and, having arrived at destiny's door, could achieve "the summit of her intellectual and moral development."[3] Without sensitivity to the real or potential risks of childbearing (let alone

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[1]See, for example, Haydn Brown, The Wife, Her Book (Philadelphia: George W. Jacobs & Company, 1870), p. 1; Elizabeth Barton Lyman, The Coming Woman: Or, The Royal Road to Physical Perfection. A Series of Medical Lectures (Lansing: W. S. George and Co., 1880), p. 274; Mary R. Melendy, Perfect Womanhood for Maids--Wives--Mothers, A Book Giving Full Information on all the Mysterious and Complete Matters Pertaining to Women (Chicago: K. T. Boland, 1903), p. 7.

[2]Emma F. Angele Drake, What a Young Wife Ought to Know (London: The Virginia Publishing Co., 1908), pp. 50-51.

[3]Walter C. Taylor, A Physician's Counsels to Women, In Health and Disease (Springfield, N. J.: Holland and Co., 1871), p. 186.

its psychological complexities), these authors consistently ruled out the possibility of inner ambivalence.

With similar didacticism, the authors made motherhood a necessity and obligation, if not for women's own benefit, then to satisfy others:

> A repugnance for maternity indicates something radically wrong in a woman's ideas of life. . . . She who deliberately evades motherhood barters her birthright. The wife who refuses motherhood robs the husband of fatherhood and he will not hold her guiltless.[1]

A physician repeated this sentiment in 1918--after statistics of high infant and maternal death rates had been publicized. For this doctor, motherhood was woman's mandate, and incidentally her blessing. "Fear of motherhood," he assured his readers, "is groundless; to purposely avoid it is a transgression of the laws of nature and of God."[2]

On another level, these books explored topics hitherto sequestered by the ethic of purity. The authors advocated female understanding of their peculiar biology; they challenged the Victorian notion of female modesty which, they urged, merely cloaked ignorance. Elizabeth

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[1]Susanna Cocroft, Motherhood, The Generative Organs, Their Purpose and Derangements, 5th ed. (New York: Readington Publishing Co., 1906), p. 127.

[2]A. C. Robinson, Physical Lifehood or What Every Woman Wants to Know, A Medical Treatise for Women (New York: The Homine's Book Co., 1918), p. 24.

Barton Lyman, an itinerant lay lecturer and teacher of anatomy, physiology and hygiene, decried the "mawkish sentimentality" which induced "false modesty," especially toward the subject of maternity.[1] To justify her somewhat graphic detailing of human physiology, a doctor related an alleged conversation with a patient. Inadvertently, she hinted at the anxiety about pregnancy women must actually have experienced. According to the author, knowledge of her biological processes would have spared the patient the "months of distressing forebodings" she described. Instead, the patient purportedly declared, "I contemplated only the shadows that lay between me and my baby."[2]

Invariably, these works offered chapters on the reproductive organs and the physiology of ovulation, menstruation, conception, and pregnancy. Growth and development of the fetus and care during pregnancy generally involved several chapters; authors outlined the stages of labor in another chapter, as they did proper

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[1]Lyman, The Coming Woman, p. 204. Examples of other authors who chastised women for their biological ignorance are E. R. Shepherd, For Girls: A Special Physiology: Being a Supplement in the Study of General Physiology (New York: Fowler and Well, 1882), p. 7; Lucien C. Warner, A Popular Treatise on the Functions and Diseases of Woman (New York: Manhattan Publishing Co., 1874), p. 7.

[7]Grace P. Murray, Mother and Babe: Their Comfort and Care, Metropolitan Pamphlet Series, Vol. VII, No. 2 (London and New York: The Butlerich Publishing Co., May 1894), p. 1.

medical attendance during the lying-in and confinement periods. They devoted another section to infant care and rearing. Clearly, the authors intended not to create a new sexual frankness in the vein of Havelock Ellis, for example, but to challenge the equation of ignorance with delicacy. It was this kind of synonomity, one author maintained, which resulted in impurity.[1] As late as 1912, a physician complained that "a false modesty has . . . forbidden any open discussion of facts connected with childbirth."[2] Notwithstanding the plethora of textual contradictions and frequent medical misinformation, the demand for this kind of knowledge must have been widespread, if measured by new titles and republications.[3] Advice in these manuals covered a wide range of subjects which considered even with its imprecision must have been

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[1]Drake, What a Wife Ought to Know, p. 3.

[2]J. Morris Slemons, The Prospective Mother, A Handbook for Women During Pregnancy (New York: D. Appleton and Co., 1912), p. 1.

[3]E.g., Thomas Bull, Hints to Mothers for the Management of Health During the Period of Pregnancy and in the Lying-in Room: With an Exposure of Popular Errors in Connection with Those Subjects, and Hints Upon Nursing, 25th ed. (London: Longmans, Green and Co., 1877); Andrea H. Proudfoot, A Mother's Ideals, A Kindergarten Mother's Conception of Family Life, 9th ed. (New York: A. Flanagan Co., 1897); Cocroft, Motherhood, 5th ed.; Marie C. Stopes, Wise Parenthood, 5th ed. (London: G. P. Putnam's Sons, 1919); William L. Robinson, Woman: Her Sex and Love Life (New York: The Critic and Guide Co.). This last book went through 22 editions between 1917 and 1931.

enlightening, given the state of ignorance. Yet while the advice served as a necessary source for women, it functioned also as an inculcator of attitudes, fears, and interests. The striking quality of this body of work is the way it magnifies pregnancy itself (and, of course, rearing) as a full-time occupation or preoccupation for middle-class women.

Passages on pregnancy began with descriptions of the mechanism of fertilization and the rejection of the "theory of frigidity." Authors reassured women that "voluptuous sensation" need not be a condition for conception. In 1917, Dr. William L. Robinson, chief of the Department of Genito-Urinary Diseases at Bronx Hospital and Dispensary, wrote that the fallacious association between orgasm and impregnation still prevailed; "so sure are some women that this is so that when they want to avoid conception they repress any orgastic feelings."[1] While feigning ill health was undoubtedly a more effective strategy for birth control, women's sexual containment often became the last perceived resort for birth

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[1]Quoted from Robinson, Sex and Love Life, p. 297. See also Tullio S. Verdi, Maternity: A Popular Treatise for Young Wives and Mothers (New York: J. B. Ford and Co., 1870), p. 25; R. T. Trall, The Mother's Hygienic Handbook; for the Normal Development and Training of Women and Children, and the treatment for their Diseases with Hygienic Agencies (New York: S. R. Wells, 1874), p. 31.

prevention when sexual contact was unavoidable.

Although authors described impregnation as a purely mechanical process, sterility, for most, suggested some failure on the part of the female. The burden of barrenness lay with the woman; either she failed to develop her ovaries properly through regular exercise and rational diet or she neglected to relax sufficiently during sex. Sterility might also result from sexual overindulgence. But medical theory primarily associated sterility with birth control. Nature, "tired of being cheated," avenged women for past use of birth preventives.[1]

Abstinence or calculated continence represented the only accepted form of birth control. However ludicrous the various methods or detailed systems of abstinence may appear, the discussion of controlled sexual contact had many significant elements. The issue represented the incipient realization that women's health suffered when pregnancies followed too closely upon each other; it attested also to women's terror of unwanted pregnancies, and the simultaneous increase in illegal abortions which continence would supposedly eliminate. Finally, it

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[1]E. Cook, Eutocia, Easy Favorable Child Bearing. A Book for all Women (Chicago: Arcade Publishing Co., 1886), p. 65; Cocroft, Motherhood, p. 131; see also George Austin, A Doctor's Talk with Maiden, Wife and Mother (Boston: Lothrop, Lee and Shepard Co., 1907), p. 113; Drake, What a Wife Ought to Know, p. 132; Robinson, Physical Lifehood, p. 24.

reflected the influence of women's initial crusade for sexual control and voluntary motherhood. The movement against haphazard sex was likely a response to awakening domestic feminist demands for reproductive autonomy. (Ironically, the complicated methods of continence accompanied complete misinformation as to the fertility cycle).[1]

Advice literature warned women that abortion is synonymous with murder, that the embryo breathes from the moment of conception, and that uterine life represents the first phase of human existence. Authors attributed the rise of deformed, moronic and criminal children to unsuccessful abortion. The books inveighed against the advertised promises of pills and other medications; occasionally, these drugs, the authors reluctantly admitted, brought on abortion, but generally they produced only invalidism or deformity in children.[2] Health counselors did not

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[1]See Daniel S. Smith, "Family Limitation, Sexual Control and Domestic Feminism in Victorian America," in Mary Hartman and Lois W. Banner, eds., Clio's Consciousness Raised, New Perspectives on the History of Women (New York: Harper and Row, 1974), pp. 119-36, for his discussion of the connection between declining birth rates and domestic feminism. The fertility cycle was not plotted correctly until the 1920s. Even then it did not receive widespread medical circulation until the next decade.

[2]See, for example, P. B. Saur, Maternity: A Book for Every Wife and Mother, 2nd ed. (Chicago: L. P. Miller and Co., 1891), pp. 149-50; Cook, Eutocia, p. 48; Brown, The Wife, Her Book, p. 124. Abortion could be induced legally only when the continuation of gestation threatened

attribute the alarming abortion rate to unmarried or working-class women, but to married women worshipping "the goddess of fashion." Especially with scientific pain relief, one doctor asserted, "the fear of child-bearing is no excuse, madam. Nature requires of woman this duty."[1] Thus temperance, not mechanic prevention or abortion, would legitimately limit women's pregnancies. Another author calculated that the carefully-controlled sex life would yield only five or six children.[2]

Thus while abortion carried with it life-threatening dangers to women, and even scholarly medical journals

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a woman's life. Before the twenty-eighth week, valid indications included uncontrollable vomitting, moribund fetus causing uterine infection, acute nephritis, diseased ovum, and uterine hemorrhage. After viability, abortion could be performed if a woman contracted a life-threatening disease, e.g., acute toxemia or heart disease; or if the fetus were pathological. J. Whitridge Williams, Professor of Obstetrics at The Johns Hopkins University and Obstetrician-in-Chief at The Johns Hopkins Hospital, wrote: "Under no circumstance should the operation [abortion] be undertaken unless a careful and thorough examination has demonstrated that the patient is in a most serious condition. Her statements are entitled to but little weight, and the decision to interfere should be based entirely upon objective symptoms. Moreover, the operation should never be undertaken without a consultation with a second physician, who assumes his share of the responsibility." Obstetrics, A Textbook for the Use of Students and Practitioners (New York: D. Appleton and Co., 1902), pp. 338-39.

[1]Austin, A Doctor's Talk, pp. 118-19.

[2]Drake, Wife Ought to Know, p. 132.

correlated birth control devices to cervical cancer,[1] female lay and medical practitioners and advisers devised schemes of continence.[2] Elizabeth Barton Lyman did not blame infanticide and abortion on women, but on men's unrestrained and irreponsible passion which "impose[d] the burden of maternity unasked and undesired upon women." But men, according to Lyman, could not be expected to initiate the movement to self-control. While upholding her sexual self-determination, at the same time the wife must slowly and tactfully convert her mate, who in time will recognize "the benefits, physical and mental, accruing

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[1]Helena H. Smith, "Wasting Women's Lives," in For Legalized Birth Control (New York: The New Republic, 1934), p. 14. Female physicians were no more reassuring about birth control than male doctors. See, for example, Adelene Rich, "Birth Control," Woman's Medical Journal 26 (December 1916):768; "Any method whether mechanical or chemical, is harmful to the wife and mother . . . if it be mechanical, it is bound to denude the mucous surface . . . and in this way it would lay the foundation for infection, scar tissue, congestion or inflammation and in time would be good field for cancer."

[2]Linda Gordon, "Voluntary Motherhood; The Beginnings of Feminist Birth Control Ideas in the United States," in Hartman and Banner, eds., Clio's Consciousness Raised, pp. 54-76. Gordon's article describes the late nineteenth-century movement for voluntary motherhood, the first feminist demand for birth control. This movement was neither a challenge to the family nor a free-love venture; rather, it was directed against the belief that male passion was uncontrollable and the inevitable fate of the wife. Women's advocacy of celibacy or mutual self-control is completely rational in the context of nineteenth-century life, when mechanical birth preventives were associated with keeping prostitutes in business.

. . . from this abstinence."[1] Alice Stockham's method of Karezza received much circulation, and others urged different system of continence, with elaborate details of mental and physical preparation for sex. Karezza called for intercourse at intervals of between two and four weeks, preceded by several days of meditation. If the couple wished to avoid conception, they must practice coitus interruptus. Stockham guaranteed her readers that within an hour physical tension would subside and that the retention of seminal fluid would have mental and spiritual value for the male. Above all, she wrote, "through Karezza unsought and undesired paternity will be a thing of the past."[2]

If not in women's sexual interest, these restrictive sexual systems moved clearly in the direction of female assertiveness; they posed strong statements of women's rights to sexual autonomy, an independence which when realized would serve men as well. The systems

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[1]Lyman, Coming Woman, pp. 254-55; see also T. L. Nichols and Mary S. Grove Nichols, Marriage: Its History, Character and Results; It Sanctibilities, and Its Profoundities; Its Science and Its Facts (New York: T. L. Nichols, 1854), p. 286, quoted in Nancy F. Cott, ed., Roots of Bitterness, Documents of the Social History of American Women (New York: E. P. Dutton and Co., 1972), pp. 285-91; Melendy, Perfect Womanhood, p. 264; Taylor, Physician's Counsels, p. 149.

[2]Alice B. Stockham, Karezza, Ethics of Marriage (New York: R. F. Fenno and Co., 1903), pp. 22, 24, 26, 29, 43, 56.

represented rudimentary demands--an insistence which became angrier in a few decades--that women need not be the inevitable victims of male sexual whims. While not directed against the family and woman's primary nurturing role, these schemes nonetheless challenged outside imposition of enforced motherhood. Moreover, by creating choice between complete celibacy or rhythmic planning, they meant, in essence, a vote of confidence for the male, an act of trust. While the nineteenth-century sexual dichotomy had debilitating effects upon women's free expression, the gender stereotype hardly flattered men. The double standard was a portrayal of men as irresponsible, uncontrollable brutes, for whom the physical dominated the cerebral, and in whom force overwhelmed reason.

Notwithstanding the value of this nascent articulation for female sexual integrity and choice, the systems reached tragic proportions for women as manuals reported fertility information incorrectly. Authors wrongly called the periods immediately after menstruation dangerous.[1] Therefore, if women could not relieve

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[1]Brown, Wife, Her Book, pp. 276-77; Robert L. Dickenson, "The 'Safe Period' as Birth Control Measure," The American Journal of Obstetrics and Gynecology 14 (December 1927):729; Melendy, Perfect Womanhood, p. 64; Marianna Wheeler, Before the Baby Comes, A Practical, Non-Technical Manual for Prospective Mothers (New York: Harper and Brothers, 1914), p. 55: "To avoid impregnation, there should be no sexual intercourse for approximately twenty days in each lunar month, leaving about

themselves of pregnancies by reading the guidebooks, they could at least learn to manage them.

Without a pregnancy diagnostic test, authors could offer women no more than "possible," "probable" and "positive" signs of pregnancy. Women might presume pregnancy if nausea, vomitting and mammary and urinary alterations accompanied the cessation of menstruation, but confirmation would not be possible until the eighteenth or twentieth week, when life or "quickening" could be felt and the fetal heartbeat discerned.[1]

Throughout the nineteenth century, none of the literature discussed prenatal care; the curative nature

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eight days during which it may be indulged with safety." Margaret Sanger related a letter, purportedly written to her by a poor woman: "I took the advice of a nurse not to have anything to do ten days before and three days after menstruation and yet why . . . must I be this way?" Motherhood in Bondage (New York: Brentano's, 1928), p. 300.

[1]Trall, Mother's Hygienic Handbook, p. 44; Henry J. Garrigues, A Text-Book of the Science and Art of Obstetrics (Philadelphia: J. B. Lippincott, 1902), p. 100; Wheeler, Before Baby Comes, p. 20; Samuel R. Meaker, Mother and Unborn Child: A Little Book of Information and Advice for the Prospective Mother (Baltimore: The Williams and Wilkens Co., 1927), p. 3; Carolyn C. Van Blarcom, Getting Ready to be a Mother, A Little Book of Information and Advice for the Young Woman who is Looking Forward to Motherhood (New York: The Macmillan Co., 1922), p. 3. In 1927, Dr. Meaker, Associate Professor of Gynecology at Boston University School of Medicine, wrote: "Previous to the fifth month the diagnosis of pregnancy depends upon evidences that are presumptive or probable, but not positive or scientifically certain." p. 30. A reliable pregnancy test was not devised and medically circulated until the 1930s.

of the medicine of the era waited upon symptoms for therapeutic intervention. Before 1900 doctors expected women to monitor themselves. They learned the danger signs and, if alerted, sought medical help. In the absence of difficulties, manuals advised women simply to reserve a doctor and nurse for confinement. Indeed, these guidebooks assumed that the physician's entrance into the lying-in chamber was his first interview with the patient. Dr. Gunning Bedford instructed his medical students in the tactful art of introduction. Categorically, he declared, a doctor must not enter with immediate talk of the situation at hand--labor:

> You enter into conversation with her, talk of any and everything except the subject directly connected with the object of your visit. Talk of France, or Egypt . . . or the marine telegraph; in this way, a little professional diplomacy will enable you very successfully to accustom your patient to your presence. The first interview has passed; she finds that, after all, it is not such an embarrassing thing to hold converse with a doctor, and you will have impressed her quite favorably merely by your manner.[1]

Without declaring whether these were inborn qualities, in 1907 a Dr. Brown reassured women that their embarrassment was groundless since a doctor was "humane, considerate

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[1]Gunning S. Bedford, The Principles and Practice of Obstetrics (New York: Samuel S. and William Wood, 1861), p. 253.

and a gentleman."[1]

Early in the twentieth century, authors began to advise women to see doctors regularly throughout pregnancy --every month through the eighth and then weekly during the last two months. Without a pregnancy test, however, women could not confidently confirm conception until the fourth or fifth month. Manuals, too, fostered a lack of confidence, cautioning women not to jump to conclusions until positive determination could be made. Hence, even in the ideal program (ideal because literature twenty and thirty years later decried the lack of prenatal care), preventive observation of the pregnant woman began relatively late in pregnancy.[2]

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[1]Brown, Wife, Her Book, p. 185. This assumption of female modesty was not erased with women's suffrage and the flapper. In the most widely-read popular guide for expectant mothers in the 1950s, Nicholson Eastman wrote: "Most women unnecessarily dread the first visit to the doctor. . . . Physicians are not unaware that the young woman is undergoing what is probably the most intimate examination she had ever experienced and they strive in every way to protect innate modesty and prevent unnecessary exposure by the use of sheets and other drapings." Expectant Motherhood, 3rd ed. (Boston: Little, Brown and Company, 1957), p. 40.

[2]Egbert H. Granden, "Comments on the Toxemia of Pregnancy and on the Operative Treatment of Uterine Displacements," American Journal of Obstetrics and Diseases of Women and Children 41 (June 1900):721-23; Richard C. Norris, "The Effects of the Toxemia of Pregnancy upon the Cardio-Vascular System," Journal of Obstetrics and Diseases of Women and Children 48 (July 1903):31-33; Walter B. Jennings, The Hygiene of Pregnancy (New York: Medical Review of Reviews, Inc., 1908), p. 14; H. Laing Gordon, The Modern Mother, A Guide to Girlhood,

The mood of these books changed in the 1920s. Now counselors aimed to attack unnecessary infant and maternal mortality and the lack of systematic care during pregnancy. They delineated, often graphically, the potential dangers of child bearing. Authors admonished women to obtain medical care at the first suspicion of pregnancy.[1] Attempting to cajole women into seeking prenatal care, authors frequently described pregnancy as more precarious to health than did their nineteenth-century predecessors. In the 1903 publication of his widely-used text, J. Whitridge Williams defined what would become the common twentieth-century medical view of pregnancy. While it

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Motherhood, and Infancy (New York: R. F. Fenno and Co., 1909), p. 113; Samuel W. Bandler, The Expectant Mother (Philadelphia: W. B. Saunders Co., 1916), p. 59. Henry Schwartz, in "Painless Childbirth and the Safe Conduct of Labor," American Journal of Obstetrics and Diseases of Women and Children 79 (January 1919):46-47, asserted that 90% of the women in the United States were not receiving any prenatal care. By the teens in the twentieth century, women were advised to collect urine over a period of 24 hours and send it to their doctors. See, for example, Slemons, Prospective Mother, p. 103; Wheeler, Before Baby Comes, p. 78; Van Blarcom, Ready to be a Mother, pp. 52-53; Imperial Granum, What Your Physician Wishes to Tell You Before Your Baby Comes (New York: John Care and Sons, 1922), p. 12.

[1]Meaker, Mother and Unborn Child, pp. 2-3, 97-98; Van Blarcom, Getting Ready to be a Mother, pp. 3, 76; J. Clifton Edgar, in the introduction to Van Blarcom's book, wrote: "Failure to get these facts [high mortality] to the public; failure to teach lay women the dangers to be avoided and the methods of protection, is one very important reason why there has been no decrease in the high mortality rates," p. xiv.

was a "normal" period:

> It is apparent that the borderline between health and disease is less distinctly marked during gestation than at other times, and derangements, so slight as to be of but little consequence under ordinary circumstances, may readily give rise to pathologic conditions which seriously threaten the life of the mother or the child, or both.[1]

In 1922, J. Clifton Edgar, Professor of Obstetrics at Cornell University Medical School and a leader in establishing better maternity care in New York City, declared:

> Statistics are available to show that less than half of all pregnancies are normal and that the illness and loss of human life, from causes associated with childbirth, are distressingly and needlessly high.[2]

In 1923, the staff of the New York Lying-In Hospital considered the outstanding cause of maternal mortality to be the public's lax and casual attitude toward pregnancy:

> For far too long there has existed in the public mind, a paradox which is still largely responsible for the present-day bad results in obstetrics . . . that human reproduction is a normal physiological process. This may have been true in prehistoric times--it is not true now.[3]

In contrast, nineteenth-century lay and medical practitioners reacted casually to pregnancy. Perhaps

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[1]Williams, Obstetrics, p. 175.

[2]Edgar, introduction to Van Blarcom, Ready to be a Mother, p. xiv.

[3]Society of the Lying-In Hospital of the City of New York, Annual Report for the Years 1922 and 1923, p. 14.

they saw gestation as a modified period of health, but certainly not as a disease.[1] According to the Bedford text, doctors should not regard pregnancy as pathologic; instead, it should simply be "denominated a period of increased health."[2] Often the same doctor who cautioned rest during "monthly sickness" chastised women for inertia during pregnancy.

Nineteenth-century maternity manuals not only exhibited a relaxed attitude toward health and pregnancy, but also paid relatively little attention to the midwife's position in the matrix of delivery service.[3] This omission

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[1]Samuel C. Busey, "The Hygiene of Pregnancy," The American Journal of Obstetrics and Diseases of Women and Children 19 (January 1886):2.

[2]Bedford, Principles and Practice of Obstetrics, p. 123.

[3]The research underlying this dissertation runs counter to much recent scholarship in women's history, which has focused on the relationship between medicine, social ideology, and women's oppression. These studies tend to view nineteenth-century medicine in a hierarchical framework, in which gender antagonism determined the nature and quality of medical therapeutics. A common thread among many recent articles is that medical justification replaced theology as the rationale for women's subordination. Biomedical views of women served a functional, prescriptive role, reinforcing social norms about women. The psychological dynamics between male physician and female patient is, for many of these authors, the central element behind the nature of the treatment and medical advice. They cite a medical ideology which tailored women's destiny around her anatomy. Women's peculiar physiology dictated a life best characterized as semi-invalidism, if normal functioning and health were to be secured. Only a life of physical and, particularly, mental moderation could guaranty reproductive capacity. If

presumably follows from the fact that midwives played an insignificant role in maternity care after mid-century,

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women perceived menstruation, pregnancy and menopause as illness, then their domestic captivity would be more rigidly controlled. In the specialty of gynecology, particularly, medical therapeutics became an arena for venting male hostility toward women.

Historians often cite the "status drives" of doctors specializing in gynecology and obstetrics as key factors behind the didactic tones of medical advice. Present research, however, has found that gynecologists' and obstetricians' efforts to make their specialty equal with other medical disciplines, thus eliminating the low status and stigma of the midwife, were a twentieth- and not a nineteenth-century phenomenon. (See Chapter VIII for a discussion of obstetricians' ostracization of the midwife.)

For a psychological interpretation of nineteenth-century medicine for women, see the following studies: G. J. Barker-Benfield, "The Spermatic Economy: A Nineteenth-Century View of Sexualtiy," Feminist Studies 1 (Summer 1972):45-74; G. J. Barker-Benfield, The Horror of the Half-Known Life. Male Attitudes Toward Women and Sexuality in Nineteenth Century America (New York: Harper and Row, 1976); Carroll Smith-Rosenberg, "Puberty to Menopause: The Cycle of Femininity in Nineteenth-Century America," Feminist Studies I (Winter-Spring 1973):58-72; Carroll Smith-Rosenberg and Charles E. Rosenberg, "The Female Animal: Medical and Biological Views of Women and Her Role in Nineteenth-Century America," Journal of American History 60 (September 1973):332-56; Charles E. Rosenberg, "Sexuality, Class and Role in Nineteenth-Century America," American Quarterly 25 (July 1973):131-53; Ann D. Wood, "The Fashionable Diseases: Women's Complaints and their Treatment in Nineteenth-Century America," Journal of Interdisciplinary History 4 (Summer 1973):25-52; John S. Haller, Jr. and Robin M. Haller, The Physician and Sexuality in Victorian America (Urbana: University of Illinois Press, 1974); Vern Bullough and Martha Voght, "Women, Menstruation, and Nineteenth-Century Medicine," Bulletin of the History of Medicine 47 (January-February 1973):66-82; Barbara Ehrenreich and Deirdre English, Complaints and Disorders: The Sexual Politics of Sickness (Old Westbury, New York: Feminist Press, 1973). While the basic thrust of this last book is political, not psychological, the authors maintain, p. 21, that nineteenth-century medical ideology held pregnancy to be inherently pathological.

and did not become a visible or potentially threatening force until the upsurge of immigration in the 1890s. Moreover, competing sects and a surplus of doctors prevented any permanent coalition against the midwife. To the extent anyone voiced antagonism to the midwife, opposition often came from female practitioners who saw obstetrics as their entering wedge into medicine.

Elizabeth Blackwell, the first female physician in the United States, regretted students' disdain toward the specialty of obstetrics. She called this the female student's great strategic mistake.

> It is through the confidence felt by the mother during our skillful attendance upon her, that we are called upon to attend other ailments of the family, and thus secure the care of the family health. It is therefore of utmost importance to our future position in medicine to establish our ability as thoroughly trustworthy obstetricians.[1]

For Blackwell, obstetrics offered the truly legitimate field for the woman doctor.[2] Another physician, Elizabeth

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[1]Elizabeth Blackwell, The Influence of Women in the Profession of Medicine. Address Given at the Opening of the Winter Session of the London School of Medicine for Women (Baltimore: n.p., 1890), p. 29.

[2]Ibid., p. 11. The two fields for which Blackwell felt women were best suited were midwifery and preventive medicine. She reasoned that these areas lent themselves best to women's innate nature of empathy and pity. Other women doctors urged that female modesty be the basis for the female doctor's choice of obstetrics. See, for example, Annual Report of the Hospital of the New York Medical College and Hospital for Women, 1882, p. 10: "Women will ofttimes suffer in silence because of a naturally sensitive dread to describe their ills to

Jarrett, writing for the student monthly of the New York Medical College and Hospital for Women, voiced as much hostility to the midwife as anyone might muster:

> Not only among the lowly and ignorant, but in the higher classes of society to-day the feeling is growing yet stronger that this sphere of work [obstetrics] belongs pre-eminently to women--not to the often ignorant, unskilled, dirty, midwife, whose sole claim to ability lies in the fact that she has seen half a dozen or more confinements--but to her cleanly, thoughtful, well-educated, and possibly really skillful sister, the woman doctor.

Jarrett continued in praise of New York City's policy of paying of the confinement of poor women as long as they used a doctor.[1]

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physicians of the opposite sex." In 1925, Dr. Anna E. Blount, in the presidential address to the Medical Women's National Association, said: "Let no woman be compelled to submit to the humiliation of prostrating themselves [sic] before a man for pelvic examination because the town has no woman doctor." In "Twelfth Annual Meeting of the MWNA, Dallas, Texas, April 18-19, 1925," Quarterly Bulletin of the Medical Women's National Association (October 1925):4. Alice B. Campbell, in an article for The Cresset (the monthly student publication of the New York Medical College and Hospital for Women) 1 (December 1897):18, held women best suited to treat females because only they held the key to their own nature.

[1]Elizabeth Jarrett, "The Midwife or the Woman Doctor," The Cresset 2 (January 1899):35. The animosity toward the midwife at New York Medical College and Hospital for Women had a history as old as the institution itself. See, for example, Second Annual Announcement and Constitution of the New York Medical College and Hospital for Women, 1864, p. 8.

Does a psychological interpretation offer the best possible explanation of the sexism of medical advice or should a more concrete approach be substituted? Psychologizing often removes historical subjects from their

If male hostility to midwives and medical characterization of pregnancy as illness do not represent nineteenth-century medical ideology, then the basis of maternity advice--which made pregnancy an all-encompassing preoccupation for women--must lie elsewhere. Even a casual or random survey of nineteenth-century medical advice literature reveals moderation as the key word: the body, like a machine, could easily be abused and lose its steam.[1] The mechanical vital energy theory produced

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social, cultural, political and economic milieus, and may thus serve contemporary rather than historical investigation. For an excellent essay questioning the validity of a psychological approach to the interpretation of medicine and women in the nineteenth century, see Regina Morantz, "The Lady and Her Physician," in Hartman and Banner, eds., Clio's Consciousness Raised, p. 39.

[1]See Barbara Sicherman, "The Paradox of Prudence: Mental Health in the Gilded Age," The Journal of American History 63 (March 1976):890-912. In discussing the mental hygienists in the nineteenth century, Sicherman notes that physicians viewed their contemporaries with possession of only limited reserve of nervous energy; to preserve mental health, the laws of moderation, dictating respect for competing organs, must be observed. "Physicians in the Gilded Age pitted themselves, probably with little effect, against popular success writers like Horatio Alger." p. 895. This statement contradicts the underlying notions in contemporary articles maintaining that medical ideology was uniquely applied to the female. See, for example, Wood "Fashionable Diseases," p. 28; and Smith-Rosenberg, "Puberty to Menopause," in Hartman and Banner, eds., Clio's Consciousness Raised, p. 24. For an example of the general application of the tenets of moderation, see Stella Gilman, Mothers to Council (New York: Harper and Brothers, 1884), pp. 175-76: "If children are kept happy, they must not be permitted to study too hard at school. I have no compassion for idleness but children have more need for rest than men and women, as their vitality is largely expended in building up their bodies."

medical warnings of overexertion. Like their male counterparts, female physicians cautioned women against overstraining their resources. Often they too referred to the womb as woman's controlling axis, "sensitive . . . easily influenced by bodily and mental conditions."[1] Female advisers warned girls against overreaching their natural boundaries of strength, "often encroaching on vitality that belongs to future years."[2]

These physicians did not oppose female education as such, but admonished temperance as a "balance between excitement and rest, especially before maturity has been reached."[3] Another female physician emphasized that "well-directed mental effort never yet made a case of hysteria. . . . It is intemperate brain-work, with worry which leads astray."[4] Yet another woman practitioner,

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[1]E. R. Shepherd, For Girls: A Special Physiology: Being a Supplement to the Study of General Physiology (New York: Fowler and Wells, 1882), pp. 37, 48; Cook, Eutocia, p. 41: "In studying this wonderful organ [the womb] I am so overwhelmed by its marvelous mechanism, and by its power to influence for good or evil the millions who are to come after us, that words seem meaningless when I undertake to describe it, or to delineate its functions."

[2]Shepherd, For Girls, pp. 105-106; see also Cocroft, Motherhood, pp. 67-68.

[3]P. B. Saur, Maternity: A Book for Every Wife and Mother (Chicago: L. P. Miller and Co., 1891), p. iii.

[4]Mary J. Studley, What Our Girls Ought to Know (New York: Funk and Wagnalls, 1882), p. 120.

Dr. E. G. Cook, admired the German upper-class custom of bed rest for two or three days "during the Monthly action." She criticized the American education system for its nervous stimulation, which resulted in blood depletion. Without taking girls out of schools, she proposed adding kitchens so that they might get practical experience in general housework, cooking and sewing: "We need strong mothers, who esteem it a privilege to raise healthy children."[1]

Without denying that many male practitioners asked women to "look upon [themselves] as . . . invalid[s] once a month,"[2] and the notion that Dr. Clarke's oft-cited book which redefined woman's sphere to the physiological and limited the body's concentration to one prime activity at a time (regular menstruation, i.e., good health, precluded sustained education), had an impact among physicians, his work also led to fierce differences among other

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[1]Cook, Eutocia, pp. 72, 138, 153; as Morantz points out in "The Lady and her Physician," p. 48, the corollary to the assumption that women were victims of male medical hostility is that women doctors "saw themselves as the saviors of their sex." This lacks historical grounding. There is little evidence of women doctors positioning themselves in battle with their male counterparts. The lack of a monolithic stance applies equally to practitioners of both sexes. Either they viewed female invalidism as resulting from abuse of the womb or they criticized the frivolous and unhealthy manner of women's dress and social habits.

[2]Taylor, A Physician's Counsels, p. 285.

physicians and feminists alike.[1]

Both Mrs. E. B. Duffey and Julia Ward Howe published trenchant refutations of Clarke's design. Duffey retorted that Clarke's book "has called out an indignant protest from women almost universally. . . . In fact, I have seen but one public endorsement of the book by a woman." Duffey maintained that lethargy (or having "nothing to do"), rather than overexertion, caused neuralgia and hysteria. She agreed with Clarke, even partially, only from the perspective of a generation which subscribed to the vital energy theory. For Duffey, overstudy and mental strain were debilitating to the young, causing nervous exhaustion for men as well as women.[2] Both Duffey and Howe saw the lack of vigorous exercise, not overstudy, as the true root of woman's frailty.

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[1]Edward H. Clarke, Sex in Education; or, A Fair Chance for Girls (Boston: James R. Osgood and Co., 1873), p. 40; W. W. Bliss, Woman, and her Thirty Years' Pilgrimmage (Boston: B. B. Russell, 1870), pp. 7, 164, 166, 168; M. E. Dirix, Woman's Complete Guide to Health (New York: W. A. Townsend and Adams, 1869), pp. 23-24, 47, 85, 96; Austin, A Doctor's Talk, p. 138: "Brilliant intellects are being dearly paid for by future invalidism." See also Bullough and Voght, "Women, Menstruation, and Nineteenth-Century Medicine," p. 69; Smith-Rosenberg, "Puberty to Menopause" in Hartman and Banner, eds., Clio's Consciousness Raised, pp. 26-27; William Alexander, Practical Gynecology (Edinburgh: Neill and Company, 1899), pp. 36-39.

[2]E. B. Duffey, No Sex in Education; or, an Equal Chance for Both Girls and Boys. Being a Review of Dr. E. H. Clarke's "Sex in Education" (Philadelphia: J. M. Stoddart and Co., 1874), pp. 7-8, 13, 74.

Fashionable dress and a cloistered existence robbed women of health.[1]

Women's advisers in the nineteenth century found little agreement when it came to women's apparent delicacy and ill health. Indeed, many practitioners, male and female, called fashion, not physiology, the cause of female invalidism--remove the corset and restore women's health.[2]

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[1]Ibid., pp. 66, 27-28, 89; Julia Ward Howe, ed., introduction, Sex and Education. A Reply to Dr. E. H. Clarke's "Sex In Education" (Boston: Roberts Borthers, 1874), pp. 27-28.

[2]If unconscious hostility lay at the foundation of physicians' admonitions and therapy, then how does one account for the disharmony among male practitioners and why were some physicians hostile and others not? To the contrary, Smith-Rosenberg, "Puberty to Menopause" in Clio's Consciousness Raised, fn 7, p. 35: The author notes that some female physicians dissented from the womb theory, advocating dress reform and exercise; but she finds these feminist arguments the exception. This research, on the other hand, finds disagreement (re female disease) prevalent among male as well as among female practitioners. Wood, "Fashionable Diseases," p. 40, justifies the presentation of a monolithic medical ideology by citing "regular" doctors, claiming that they represented the elite core, "the higher echelons of American medicine." But as Richard H. Shyrock, Medicine in America, Historical Essays (Baltimore: The Johns Hopkins Press, 1966) and Charles Rosenberg, "The Practice of Medicine in New York a Century Ago," Bulletin of the History of Medicine 41 (May-June, 1967): 223-53, clearly demonstrate, there was no medical elite in the nineteenth century. Instead, there was an overabundance of doctors, causing enormous and often bitter competition. For example, see Shyrock, p. 155: "By 1860, there was one practitioner for every 572 persons in the population as a whole." In New York City (ca. 1860), Rosenberg estimated that "about 1500 New Yorkers treated the sick in some manner, a ratio of one physician to roughly 500 inhabitants," p. 225. Ehrenreich and English,

Hygienists, for example, concurred that menstruation should be free of pain and maternity a normal event, but insisted that "artificial habits of society" had distorted nature's intent. They suggested activity, fresh-air exercise, and dress reform, not rest. R. T. Trall, founder of the American hydrolic sect, declared:

> One of the most pernicious errors abroad is that woman is the "weaker vessel" physically; thus accounting for, if not excusing her manifold infirmities. . . . The fact that woman in civilized life is, as a rule feebler than man, is taken as the evidence of constitutional and natural infirmity. There is no truth to this notion. Physically woman is man's equal.

Trall cited Sarah J. Hale, who died in 1874 at the age of eighty-four, and Lucretia Mott, who lived until her eightieth birthday, as illustrations of female vitality.[1]

Hygienists found sound physiological bases for women's complaints; uterine displacement, leading to back pain and head ache, constipation, nervousness,

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Complaints and Disorder, p. 24, make the comparison: "In 1900 there were 173 doctors engaged in primary patient care per 100,000 population, compared to 50 per 100,000 today." By 1840, the status of "regular" doctors was at its lowest, resulting from public disgust with heroic techniques. Physicians organized the A.M.A. in 1847, primarily to renew public confidence in the regular physician. But not until the end of the nineteenth century, after the discoveries of Lister, Pasteur and Koch, did the prestige of the regular medical profession revive. See Shyrock, Medicine in America, pp. 224, 256.

[1]Trall, Mother's Hygienic Handbook, pp. 6-7.

weakness, and general inertia, along with unmended lesions resulting from childbirth, caused real distress. When disease did not evolve from organic causes or medical malpractice, it followed ignorance and stubbornness, not overstepping natural boundaries--engaging in "unfeminine" pursuits. According to hygienists, if women eliminated sedentary habits (which weakened abdominal muscles) and lacing (which constricted the chest and inner organs), they would find new energy.[1]

Many regular physicians echoed the admonitions of hygienists. Lucien C. Warner wrote in 1874 that girls' illogical upbringing "train[ed them] for invalids, even from childhood, a girl scarcely reaches the age of ten before she is told that it is not pretty to rope, and roll the hoop."[2] Cultivation of women's bodies would eradicate nervous disease and hysteria. Robert Latou Dickenson, a regular physician who became one of the

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[1]See Ibid., pp. 26-27; Stockham, Tokology. A Book for Every Woman (Chicago: Alice B. Stockham and Co., 1898), pp. 27, 95-96, 255-56; Cook, Eutocia, pp. 18-19; Saur, Maternity, pp. 12, 67; Shepherd, For Girls, p. 25, 51-53, 64, 86-87; Studley, What Our Girls Ought to Know, pp. 116-17, 175-76.

[2]Warner, Functions and Diseases of Woman, p. 115; see also Bernarr MacFadden, Health, Beauty, Sexuality. From Girlhood to Womanhood (New York: Physical Culture Publishing Co., 1904), pp. 56-57, 178-79; Brown, Wife Her Book, pp. 10-14, 19; Drake, Wife Ought to Know, pp. 42, 44, 48-49. Drake wrote: "Think of sixty millions of corsets sold in a year in America. . . . Is it strange that our women are invalids?" p. 50.

twentieth century's most respected gynecologists, in 1895 decided that the chronically ill female was nothing more than an atrophied and bounded human being. Deploring the lack of exercise and "false habits" of dress, he held that menstruation and labor could be painless. For the restoration of woman's pelvic structure, he recommended the new sport of bicycling.[1]

Since there was considerable dissent concerning the origins of female delicacy and because the lines are not drawn neatly between male and female practitioners' attitudes, then still another foundation must be sought for the rather prescriptive health admonitions directed toward women in the nineteenth century. If nineteenth-century medicine is seen as a graded system, influenced primarily by class rather than gender, then women's invalidism served definite functional necessities for regular physicians seeking to gain preeminence over their myriad competitors.[2] Elite nineteenth-century medical

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[1]Robert L. Dickenson, "Bicycling for Women from the Standpoint of the Gynecologist," The American Journal of Obstetrics and Diseases of Women and Children 31 (January 1895):25, 29-32.

[2]This was a period when state-licensing laws were virtually nullified; self-styled doctors practiced as they pleased. Regular physicians fought--unsuccessfully until the turn of the century--for stringent licensing laws which not only set educational standards but also regulated the number of doctors. See Shyrock, Medicine in America, p. 122; William G. Rothstein,

theory depicted middle-class women as sickly and lower-class women as paragons of health. This contrast meant that poor women could be left untreated, while the wealthy paid endlessly for home visits, local treatment, drug therapy, and often spa retreats. In an era when doctors complained of unpaid bills, this dichotomy coincided completely with physicians' financial necessities. Were hygienists less hostile to women, or did they not share the same class background and orientation of regular physicians? Sectarians (with the exception of homeopaths, who virtually merged with the regular establishment in the early twentieth century)[1] came predominantly from poorer stock than the so-called regular doctors; similarly, their medical appeal was to a lower stratum; their professional aim was rebellion, not establishment.[2]

American Physicians in the Nineteenth Century (Baltimore: The Johns Hopkins Press, 1972), p. 305.

[1]Homeopathy represented a major defection among regular physicians; it "constituted the first attack on heroic therapy by physicians, rather than outsiders." Rothstein, American Physicians, p. 138. At pp. 225 and 301, Rothstein describes the growing strength of homeopaths and their eventual adoption of "regular" drugs. This strength meant that regular physicians, in order to win legislative efforts for licensing laws, had to share state boards with homeopaths.

[2]Ibid., pp. 159, 177, 225. Present-day analysis is accurate insofar as it suggests that many regular physicians sought to, and probably did, make women invalids. Yet to ascribe this derogation of women to latent psychological reasons, while superficially attractive, goes beyond the historical evidence and even at best

Mary Putnam Jacobi recognized the contradictions imposed by a class-stratified medical ideology. In her classic work refuting the necessity of rest during menstruation, she asked how repose and inactivity during monthly periods could be reconciled with female industrial participation.[1] But the doctors of Jacobi's generation had resolved the dilemma. "While hard physical labor [might] drain the system of vital force," it left the nervous system--controlled, supposedly, by the uterus--unscathed.[2] Many physicians thus accepted women's physical labor, but pointed to the dangers of thinking. Nineteenth-century physicians imagined, or perhaps hoped that their readers would imagine, that working class people, Indians and Negroes somehow avoided chronic

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finds little support in the record. Cultivation of middle-class illness created lucrative practices and gave doctors the aura of legitimacy, still consistent with accepted belief in the vital energy theory. (The condescension and god-like qualities of the nineteenth-century physician that Wood and the Hallers describe was not reserved exclusively for women. The AMA code, written in 1847, poses the archetypical statement of medical arrogance: The patient should see the professional as his confident; but as close as the patient and doctor might become, the patient must pay promptly. The patient should obey unquestioningly the prescriptions of the physician and "never permit his own crude opinions as to their fitness to influence his attention to them." Quoted in Rothstein, American Physicians, p. 173).

[1]Mary Putnam Jacobi, The Question of Rest for Women During Menstruation (New York: G. P. Putnam's Sons, 1886), pp. 17-20.

[2]Verdi, Maternity, p. 376.

disease. Authors agreed that these were problems reserved to refined society and saw medicine as a science for the upper classes.[1]

Only a small group of nineteenth-century doctors understood and deplored the financial possibilities this scheme promised. Trall called gynecology "the disgrace of medical science. No diseases, on the whole, are treated so unsuccessfully, not to say injuriously, and yet their treatment constitutes considerably more than one half of all the business of the medical profession."[2] In outrage, Stockham derided the local treatments--applications of nitrate of silver, sulphate of zinc, or nitrate acid to women's insides--for uterine complaints; these "therapies" kept women in bondage to their physicians, often for two or three years, or until complete deterioration of health dictated termination.[3] Jacobi saw clearly in 1895 that the poor health of women rose proportionally to "their new function as lucrative patients."[4]

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[1]See Bliss, Thirty Years' Pilgrimage, p. 175; Taylor, Physician's Counsels, pp. 275-76; Warner, A Popular Treatise, pp. 109-10, 115, 117-19, 123; Verdi, Maternity, p. 376.

[2]Trall, Mother's Hygienic Handbook, p. 34.

[3]Stockham, Tokology, pp. 269-70.

[4]Mary P. Jacobi, Letter to Dr. Edes on female invalidism, 1895, in Mary Putnam Jacobi, M.D.: Pathfinder

Indeed, the nineteenth-century advice literature sets itself distinctly in a middle-class genre, one which would insure leisure by turning women's concentration inward with great attention to every detail of women's health and socializing capacities. Without a medical ideology of class, the hygienic routine of pregnancy would foreclose childbirth to working-class women. Moderation constitutes the central concept in this advice literature. Authors counselled readers to avoid violent movements, seasoned foods, and heightened passions. In the nine months of concentrated effort to produce offspring, women must walk a tightrope.

Books advised loose dress, suspended from the shoulders, which would provide the necessary warmth for proper bodily excretion. Doctors warned women against the

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in Medicine, ed. by The Women's Medical Association of New York City (New York: B. P. Putnam's Sons, 1925), selection in Cott, Roots of Bitterness, pp. 302-08. Obviously, there is a reciprocity between science and society; science influences social events, while social relationships have impact on scientific thought and practice. The question is whether scientific ideology derives from psyches or from social structure: Conservatives used medical arguments to limit middle-class women to the home; doctors became agents of social control, legitimizers of the extent of women's social participation. (See Talcott Parsons, The Social System, 5th ed. (New York: The Free Press of Glencoe, 1969), pp. 436-37). Yet to attribute causation to male hostility is facile and obscures the diffuse nature of nineteenth-century medicine, thereby avoiding a social structure, with no room for middle-class women in its productive economic framework, which boasted an aspiring and profit-oriented medical profession.

use of normal corsets beyond the third or fourth month and proscribed any compression of chest or abdomen, decrying a "pride in appearance" with attempts to conceal actual physique.[1] Since, one doctor reasoned in 1912, "no one can honestly believe that corsets will soon be banished," he advised the use of maternity corsets, providing abdominal support and accommodation without any constriction. An abdominal supporter or binder--a strip of linen or rubber--should replace the corset in the last few weeks of pregnancy to maintain the "pendulous" abdomen.[2] In a period when everyday use of binding corsets fostered muscular laxity, women presumably found this clumsy and heavy under attire necessary.

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[1]Murray, Mother and Babe, p. 2; Bull, Hints to Mothers, p. 2. As late as 1957, doctors felt constrained to assure women that their looks would not be lost in pregnancy: "As the appearance of many expectant mothers attests, it is possible to look as attractive at this time as at any other. To be sure, the abdominal rotundity is a handicap, but, for some reasons, during the middle months of pregnancy women develop a special radiance which is most becoming and tends to offset this. Moreover, maternity dresses are so ingeniously contrived these days that they resemble an optical illusion in their ability to beguile the eye in regard to your real contour--which, incidentally, is always more noticeable to you than to anyone else." Nicholson Eastman, Expectant Motherhood, 3rd ed. (Boston: Little, Brown and Co., 1957), p. 68.

[1]For discussions of appropriate dress during pregnancy see Slemons, Prospective Mother, pp. 116-19; Imperial Granum, Before your Baby Comes, p. 6; Bandler, Expectant Mother, p. 50; Meaker, Mother and Unborn Child, pp. 81-82; Wheeler, Before the Baby Comes, p. 85; Van Blarcom, Ready to be a Mother, pp. 58-59.

General expectation held that women would gain approximately thirty pounds during term. Authors warned against the prevalent myth that a pregnant woman must eat for two. Their chief concern with diet involved the requirement that food have laxative qualities. The dietary regime called for three quarts of fluids--two of which should be water. Books strictly interdicted alcohol, and permitted only sparing consumption of coffee and tea. The ideal diet consisted of large quantities of fresh fruit, vegetables, and cereals, with only small portions of meat.[1]

Writers consistently and urgently recommended fresh-air exercise. Women should not regard themselves as "delicate" and become "fixtures in the house." Sedentary life would leave the body sluggish and the mind depressed, and cause difficult labor.[2] Manuals forbid ordinary sports and games--swimming, tennis, golf, dancing,

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[1]For discussions of proper diet, see Cocroft, Motherhood, p. 115; Melendy, Perfect Womanhood, p. 133; Margaret J. Modeland, The Expectant Mother and Her Child, Containing the Essential Things that Every Mother and Woman Should Know (Philadelphia: The John C. Winteon Co., 1915), p. 18; Murray, Mother and Babe, pp. 4-5; Anne A. Stevens, Maternity Handbook for Pregnant Mothers and Expectant Fathers (New York: G. P. Putnam's Sons, 1932), p. 54; Slemons, The Prospective Mother, pp. 85, 89; Van Blarcom, Ready to be a Mother, pp. 50, 69.

[2]Meaker, Mother and Unborn Child, p. 75; see also Murray, Mother and Babe, pp. 2-3; Slemons, The Prospective Mother.

or horseback riding. Although authors found croquet acceptable, they considered walking the perfect form of bodily movement.

Thus the pregnant woman must not remain idle. She should revolve her day around an exercise schedule, filling the remaining time with "congenial work." While authors assured women that "domestic duties" need not be abandoned, women must not become exhausted. The middle-class orientation of this literature, which warned against violent exertions, "all masculine and fatiguing employments whatever,"[1] such as sweeping, scrubbing, laundering, heavy lifting, frequent climbing of stairs, long standing, and running a sewing machine by foot, is startling.[2] This middle-class bias, which is highlighted again in doctors' discussion of miscarriage and prenatal culture, suggests that discussion of women and medicine must reflect socio-economic breakdowns. In order to maintain a hierarchy of power and privilege, women have been treated differently. Gender itself hardly posed the sole determinant in the relationship between medical ideology, therapeutics, and women. Indeed, the etiology of disease

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[1]Bull, Hints to Mothers, p. 32.

[2]Meaker, Mother and Unborn Child, pp. 76-79; Slemons, The Prospective Mother, p. 132; Mary L. Read, The Mothercraft Manual (Boston: Little, Brown and Co., 1921), p. 70; Van Blarcom, Ready to be a Mother, p. 64.

followed differences of race, class and economics.

For nineteenth-century medical advisers, if menstruation were women's monthly nemesis, its cessation during pregnancy promised no relief. Advice urged pregnant women to take special care not to overtax themselves when menses would normally have occurred. The myth that the timing of miscarriage corresponded to the former menstrual cycle persisted among doctors and the lay public.[1]

Advice on the prevention of miscarriage traversed the ludicrous--that ice cream and cold beverages brought on abortion[2]--to the repeated warning that sexual indulgence caused loss of the fetus. Sex and pregnancy did not mix well. Even when authors advised only against excessive coitus, definitions lacked precision and were often riddled with contradictions. For instance, the statement that "intercourse may be regularly--if carefully--practiced; but it should certainly be restricted as much as possible,"[3] was bound, at the very least, to cause

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[1]Cocroft, Motherhood, p. 139; W. Lewis Howe, A Treatise on the Care of the Expectant Mother During Pregnancy and Childbirth and Care of the Child from Birth Until Puberty (Philadelphia: F. A. Davis Co., 1903), p. 10; Van Blarcom, Ready to be a Mother, p. 65.

[2]Trall, Mother's Hygienic Handbook, p. 56.

[3]Norman Barnesby, The Mother and the Child (New York: Mitchell Kennerley, 1913), p. 12.

confusion. Other counselors reduced equivocation with the absolute imperative that the "patient must sleep alone."[1]

Advisers interdicted sex during pregnancy not merely to prevent abortion, but also to protect the future character of the embryo. The moral purity movement viewed men as inherently lustful. Abstinence during pregnancy would prevent the transfer of this lust to the unborn child.[2] "Whole families of children," wrote one female hygienist, "have been ruined, because the head of the family claimed his marital rights."[3] Many saw women as asexual during gestation; if female desire were manifest, according to some advisers, it should be treated as "unnatural," a sign of uterine disease, demanding medical consultation.[4] Stockham attributed morning sickness to sex during pregnancy; even a kiss or touch from the husband could cause "nausea and other distressing

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[1]Bull, Hints to Mothers, p. 119. For other authors who forbid sex during pregnancy, see Cocroft, Motherhood, pp. 126, 139; Gordon, The Modern Mother, p. 110; Modeland, The Expectant Mother, pp. 27-28; Robinson, Physical Lifehood, p. 47; Robinson, Sex and Love Life, p. 280; Saur, Maternity, pp. 143-44; Wheeler, Before the Baby Comes, p. 87; Verdi, Maternity, p. 93.

[2]Drake, Young Wife Ought to Know, p. 90; Lyman, Coming Woman, p. 219.

[3]Cook, Eutocia, p. 59.

[4]Austin, Maiden, Wife, and Mother, pp. 92-93; Drake, What a Young Wife Ought to Know, p. 93; Lyman, Coming Woman, p. 219.

symptoms."[1] Thus the distinction between restriction of sex and prescription appears misty. Minimally, the advice led to female sexual hesitation and the promiscuity of the middle-class married man.

Poor women found unavoidable the fatigue which manuals admonished middle-class women to avoid. Likewise, completion of a successful pregnancy would require the emotional sequestration of women, a demanding stipulation for anyone, but more so for women whose normal existence required a struggle for livelihood. Nineteenth-century writers held that pregnancy called for emotional readjustment since it altered woman's nervous sytem, making her easily impressionable and susceptible to mental agitation. A kind of stoicism, "the paramount duty of guarding against the emotions and passions," helped substantially to prevent miscarriage.[2] Women, on the one hand, must not worry, fear or grieve, yet should eschew any pleasurable amusements:

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[1]Stockham, Tokology, pp. 47, 159.

[2]Samuel Bard, A Compendium of the Theory and Practice of Midwifery, Containing Practical Instructions for the Management of Women During Pregnancy, in Labour, and in Child-Bed; Calculated to Correct Errors, and to Improve the Practice of Midwives, as well as to serve as an Introduction to the Study of this Art, for Students and Young Practitioners (New York: Collums and Perkins, 1807), pp. 88-89; Taylor, Physicians' Counsels, pp. 159, 169; Verdi, Maternity, pp. 91-92.

> Crowded assemblies . . . of all kinds, public spectacles, and large parties--in short, everything calculated to rouse strong feelings, to depress the mind, or excite the passions--ought to be sedulously avoided.[1]

Authors acknowledged common apprehension among their patients; "undefined fear of pending evil, anxiety about the future, and fear of dying" led some women to near despair.[2] As long as statistics were not collected, the myth prevailed that working-class women were sturdier; that "the finer the breeding, the less hardy is the plant, the animal, or the individual."[3] Oblivious to any contradictions, these writers sympathized with the forebodings of the wealthy, asking husbands to cater solicitously to she who is doing her "duty to the race" and endure her frets and ills "with loving patience."[4]

Pregnancy guidebooks carry the implicit message that medical attention must concentrate on the affluent since gestation for "the common people" somehow avoided mishap. Lower-class women should be envied; they enjoyed quick and easy labors, with their recoveries fast and

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[1]Bull, Hints to Mothers, p. 30.

[2]Verdi, Maternity, p. 44. See also Bull, Hints to Mothers, p. 30.

[3]Austin, Maiden, Wife, and Mother, p. 64.

[4]Warner, Functions and Diseases of Women, p. 92; see also Cook, Eutocia, p. 53; Melendy, Perfect Womanhood, p. 95; Verdi, Maternity, p. 45.

their babies "rosy, healthy, and strong."[1] Echoing these illusions sixteen years later, a physician happily noted the advantage to the nation of large working-class families: "The children of workers are worth a dozen times as much as the children of the rich and idle."[2] Nineteenth-century medical theory denied anxiety to poor women. Their active lives and strong framework caused them to "think little of confinement."[3]

Historically, the process of gestation has been colored with superstition. Even by the late nineteenth and early twentieth centuries, when medical advance had unraveled the physiology of birth, myth persisted.

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[1]Pye Henry Chavesse, Wife and Mother; or, Information for Every Woman (Philadelphia: H. J. Smith and Co., 1870), p. 316.

[2]Cook, Eutocia, p. 150.

[3]Saur, Maternity, p. 70. By the turn of the century, with evidence derived from statistical compilation and medical preventive work, this myth began to break down. Henry J. Garrigues wrote that the speedy return to work among poor women caused them to suffer greater gynecological disease subsequent to birth than did the wealthy, A Textbook of the Science and Art of Obstetrics (Philadelphia: J. B. Lippincott, 1902), p. 242. Among this selection of advice manuals, only Slemons, Prospective Motherhood, pp. 133-35, cited European legislation prohibiting the employment of working women immediately before and after confinement. He noted that not only were miscarriages more frequent among the poor, but also that the birth weight of infants of mothers working up to their delivery compared unfavorably to women with more leisure. This discovery, however, would have to be repeated again and again by health workers before remedial action followed. See Chapters V, VI, VII, and VIII, infra.

Folklore held that a premature seven-month baby would live while an eight-month baby would not be viable, and that the right ovary would produce male offspring while the left generated female. A variation of this urged that women determined the sex of the child after conception. Reaching above the head, or sleeping with arms upwardly extended, would entangle and strangulate the fetus with the umbilical cord. Similarly, sitting cross-legged would affect the position of the child. Many women went on craze diets in the hope of easy delivery. Other women gained excessive weight on the assumption that they must eat for two.[1]

Women found the belief in maternal impressions and markings, with derivative and elaborate schemes for prenatal culture, the most debilitating myth psychologically. Maternal transmission to the developing embryo thus took two forms. A mother might variously "impress" the fetus to develop particular talents, desirable personality traits, or physical beauty. Moreover, the expectant mother could "mark" the child with bodily malformation or

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[1]Bandler, Expectant Mother, p. 56; Meaker, Mother and Unborn Child, p. 64; Frank Howard Richardson, A Doctor's Letters to Expectant Parents (New York: The Children, Parents' Magazine and W. W. Norton and Co., 1929), p. 44; Slemons, Prospective Mother, pp. 52, 95; For a woman's descriptions of her anxieties during pregnancy, see Charlotte T. Hirsch, The Diary of an Expectant Mother (Chicago: A. C. McClurg and Co., 1917).

deformity, by witnessing horrifying sights or experiencing discordant, unpleasant emotions. Anything but the appropriate state of calm might stamp the unborn child with despondency, pessimism or insolence.

The theory fell into medical disrepute in the middle of the nineteenth century, yet regained popularity by the 1870s. With middle-class women's withdrawal from productive labor, motherhood became increasingly privatized as well as emotionally exaggerated. In 1871, Dr. Walter C. Taylor asserted that science had finally validated this sturdy popular belief. The pregnant woman must be shielded from all agitating stimuli and sights, for "the education of the child in the womb is no chimerical idea. It is real and practical."[1] Both excitement and depression affected the unborn child; theatre--especially tragedies --was thus forbidden. Believers attributed birthmarks, moles, and actual malformations to unfulfilled longings or frightful sights of repugnant animals or people. "It is wrong to allow cripples, and diseased and deformed persons to be on exhibition in the streets."[2]

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[1]Taylor, Physician's Counsels, pp. 170-172, 179, 181.

[2]Trall, Mother's Hygienic Handbook, p. 79; see also Warner, Functions and Diseases of Woman, pp. 280-81; Bull, Hints to Mothers, pp. 41, 43; Cook, Eutocia, p. 51; J. H. Greer, Marriage, Maternity, Health and Hygiene (Chicago: Charles H. Kerr and Co., 1899), pp. 15, 21;

Fordyce Barker, a staunch advocate of prenatal maternal omnipotence, responded to critics who would not credit the theory since there were no nerve connections between fetus and carrier. Barker claimed that the mother's blood provided the viaduct, and that experiences during term could thwart development or construct nascent sensibilities. Indeed, he went further, and insisted that woman's mental status could even affect her ovaries, so that ova, affected years before their release into the fallopian tubes, might reflect prior influence once fertilized. Citing example after example, Barker called authentication "as certain as any other fact which cannot be explained by science, and there are many such." He recalled a brunette woman, married in 1850 to a fair man; the man died in 1856, leaving his wife with no children. The woman remarried a brunette man and together, had a blond, almost albino, child, whose mannerisms also resembled the first husband.

On the defensive, Barker filled an entire book with his perceived substantiation for the validity of maternal impressions.[1] Yet the notion needed no defending;

Seth Pancoast, The Ladies' Medical Guide (Philadelphia: John E. Potter and Co., 1875).

[1]Fordyce Barker, "The Influence of Maternal Impressions on the Fetus," Reprint from Gynecological Transactions 15 (1886):8-10, 13, 16.

its longevity was remarkable. Writing in 1921, Dr. H. W. Long, a neurologist and psychologist, gave primary credit to Napoleon's mother, who in pregnancy had surrounded herself with military regalia. But Long warned that fetal transmission was not simply mechanical. A woman who loved music might create a musical genius, while a trained musician could produce a tone-deaf child. Woman's soul, not her brain, became her chief asset. Long asked his patients to maintain diaries throughout their pregnancies, recording their efforts at prenatal determination as well as any unpleasant feelings, and to construct imaginary pictures of their children, thereby endowing them with traits and faculties extending into adulthood.[1]

Women carried an enormous burden of responsibility; with expectations so high, guilt posed a necessary corollary. Proper conduct denied women such malevolent feelings as hatred, anger, envy or covetousness. During the nine-month period, all thought was to be premeditated, all action purposeful. A woman must direct her unborn offspring toward useful occupation; to enhance future success, she should avoid scenes of "poverty, vagabondism and crime."[2] Manuals suggested that she surround herself with

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[1]H. W. Long, Motherhood. A Practical Guide for the Newly Married (Boston: The Gorham Press, 1921), pp. 96, 100, 113, 127-28.

[2]Saur, Maternity, pp. 190, 192-93.

beauty, studying art and music, for

> . . . statistics prove that children born of mothers thus surrounded during their pregnancy are more lovely in feature, form and disposition than those who come into the world . . . to semi-melancholy mothers.

This author urged that the prevalence of imbecility among eldest children reflected the inevitable tension and uncertainty of a woman carrying her first child.[1]

The proper framework for maternal transferance required that conception take place only after a sustained period of abstinence and mental preparation. The partners, having established a future profession for the child, must be free of any ambivalence or fear, with "bodies clean, sweet, and wholesome."[2] During intercourse, the father had his primary opportunity for contribution. Physically and spiritually, he must be at his prime. Thereafter, his only effect would be as the atmospheric tranquilizer for the prospective mother.[3]

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[1]Murray, Mother and Babe, pp. 1-3. See also Brown, Wife, Her Book, p. 60; Drake, Wife Ought to Know, pp. 106-07, 108; Modeland, Expectant Mother, p. 26; Cocroft, Motherhood, pp. 17-18: Cocroft comforted her less affluent readers: "If one is not financially able to procure paintings, a few simple prints, of great masterpieces, may serve the purpose of fixing the true ideals of art, and thus create the atmosphere most beneficial to foster the artistic tastes in her child."

[2]Long, Motherhood, pp. 53-54. See also Lyman, Coming Woman, p. 251.

[3]Lyman, Coming Woman, p. 210; Cocroft, Motherhood, p. 22.

Nineteenth-century advocates adopted the theory of phrenology, depicting the brain as a congeries of organs correlating to each bodily function. During gestation, therefore, if a woman concentrated on particular brain organs in herself, she would transmit those imprints to the corresponding organ group in the brain of her fetus. The theory's upholders thought that in the early months of pregnancy, when the embryo's muscular development took place, the mother should be involved in active exercise. In the latter part of term, mental concentration would be necessary.[1]

Medical opinions as to maternal impression, especially among obstetricians with hospital connections in the twentieth century, differed. Dissenters urged that since the embryo reached full formation by the second month, when many women had no suspicion of pregnancy, mothers could not implant traits or cause deformity.[2]

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[1]Lyman, Coming Woman, pp. 215-16; Melendy, Perfect Womanhood, p. 121; Saur, Maternity, pp. 158-95.

[2]Authors who discounted the maternal impressions thesis included Bandler, The Expectant Mother, pp. 54-55; Henry F. Lewis, "Maternal Impressions," The American Journal of Obstetrics and Diseases of Women and Children 40 (July-December 1899):91; Meaker, Mother and Unborn Child, p. 64; Read, Mothercraft Manual, p. 73; Richardson, Doctor's Letters, p. 29; Robinson, Sex Knowledge for Women, pp. 77, 88; Slemons, Prospective Mother, p. 52; Van Blarcom, Ready to be a Mother, pp. 47-49; Wheeler, Before the Baby Comes, p. 66.

Yet the lay belief persisted. In its manual on prenatal care in 1913, the Children's Bureau saw it necessary to allay fears, since the belief in "marking of babies is so widespread and productive of so much anxiety, it will be comforting to many women to learn on what slight foundations the belief rests."[1] Indeed, in 1957 the author of a popular guide to pregnancy felt constrained to discount maternal impressions: "Do not think . . . though you devote all your nights to symphony concerts, that your child will be one bit cheerier or one whit more musical because of it."[2]

The belief led ultimately to mother responsibility, hence mother blame. Blame and guilt continued as woman's albatross. If the mother's possibilities and control were limitless, inevitably she bore responsibility for any deviation the child manifested. Indeed, with typical irony, the same experts ignored the reality that mothers' prenatal physical conditions often resulted in infant difficulties or damage. Perhaps these authors acted innocently, but the seeds of guilt had been planted:

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[1]U.S., Department of Labor, Children's Bureau, Prenatal Care, by Mrs. Max West, Bureau Publication No. 4 (Washington, D.C.: Government Printing Office, 1913), p. 19. In 1932, the Maternity Center Association issued the same reassurance. See Maternity Handbook for Pregnant Mothers and Expectant Fathers, p. 15.

[2]Eastman, Expectant Motherhood, p. 38.

> It is possible for the prospective mother by the exercise of clean thoughts, pure desires and right purpose to lay a foundation that will develop the same in the nature forming under her tutorage. . . . It is as possible for a child to come into the world possessed of the germs of honor, sobriety, truth and uprightness, as with a beautiful face and well developed body.

The author continued that thieves, vandals and scoundrels had their genesis "in [the] governed rather than [the] ungovernable temper of the mother."[1]

This reinforced the individualization and isolation of the mother. Circumstance in a child's life could not be condemned; the long history of mother as whipping-boy commenced. The attitude of ask nothing from society but everything from women had begun to seep into women's consciousness, and would take decades to eradicate.

> All the churches, temperance societies, and divines in the world combined . . . cannot do as mothers in the months of prenatal life. If . . . both parents observe from a month to a year's preparation [before conception], the prisons and almshouses, hospitals and asylums would not require the . . . unceasing labor, nor need the millions of treasure which are now used to support them.[2]

The individual responsibilities of the middle-class woman segregated her from other women and isolated her from the poor woman who mothered as she did.

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[1]Melendy, Perfect Womanhood, pp. 117-18.

[2]Cook, Eutocia, p. 61. See also Saur, Maternity, p. 161.

Essentially, the theory of maternal impressions reflected a kind of elitism, with divide and rule implications. Advisors told middle-class women that they were raising "special children." The "drunken, vicious, unhappy" mother, "who is starved, overworked and overstrained, reacts upon the physical and mental well-being of her unborn child."[1] Obviously, lower-class women had neither the time nor the environment to provide the prenatal ambiance required for healthy post-uterine life.

The use of anesthesia in obstetrics came initially as a progressive medical step, as church and lay authorities benignly regarded woman's birth pains as punishment for Eve's original sin. For centuries, official opinion viewed pain as the necessary requisite for "maternal joy and sorrow." Man's fall brought disease and "guilt of the soul" to men and women alike, but woman would suffer uniquely. Her burden, accepted with fatalism through the mid-nineteenth century, would include not only "the trial" of labor, but frequently "protracted debility"--a life-long reminder of God's specific sentence. The tribulations of motherhood, the "care and trouble" which children bring, would not be woman's experience, "had not Eve, our

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[1]Elizabeth Sloan Chesser, Woman, Marriage and Motherhood (New York: Funk and Wagnalls, 1913), p. 93.

mother, learned to sin."[1]

The legacy of this resignation and indifference prevailed into the late nineteenth century. In 1881, an obstetrician writing for The Journal of Obstetrics and Diseases of Women and Children observed:

> To see women, especially primiparae, suffering in the throes of labor is so common and so much expected by the majority of physicians that they seldom do anything efficient to relieve the pain.[2]

Dr. J. Slemons, Professor of Obstetrics at The Johns Hopkins Hospital, and Henry S. Williams, medical superintendant to the New York Infant Asylum and the Randall's Island Hospital, in 1912 and 1914 respectively, both advocated the disassociation of pain in labor and the "curse of Eve," notwithstanding the wide availability and use of anesthesia in other areas of medicine.[3]

Like the exaggerated pathology of pregnancy, the routine application of anesthesia, with its desensitizing

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[1]Thomas Searle, A Companion for the Seasons of Maternal Solicitude. With an Appendix, containing Hints for the Nursery (New York: Moore and Payne, 1834), pp. 14-15, 21, 28, 29.

[2]H. H. Kane, "Chloral Hydrate: Its Use in Obstetric Practice," The American Journal of Obstetrics and Diseases of Women and Children 14 (April 1881):261.

[3]Slemons, Prospective Mother, p. 238; Henry S. Williams, Twilight Sleep. A Simple Account of New Discoveries in Painless Childbirth (New York: Harper and Brothers, 1914), pp. 10-11.

and dehumanizing implications,[1] did not coincide with the Victorian myth of motherhood and female delicacy. Nineteenth- and early twentieth-century practitioners cautioned moderation and hesitation before physicians employed anesthesia. Bedford pleaded for woman's cognizance during the significant event. All other medical factors being equal,

> . . . the female, at the most interesting period of her life--the time of labor, should . . . have her mind unclouded, her intellect undisturbed, her judgment fully adequate to realize and appreciate the advent of a new and important era in her existence--the birth of her child.[2]

Normal labors should proceed with no drug interference. Only in deviant cases, where a mother might be losing her stamina or begin to convulse, or the attendant saw indications for operative midwifery or instrumental delivery, should anesthesia be used. Even then, good practice avoided total unconsciousness.[3]

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[1]See Suzanne Arms, Immaculate Deception: A New Look at Women and Childbirth in America (Boston: Houghton, Mifflin Co., 1975), and Adrienne Rich, Of Woman Born: Motherhood as Experience and Institution (New York: W. W. Norton and Co., 1976), for modern feminist arguments against the automatic use of anesthesia.

[2]Bedford, Principles and Practice of Obstetrics, p. 711.

[3]Ibid., pp. 711-13; Brown, Wife, Her Book, p. 190; Kane, "Chloral Hydrate," pp. 265, 268. Kane advised the use of chloral hydrate rather than ether or chloroform, since the object should not be to anesthetize but simply to dull pain, allowing the patient to doze between contractions.

Fears that abatement of pain would allay a woman's affection for her child did not justify the cautious application of pain relief; rather, hesitation stood on rational awareness that the drugs were potentially dangerous to the mother and child, and that while nullifying pain they retarded labor. Authors described pain as a function of uterine contraction, the necessary propellent in birth: "As a rule, the stronger these pains the more rapid the birth."[1] At best, chloroform should be administered only at the end of the second stage of labor, after the woman had completed her role in assisting the speedy delivery of the child.[2]

Nineteenth-century hygienists went beyond the regular physicians' calls for caution. For hygienists, if women lived properly, birth could be a painless experience, free of drugs. Certain that chloroform risked injury to mother and child, they regarded its use "as a choice of evils," dictated only by "extraordinary complications."[3] Improper habits of food and clothing distorted childbirth into an unnaturally painful event. Sedentary

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[1]Wheeler, Before the Baby Comes, p. 67. See also Kane, "Chloral Hydrate," p. 262.

[2]Bandler, Expectant Mother, pp. 103, 105, 107; Meaker, Mother and Unborn Child, p. 297; Slemons, Prospective Mother, p. 250.

[3]Trall, Mother's Hygienic Handbook, pp. 12, 69, 70, 96.

life atrophied abdominal muscles, which in turn failed to cooperate with the flow of uterine contractions. According to Stockham's Tokology (the science and art of midwifery), dystocia, or difficult delivery, resulted from the artificial life-style which "civilization" imposed. Like present-day natural childbirth theorists, these nineteenth-century hygienists urged that the tension attendant at birth not be considered synonymous with pain.[1]

After 1910 or 1915, the obstetrical profession crusaded against the modern "outrage" which countenanced "the agony" with which women "are forced to endure in bearing children." The public now linked acute pain and childbirth inseparably. Logic held that women's sensibilities increased in a demanding civilization which "developed a type of nervous system that is very susceptible to painful impressions." Consequently, any suffering would drain human vital energy unnecessarily, resulting in deleterious nervous exhaustion.[2]

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[1]Stockham, Tokology, pp. 17, 40. See also Cocroft, Motherhood, p. 109; Saur, Maternity, pp. 195-96; Nathan Allen, "The Normal Standard of Woman for Propagation," The American Journal of Obstetrics and Diseases of Women and Children 9 (April 1876):12, 35, 39.

[2]Mary Boyd, "The Story of Damnerschlaf, An American Woman's Personal Experience and Study at Freiburg," The Survey 33 (November 7, 1914):128; W. Frances B. Wakefield, "Painless Childbirth," American Journal

In early twentieth-century America, twilight sleep became the rage, until physicians found it to affect the child adversely. This German discovery--the combination of morphine and scopolamine which worked so that the laboring woman showed all outward manifestations of suffering but obliterated all memory of discomfort--virtually reached crusade proportions in the United States. Sponsors established the Twilight Sleep Association in 1915. The group hired speakers to advance the use of these drugs, publishing lists of hospitals and doctors which used them.[1] Mary Boyd, who traveled to Freiberg Medical School and became the first American woman to give birth under twilight sleep, contended that "the fear of childbirth has poisoned the happiness of many women at a time when they should be happiest."[2] The enthusiastic proponents of twilight sleep called the memory of childbirth agony a form of negative reinforcement; pain should teach avoidence. Shall women be warned

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of Obstetrics and Diseases of Women and Children 77 (May 1918):792; Williams, Twilight Sleep, p. 26.

[1]"Twilight Sleep Association Organized," The Survey 33 (February 6, 1915):474; Theodore Cianfrani, A Short History of Obstetrics and Gynecology (Springfield, Ill., 1960), p. 402; Roy P. Finney, The Story of Motherhood (New York: Liveright Publishing Corp., 1937), pp. 186-87.

[2]Boyd, "An American Woman's Personal Experience," pp. 125-27, 129.

not to bear more children, they asked? Women will have more, enthusiasts replied, if they "are spared all knowledge of obnoxious details connected with . . . delivery."[1] Hence began the glorification of woman passively yielding the experience of birth to medical experts. The ideal obstetrical situation occurred with a woman who had just given birth:

> . . . when a few moments later the child is brought in by the nurse . . . and placed in the mother's arms, the patient does not recognize the child as her own, or realize that she has yet been delivered.[2]

American obstetricians abandoned twilight sleep in the early 1920s, when evidence of its toxic effects mounted. The drugs worked as respiratory depressants on the infants. While complete asphyxiation was rare, physicians recognize today that partial breathing paralysis, requiring active resuscitation efforts, causes brain damage. The drugs prolonged labor and made the patient incapable of participating in the bearing down process. This immobilization also made forceps delivery more common.[3]

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[1]Wakefield, "Painless Childbirth," p. 793.

[2]Williams, Twilight Sleep, p. 18.

[3]Bandler, Expectant Mother, pp. 143-44; Finney, Story of Motherhood, pp. 186-87; Williams, Obstetrics, 1917 rev. ed., p. 348.

While doctors discarded twilight sleep, the disconnection between woman and her delivery prevailed for many years. In 1957, Nicholson Eastman assured women that they could look forward to labor with "nonchalance." He and other specialists "pride[d] themselves on the large proportion of their patients who retain little or no memory of their labors."[1] Gone was the advice of the late nineteenth and early twentieth centuries, urging women to cooperate in their labors, to coordinate their breathing with uterine contractions, and to aid in the progress of delivery and diminish tension.

Reliance on anesthesia, requiring special expertise and observation, boosted the movement for hospital confinement. Hospitals had traditionally operated as places of last resort. Medical specialists in the early twentieth century worked assiduously to break down public prejudice against hospitals, aided by the transformation of medicine from a curative to a preventive science. This change engendered greater public confidence in hospitals. But popular sentiment clung to home delivery, and this reversal was more difficult to achieve. Often with subtle ingenuity, twentieth-century advice literature urged hospital confinement. In 1912, Slemons wrote that while physicians attended the majority of obstetrical

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[1]Eastman, Expectant Motherhood, p. 156.

patients at home without problem, he advised hospital entry if complications were anticipated. To be perfectly safe, he continued, all first deliveries should be in hospitals, whether or not abnormalities were forecast.[1] This became the repeated argument: that although delivery was largely successful at home, hospitals provided greater safety guaranties.[2] The ultimate argument called hospitals cheaper, less expensive, that is, if women followed the proper antiseptic precautions at home.[3] If women chose home birth, they would have to outfit their homes with sterilized obstetrical equipment. The roster of items to be purchased could dissuade any prospective mother from home delivery.[4]

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[1]Slemons, Prospective Mother, pp. 231-32.

[2]Bandler, Expectant Mother, p. 138; Meaker, Mother and Unborn Child, p. 100.

[3]Imperial Granum, Before Your Baby Comes, p. 17; Slemons, Prospective Mother, p. 232; Wheeler, Before the Baby Comes, p. 105.

[4]See Van Blarcom, Ready to be a Mother, pp. 87-91 and Wheeler, Before the Baby Comes, pp. 91-93, for a complete list of what women would have to purchase for safe home delivery. Among the items: A dozen sheets and towels; six delivery pads, rubber sheeting, sterile scissors, a quart of boric acid solution, 50 bichloride-of-mercury tablets (these were highly poisonous), 4 ounces of chloroform, one pint of grain alcohol, one-half dozen sanitary pads and five or six dozen sponges. According to the books, the woman bore responsibility for doing the sterlization.

Whether arguments of economy or the detailing of possible emergencies with which hospitals could manage convinced women, upper- and middle-class women especially turned to the hospitals for the births of their babies. The immigrant poor held out longer, but with the decline of free home service and the debasement of the midwife's capacities, by the 1920s they, too, had their second children in hospitals. (By 1957, 93 percent of all deliveries in the United States took place in hospitals.)

According to the manuals, confinement required long bed rest, for which guidebooks depicted a hospital setting. Authors recommended the recumbent position for a minimum of ten days after delivery, after which a woman might sit up. She might begin to walk after two weeks. They forbid light housework for at least six weeks following delivery, and proscribed heavy work for much longer. This advice, which was geared distinctly to affluent women, led to many unnecessary deaths, recognized today as embolic reactions to stationary bed rest.[1]

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[1]For details on the restrictions of the confinement period, see Brown, Wife, Her Book, p. 106; Cook, Eutocia, p. 82; Howe, Care of the Expectant Mother, p. 25; Imperial Granum, Before Your Baby Comes, p. 27; S. L. Jepson, "Sudden Death in Puerperal Cases," The American Journal of Obstetrics and Diseases of Women and Children 5 (August 1872):223; Meaker, Mother and Unborn Child, p. 162; Edward Reynolds, "The Relation of Gynecological Surgery to Bad Obstetrics," American Association for the Study and Prevention of Infant Mortality, Transactions of

The universal mandate to breast feed infants for ten months (longer if weaning coincided with the summer) made actual confinement at home much longer.[1] The child's birthright became the mother's emotional straitjacket. Once again, now during lactation, the woman must guard her feelings; her state of mind might poison her milk. Therefore, all "fit of temper, fright, grief, anxiety or any marked emotional disturbance" must be contained.[2] Thus in an era when birth control information and devices were illegal while the myth prevailed that nursing precluded conception, women often found themselves pregnant before the time came to wean, renewing the same cloistered process.

Most of this advice literature included portions purporting to educate the mother as infant rearer. In

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the Fifth Annual Meeting, Boston, Mass., November 12-14, 1914, pp. 113-14; Robinson, Physical Lifehood, p. 72; Van Blarcom, Ready to be a Mother, p. 114. In the 1924-1925 annual report of the Society of the Lying-In Hospital, pp. 11-12, the managers attributed three deaths--caused by clots in the lung or heart--to nonobstetric reasons. These deaths quite feasibly resulted from overlong bed rest.

[1]See, for example, Meaker, Mother and Unborn Child, p. 196; Modeland, The Expectant Mother, p. 84; Richardson, A Doctor's Letters, p. 73; Van Blarcom, Ready to be a Mother, p. 147.

[2]Van Blarcom, Ready to be a Mother, p. 139; see also Taylor, A Physician's Counsels, p. 229; Trall, Mother's Hygienic Handbook, p. 104; Bull, Hints to Mothers, p. 234.

seeming contradiction to prior implantation of prenatal disposition, advisers called infancy crucial; character formation began in the first few months of life. From the late nineteenth century through 1930, infancy meant a time for neither happy solicitation nor sensuous coddling, but an occasion for serious education. The stern purpose of child training (in the late nineteenth and early twentieth centuries to develop character and in the 1920s to root out psychological and personality problems), if taken seriously, robbed motherhood of all its pleasures. For women, for mothers, life revolved around a series of chores, romanticized by the safe refuge women supposedly created for harassed husbands and unrelenting attentive instruction to their children.

In child-rearing literature the key word was regularity, aimed at establishing good habits and self-control. Rigid adherence to schedule would diminish disciplinary problems, permitting control without punishment.[1] In part, this reflected the individualization and

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[1]U.S., Department of Labor, Children's Bureau, Infant Care, by Mrs. Max West, Bureau Publication No. 8 (Washington, D.C.: Government Printing Office, 1914), 63; Garrigues, Text-book of Obstetrics, p. 247; Marion Harland, Common Sense in the Nursery (New York: Charles Scribner's Sons, 1885), p. 195; Verdi, Maternity, p. 210. "Child Culture," Florence Crittenton Magazine 4 (January 1903):361, typically reflects this attitude: "Child training must be begun in the cradle if it is to be effective and not when womanhood or manhood approaches. The habits have been formed and the desires acquired, and the days are past for any change."

dissection of community into autonomous households. It presumed mothers to have almost unlimited abilities to determine their children's destinies. Unquestionably, these awesome responsibilities took their toll on women's psychological health.

The thrust of literature pitted mother against child in psychological battle. Only mother's close supervision would prevent the child's ever-threatening tyranny: "The baby who is fed whenever he frets, readily learns to use fretting as a weapon forgetting what he wants on all occasions."[1] Advisers expected infants to develop self-reliance, but not self-assertiveness or over-confidence. The values or faculties to be instilled in the infant conflicted. According to the literature, the child must acquire regular habits and learn through imitation, yet become imaginative.[2]

Strict obedience should be the cradle's first lesson. "A methodical, well taught baby becomes a tractable child . . . while a baby, humored in every whim, becomes a child and adult of the same demands."[3] The

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[1]The East Harlem Workers' Handbook on Infant Development Care and Training (New York: The East Harlem Nursing and Health Service, Inc., 1931), p. 18.

[2]Gordon, The Modern Mother, p. 249.

[3]Drake, Wife Ought to Know, p. 251. See also Gabrielle E. Jackson, A Series of Don'ts for Mothers who may, or May Not, Stand in Need of Them (Boston: Lee and

essence of disciplinary expectation called for perfect self-control from women: "Never let your children see that they can vex you or make you lose your self-command."[1] In the end, these projections vitiated woman's emotional complexity. Disobedience required mandatory punishment, but mothers should not punish in anger. The reiteration of the placidity and impressionability of infancy would keep woman on her guard, for the child learned primarily through imitation of mother.[2]

Throughout this period, child-rearing advice had a basic continuity. In 1874, Trall reminded his readers that "character as well as flesh may be made or unmade in infancy"; in 1903, Gabrielle Jackson wrote a book of prescriptions for mothers, warning women "that the wise gardener trains his tendrils while the vine is still tender and pliable. You cannot begin too early"; and in 1921, Mary Read restated the theme, saying "social virtues

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Shepard, 1903), p. 14; Mrs. Burton Chance, Self-Training for Mothers (Philadelphia: J. B. Lippincott Co., 1914), p. 81. Chance wrote, Ibid., that "the boy who obeys grows into the man who commands."

[1]"Of Interest to Mothers," Florence Crittenton Magazine 4 (March 1902):20.

[2]Barnesby, Mother and Child, p. 183: "Never forget that you cannot expect a child to be thoughtful, considerate and happy, if you yourself are thoughtless, careless, fretful, irritable or melancholy." See also Maternity Center Association Handbook, p. 81, for a later version of the need for mother's self-control.

should be inculcated from infancy."[1]

With apparent unawareness of different stages of development and with varying capacities for self-regulation, authors insisted that the mother's primary role should be the inculcation of self-control in her infant. For the late nineteenth century, the mother's nurturing must produce upright character. By 1910, the goal became production of good citizens. Women were not to pick up a crying baby, for the

> . . . baby's cry for attention is a deep-seated individualism. . . . If encouraged, it makes later altruism more difficult. Self-reliance and self-dependence for physical care and amusement, should be systematically developed, instead of constant care.[2]

Rocking a child to sleep was taboo. Nor could an infant comfort himself with the pacifier or thumb. Advisers also counselled against playing with a child, on the premise that it caused nervous irritability.[3]

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[1]Trall, Mother's Hygienic Handbook, p. 153; Jackson, Don'ts for Mothers, p. 15; Read, Mothercraft Manual, p. 211.

[2]Read, Mothercraft Manual, p. 211. See also Jackson, Don'ts for Mothers, p. 13.

[3]Margaret E. Sangster, The Mother Book (Chicago: A. C. McClurg and Co., 1912), pp. 4-5; Harland, Common Sense, p. 26; Meaker, Mother and Unborn Child, p. 147; Modeland, The Expectant Mother, p. 65; Children's Bureau, Infant Care, No. 8, pp. 59-60. If a baby sucked its thumb, authors recommended either a sleeveless sack dress or stiff arm cuffs. See Read, Mothercraft Manual, p. 211 and Van Blarcom, Ready to be a Mother, pp. 203-04.

L. Emmet Holt, Professor of Diseases of Children in the New York Polyclinic and Attending Physician to Babies' Hospital and The Nursery and Child's Hospital, wrote The Care and Feeding of Infants in 1894. The book became the bible for young mothers, and went through twenty editions between 1900 and 1943. In it, Holt confidently forbid play until the fourth month and then confined it only to the morning or early afternoon.[1] Controlled demonstrations of attention would yield self-reliance. The child will "learn to be with people without expecting them to do something for him."[2] Every action on the mother's part must be geared to teach a lesson.

The guidebooks stressed consistently the early control of an infant's excretory functions. Some authors advised the training procedure to begin in the third or fourth week, while others counselled waiting until the third month. In any event, training commenced with bowel control, to be accomplished successfully within four weeks of training initiation. Bladder control, considered more difficult, often did not follow until the

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[1]L. Emmett Holt, The Care and Feeding of Children. A Catechism for the Use of Mothers and Nurses (New York: D. Appleton and Co., 1894), p. 57; the book was republished in 1900, 1901, 1904, 1905, 1906, 1907, 1909, 1910, 1911, 1912, 1913, 1914, 1915, 1917, 1919, 1920, 1924, 1926, 1934 and 1943.

[2]Maternity Center Association, Handbook, p. 103.

child was 18 months or even two years old. The establishment of the bowel habit required that the mother place her child on a lap chamber four times a day, initially using a soap suppository. If the procedure were repeated without deviation at the same time every day, the suppository could be eliminated within a month. The chamber itself would then provide the adequate stimulus for proper response.[1]

Regular feeding schedules, determined by the clock rather than human physiology, persisted in this period. Manuals told mothers to nurse at regular intervals, waking the baby if necessary. When infants saw it differently, women were to wait, covering their ears when necessary if babies' incessant cries threatened to undermine their plans. Some nineteenth-century literature connected demand feeding to character malformation, an overindulgence which would produce intellectually and morally uncontrollable children. But increasingly guidebooks connected this regularity to real concerns for the child's physical survival, and in the early twentieth century feeding regularity became basic to the philosophy of the baby-saving

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[1]Stockham, Tokology, p. 209; Gordon, The Modern Mother, p. 252; Howe, Care of the Expectant Mother, p. 46; Richardson, A Doctor's Letters, pp. 100-01; Van Blarcom, Ready to be a Mother, pp. 201-03; Read, Mothercraft Manual, p. 91; Holt, Care and Feeding of Infants, p. 50; Maternity Center Association, Handbook, p. 93; East Harlem Workers Handbook, pp. 19-20, 43.

movement. In the 1920s the methods remained the same, but the books' tone altered. Influenced by the Watsonian behaviorist philosophy, health writers advised feeding rigidity for psychological reasons.

Although present-day pediatricians and psychologists urge demand feeding on the individuality of physical need and the ravenous and instinctive hunger of the young infant, harsh judgment of earlier child-care advisers is unjustified in light of the appalling infant death rate. Demand feeding often meant that children developed severe gastrointestinal diseases, not only from impure milk but also from overfeeding. Many people, especially the poor, believed that a fat child was necessarily a healthy one. By the late nineteenth century, doctors were beginning to suggest that digestive disorders in infancy could be traced to ignorant management, especially as to infant nourishment. The connection drawn between excessive feeding and illness led to more controlled feeding patterns.[1]

A major part of the feeding problem--again, more prevalent among the poor--arose out of prematurely feeding

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[1]Cook, Eutocia, p. 173; Benjamin F. Dawson, "The Relation Between Alimentation and the Gastrointestinal Disorders of Infants and Children," The American Journal of Obstetrics and Diseases of Women and Children 8 (August 1875):218, 236; Harland, Common Sense, p. 182; Walter B. Jennings, The Hygiene of Pregnancy (New York: Medical Review of Reviews, Inc., 1908), p. 30.

solids to young infants. The crusade against offering farinaceous foods to infants before dentation began in the 1870s, but the problem continued to plague health officials until about 1920.[1] Breast milk, and when that failed, modified cow's milk, should be the sole constituent of a young infant's diet.[2]

Warnings against the use of patent medicines, proprietary preparations, soothing syrups and cordials continued through the first fifteen or twenty years of the twentieth century. Books discussed the baby nurse in connection with this issue. Health advisers charged nurses with instilling fears in children to command obedience, with pacifying fretful infants with candies and cake, and most important, with abusing patent medicines and inducing masturbation to quiet restless

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[1]Advisers deprecated the feeding of bread, cakes, gingerbread, etc. to young infants. See Trall, Mother's Hygienic Handbook, pp. 160-67; Bull, Hints to Mothers, pp. 254-55; Dawson, "Alimentation and Gastrointestinal Disorders," p. 235; Stockham, Tokology, p. 211; Harland, Common Sense, p. 189. Twentieth-century authors, with greater knowledge of vitamin necessity and deficiency, also condemned the use of infant foods, such as Millen Malted Milk, Nestle's Food and Imperial Granum, on the theory that they contained excessive starch and sugar. See, for example, Jennings, Hygiene of Pregnancy, pp. 32-33.

[2]L. Emmett Holt, "Artificial Feeding," pamphlet extracted from Diseases of Infancy and Childhood (New York: D. Appleton and Co., 1897), p. 1; Holt, Care and Feeding of Infants, pp. 3, 25; Williams, Obstetrics, p. 322.

children.[1] Even for the woman with money, there was, then, no relief. She "cannot be too watchful of nursemaids and the methods they use to quiet or amuse a baby."[2] Mother must never cease her vigilant role.

Thus an increased emphasis of mothers' prenatal and maternal responsibilities served to balance the withdrawal of middle class women from productive labor. Yet "professionals" or "experts" increasingly dictated the dimensions and the content of domestic roles; this framework forbid mothers spontaneous behavior. Instead, the commands and rules of regularity led often to fear, anxiety, and excessive guilt. Indeed, this domestic encapsulation of women played directly into the hands of physicians, who found in idle middle-class woman an untapped supply of paying patients. Ironically, in the long run, the etiology of women's symptoms often found domestic inspiration.

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[1]The consistency of these warnings is remarkable. See Taylor, Physicians' Counsels, p. 259; Trall, Mother's Hygienic Handbook, p. 145; Warner, Functions and Diseases of Women, p. 329; Brown, Wife, Her Book, pp. 253-54; Barnesby, Mother and Child, p. 80; Children's Bureau, Infant Care, No. 8, pp. 26, 58, 61-62, 76; Bull, Hints to Mothers, pp. 250-52, 295-96; Abraham Jacobi, "On Masturbation and Hysteria in Young Children," The American Journal of Obstetrics and Diseases of Women and Children 8 (February 1876):598-99; Modeland, Expectant Mother, pp. 49, 108-09; Read, Mothercraft Manual, p. 117; Drake, Wife Ought to Know, p. 238; Robinson, Physical Lifehood, p. 136; Robinson, Sex Knowledge, pp. 102-03.

[2]Children's Bureau, Infant Care, No. 8, pp. 61-62.

CHAPTER IV

THE INFANT EDUCATES THE DOCTOR:

THE PUBLIC HEALTH MOVEMENT

> The newborn babe, the most helpless and precious of all animals, is the most valuable asset to our nation.
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> --Dr. Leda Stewart-Cogill
> Medical Woman's Journal, 1921

> We first made progress in saving babies when we stopped caring for sick babies and concentrated on keeping the others well.
>
> --Dr. S. Josephine Baker

Nineteenth-century medicine was a distinctly upper- and middle-class service. Hospital care for poor women was superficial, haphazard, and often humiliating. Although the reasons varied, the fact is that the medical profession had yet to analyze the structural realities and the social and economic boundaries of lower-class life. Medicine did not ignore poor people--it simply subordinated them by reserving their treatment to hospitals and dispensaries.

At the century's end, medicine grew up. Imprecise diagnosis and aimless treatment succumbed to the fruits of the germ theory, as the scientific method presented new tools for the definition and prevention of disease and gave real hope for the cure of previously uncontrollable illness.

Twentieth-century medicine expanded its target groups from the traditional privileged portion of the population, as medical science approached rational social analysis.

The development of preventive medicine parallels the evolution in social work from amelioration to reform. As social work sought to move beyond the palliative approach of philanthropy, medicine became more diagnostic; prognosis and treatment had social as well as individual ramifications. Yet similar to the development in social welfare work, the private predominated over the public. Local progressive experiments suffered without federal reinforcement. Unlike the European experience, the national government did not ultimately assume pioneering local pilot work in the United States. While the public health movement broadened medicine's clientele group, social class still determined the quantity and quality of care. The inability of the American public health movement to provide free opportunity for medical care to all can be traced to the failure to eradicate this class orientation. Although medicine incorporated new target groups, reformers never obliterated the distinction between pay and "charity" patients.

This failure, based upon complex social and economic configurations, found its roots in America's somewhat unique development, colored by what appeared to be a boundless frontier. An optimism merged with rapacious industrial and

capitalistic growth, retarding honest appraisal of social reality. American medicine developed as a business and a privilege, in spite of countervailing pressure for it to become a right and a social service. By the late teens of the new century, the struggle became like a tug of war, with the public health movement deployed against the forces of tradition.

The theory that germs were the etiological agents of disease transformed medicine from empirical art to preventive science. Before the bacteriological revolution, medical concern revolved around the symptomatic manifestations of disease, with the underlying assumption that human longevity depended upon almost mystical and certainly indiscernable individual physical or God-given endowments. Pain might be alleviated, but disease and death were inevitable, seemingly beyond man's control. After this rather anarchistic approach, the next progressive step was the miasmatic theory--that filth or noxious gases created by putrefying organic matter and transmitted by impure water and air triggered disease. This inspired sanitary reform, with an emphasis on ventilation, clean water and streets, garbage removal and sewers. Sanitary improvement, which prompted the establishment of municipal and state boards of health,[1] led to the public health movement.

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[1]Massachusetts established the first state board of health in 1869; California and Virginia followed in

Notwithstanding the devotion of the administrators of the first phase of public health efforts (environmental clean-up), they found no encouragement in results, as communicable diseases continued to evade attack. The discoveries of Pasteur and Koch must be viewed in the context of a medical science already anxious to discard past fatalism and ready to welcome the dawn of human hegemony over illness. Although the first announcements of the germ theory engendered a certain skepticism among practitioners, mockery quickly vanished as the discoveries of the causative factors of man's most dreaded diseases followed closely upon each other.[1]

1871. (New York City had created the Metropolitan Board of Health in 1866 and the District of Columbia had a health board in 1870.) By 1920, every state had its health department. In 1871, the American Public Health Association was established. The federal government created a National Board of Health in 1879; however, it lasted but four years. See Charles V. Chapin, "History of State and Municipal Control of Disease," in Mazyck P. Ravenel, ed., A Half Century of Public Health. Jubilee Historical Volume of the American Public Health Association, In Commemoratory of the Fiftieth Anniversary Celebration of Its Foundation, New York City, November 14-18, 1921 (New York: The American Public Health Association, 1921, reprint ed., New York: Arno Press, 1970), p. 155; Mazyck P. Ravenel, "The American Public Health Association, Past Present, Future," in Ravenel, ed., A Half Century of Public Health, pp. 14-15; Steven Smith, "The History of Public Health," in Ravenel, ed., A Half Century of Public Health, p. 3.

[1]Discovery dates of the origins of the infectious diseases include typhoid, leprosy, and malaria in 1880; tuberculosis in 1882; cholera in 1883; tetanus and bubonic plague in 1884; diphtheria in 1890; and dysentery in 1898. See Walter I. Trattner, From Poor Law to Welfare State: A History of Social Welfare in America (New York: The Free Press, 1974), p. 121.

Effusive confidence and buoyant enthusiasm characterized the public health movement, beginning in the 1880s and continuing into the 1920s. The movement fostered public education aimed at personal hygiene and individual medical safeguards, as opposed to past emphasis on municipal cleanliness.[1]

The full-fledged public health movement focused its first concerted efforts upon the infant poor. Through them public health workers gained new insights into the lives of the people their medical predecessors had depicted as the bulwarks of health. While on the one hand initial attention to the infant may have been somewhat facile (regardless of

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[1]For discussions of the public health movement, see Smith, "The History of Public Health," in Ravenel, ed., A Half Century of Public Health, pp. 1-12; Ravenel, "The American Public Health Association," in Ravenel, ed., A Half Century of Public Health, pp. 13-55; Chapin, "History of State and Municipal Control of Disease," in Ravenel, ed., A Half Century of Public Health, pp. 133-160; Trattner, From Poor Law to Welfare State; Richard Shryock, "The Origins and Significance of the Public Health Movement in the U.S.," Annals of Medical History I (1929):645-65; Harry Wain, A History of Preventive Medicine (Springfield, Ill.: Charles C. Thomas, 1970); George Rosen, A History of Public Health (New York: Medical Publications, 1958); John Duffy, A History of Public Health in New York City: 1966-1966 (New York: Russell Sage Foundation, 1974); Richard H. Shryock, "The Health of the American People. An Historical Survey," Proceedings of the American Philosophic Society 90 (1946):251-58; Charles E. Rosenberg and Carroll Smith-Rosenberg, "Pietism and the Origins of the American Public Health Movement: A Note on John H. Griscom and Robert H. Hartley," Journal of the History of Medicine and Allied Science 23 (January 1968):16-35; Lloyd C. Taylor, The Medical Profession and Social Reform (New York: St. Martin's Press, 1974).

class or color, an infant usually evokes universal feelings of tenderness and sympathy), this concern also represented an early stirring for change in a world dominated by stasis which virtually rewarded social inertia.

Indeed, throughout the eighteenth and early nineteenth centuries, observers regarded the great loss of infant life with a fatalism, almost cruel had it not been a defensive reaction to uncontrollable reality. In 1834, the author of a woman's health manual chastised his readers, who upon the loss of a child "repine and say, why did I suffer all that anxiety beforehand, and so much pain at the birth, to have the child so soon taken from my maternal embrace." The author sternly rejoined "that it is the duty of parents cheerfully to submit to the will of God, is so clear, that it is scarcely necessary to prove it."[1]

Social Darwinism added a new dimension to this complacency. Health workers had to remind their antagonists that "it is not the unfit, but the unfortunate, baby that dies."[2] Conservatism predicated itself on the argument that

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[1]Thomas Searle, A Companion for the Seasons of Maternal Solicitude, With an Appendix, Containing Hints for the Nursery (New York: Moore and Payne, 1834), p. 184.

[2]S. Josephine Baker, "Address," American Association for the Study and Prevention of Infant Mortality, Fifth Annual Meeting, Boston, November 12-14, 1914, pp. 270-71. See also New York Milk Committee, Sixth Annual Report of the New York Milk Committee for the Year Ending December 31, 1912, p. 37.

both ill-suited children and society--a society already burdened with public caretaking institutions--were better off leaving the natural processes alone to root out the inferior.

A new interest in preserving infant vitality gradually replaced indifference. This concern had a variety of motives. Among the more mundane, middle-class perceptions of self-defense, aimed at a social control "to prevent crime and suffering . . . and . . . diminish in large measure the objects of our charity," played a role.[1] Britain's wholesale rejection of recruits found physically unfit for service during the Boer War stirred questions of national

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[1]New York Diet Kitchen Association, Twenty-Ninth Annual Report of the New York Diet Kitchen Association for Providing Nourishing Food for the Sick Poor for the Year 1901, p. 9. See also Barbara Ehrenreich and Dierdre English, Complaints and Disorders. The Sexual Politics of Sickness (New York: The Feminist Press, 1973), pp. 47-59, 62-63, 70. The authors see social control as the central element behind both the public health and the birth control movements. Although they do not attempt to resolve definitively whether there would have been a public health movement had it not been in the perceived self-interest of the wealthy, the authors do contend that the chief motivation was not the health of the poor, but the fear they engendered as agents of disease. The germ theory, according to the authors, allowed people to individualize the cause of contagion (no longer attributing it to filth). The birth control movement is depicted as an effort on the part of the upper classes to prevent race (WASP) suicide. The authors write: "In the biological class warfare, the two major middle-class thrusts were the public health movement and the birth control movement, directed against the twin threats of contagion and 'outbreeding,'" pp. 62-63. The present research, on the other hand, did not find social control central to the public health movement.

vigor. Public shock in England, France, and America over the likely condition of its young men coincided with imperialistic drives in which the United States joined. Interest in colonies, markets and raw materials coincided also with the emerging data on declining birth rates, inducing alarming discussions of race and national suicide.[1] "In the modern conception of charity preventive work takes a prominent place. Conservation of natural resources naturally begins with the protection of infancy."[2] The child became

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[1]Sophonisba P. Breckinridge, New Homes for Old, in Americanization Studies, the Acculturation of Immigrant Groups into American Society, William S. Bernar, ed. (New York: Harper and Row, 1921; reprint ed., Montclair, New Jersey: Paterson Smith reprint Series, Pub. No. 125, 1971), p. 263; H. Llewellyn Heath, The Infant, the Parent and the State (London: P. S. King and Son, 1907), p. 45: "The decline in the general birth rate is a condition that must be viewed with alarm. . . . The English birth rate for the ten-year period 1870-1880 was 35.4 per 1,000 of the population; in 1905 it was 27.2." See also G. F. McCleary, The Maternity and Child Welfare Movement (London: P. S. King and Son, Ltd., 1935), p. 8: "It was largely from the fear of depopulation that public interest in infant welfare began . . . ." Although birth and death rates were not collected nationally in the United States, there was still much public discussion of the issue of race suicide. See such examples as Frederick A. Bushel, "The Declining Birth Rate and Its Cause," Popular Science Monthly 63 (August 1903):355-61; Edward L. Thorndike, "The Decrease in the Size of American Families," Popular Science Monthly 62 (May 1903):64-70; Charles F. Emerick, "Is the Diminishing Birth Rate Volitional?" Popular Science Monthly 78 (January 1911):71-80; Annette Fiske, "Where Race Suicide Does Not Prevail," Survey 29 (November 23, 1912):244-46; Christine T. Herrick, "Concerning Race Suicide," North American Review 184 (February 15, 1907):407-12.

[2]New York Milk Committee, Fifth Annual Report of the New York Milk Committee for the Year Ending December 31, 1911, p. 4.

a national asset, so that his illness and death were dysfunctional.[1]

Yet less self-serving goals emerged from the new possibilities that science now held open. Infants' birthright now included good health and care. Workers declared the constituent elements of society interdependent, united in either multilateral advance or demise; that "aid must be given, not as alms or charity, but as a right."[2] They became convinced that the hundreds of thousands of infant deaths annually were needless and preventable, and that blame lay not upon individuals but with socioeconomic conditions.[3]

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[1]In analyzing health care vis-a-vis a social system, Talcott Parsons wrote: "The birth and rearing of a child constitute a 'cost' to the society, through pregnancy, child care, socialization and formal training and many other channels. Premature death, before the individual has had the opportunity to play out his full quota of social roles, means that only a partial 'return' for this cost has been received." The Social System (New York: The Free Press of Glencoe, 1965), 5th ed., p. 430.

[2]J. H. Mason Knox, "The Care of Institutional Infants Outside of Institutions," in American Association for the Study and Prevention of Infant Mortality, 5th Annual Meeting, November 12-14, 1914, Boston, p. 133; see also American Association for the Study and Prevention of Infant Mortality, Save the Babies, 3rd ed. (Baltimore: by the Association, 1911), p. 6.

[3]American Association for the Study and Prevention of Infant Mortality, The Care of the Baby (Pittsburgh: Bureau of Child Welfare, 1914), p. 3; American Association for the Study and Prevention of Infant Mortality, Save the Babies, p. 6; Ernst C. Meyer, Infant Mortality in New York City, A Study of the Results Accomplished by Infant Life-Saving Agencies, 1885-1920 (New York: The Rockefeller

In the United States, the foundling sparked initial interest in infant life-saving work. Health advocates called attention to orphan asylums' soaring mortality rates, which ran as high as from 50 to 80 percent for infants under a year old.[1] Studies of orphan and foundling institutions yielded increasingly uniform opinions that the absence of

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Foundation, 1921), p. 2; Wilbur C. Phillips, "The Mother and the Baby," Survey 22 (1909):623.

[1]In Baltimore between 1904 and 1913, of the 229 foundlings committed to the city's institutions, 204 (or 88 percent) died before reaching a year's age. See Knox, "The Care of Institutional Infants Outside of Institutions," p. 134. Dr. S. Josephine Baker reported that when she became the head of the New York City Bureau of Child Hygiene in 1908, every other foundling in the City died in its first year. See S. Josephine Baker, Fighting for Life (New York: The Macmillan Co., 1939), pp. 118-19. In 1915, Dr. Henry D. Chapin published his study of ten large institutions in various American cities. For every 100 infants under two years of age, in only one institution was the rate of death as low as 31; in four institutions, the death rate ranged between 40 and 59; in two institutions, the rates were 60 and 65; and in one, three-fourths of the children died. Had Chapin studied death rates of infants a year or under, the rates would unquestionably have been higher. See The Survey 34 (May 22, 1915):182. A 1914 study of the New York State Department of Charities "shows that from 1909 to 1913, inclusive, 28,210 children under two years of age were cared for in eleven institutions in the state, and that the death rate for babies under two years for this same period, based upon the total number of children cared for, varied in the different institutions from 183 to 576 per 1,000 with an average mortality rate for the eleven of 422.5 for the five years." (In New York State in these five years, the general death rate for children under two was 87.4 per 1,000). See Committee on Vital and Social Statistics and the Committee on Pediatrics, "Mortality in so-called Foundling Institutions," American Association for the Study and Prevention of Infant Mortality, Transactions of the Fifth Annual Meeting, 12-14, 1914, Boston, p. 169.

individualized "mothering" was the key factor behind the high infant death toll. Notwithstanding excellent sanitary conditions and adequate medical attention, infants, without recognizable signs of illness, withered quickly and died.[1] Health workers surmised that even mothered children reared in dirty tenements developed greater survival abilities than did orphans in the most hygienic facility. In institutions, "the long row of cribs a foot or two apart, the necessarily mechanical rules of feeding and care, the frequent lack of sufficient air-space, the constant crying of some babies, the rapid moving to and fro of attendants, these and similar

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[1]Selma Fraiberg, a contemporary psychologist, interprets the high infant death toll in institutions: In early infancy, mother is crucial as the child's representative of the outside world. The manner in which she resolves his physical needs will determine his interest in relating to and trust in the world beyond his immediate physical self. For infants in institutions, "since the outer world has no human representative who is consistently associated with satisfaction, pleasure and protection, there is no attraction to the world outside." A normally-raised child will gradually be able to postpone need gratification and turn outward; this is not simply a result of physical development but a product of love. See The Magic Years, Understanding and Handling the Problems of Early Childhood (New York: Charles Scribner's Sons, 1959), pp. 46-56. Some feminists today resent the implication of the infant institutionalization syndrome. The concept suggests that mothers are indispensable, they say, and only adds to women's guilt if attempts are made to combine motherhood with pecuniary employment. For example, Ann Oakley claims that it is not "maternal deprivation in the form of mother, but the lack of consistent love and recognition of individuality from adults or many adults that causes infant withdrawal and death." Woman's Work. The Housewife, Past and Present (New York: Pantheon Books, 1974), p. 207.

factors create an atmosphere, in which it seems to be impossible for an average healthy baby to thrive."[1]

Infant workers, impressed by European trends against permanent institutionalization of infants,[2] called for the boarding-out of orphans or, expediently, for temporary institutional residence in small cottage units.[3] Henry Dwight Chapin, an activist on behalf of boarding-out, declared: "The danger of institutional care to infants is in inverse proportion to their age, being very great under one year and diminishing as the children grow older."[4]

Infant sensitivity, susceptibility to environment, and requirements for individual care meant that infants became less able to cope as conditions grew more removed

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[1]Knox, "The Care of Institutional Children Outside of Institutions," p. 134.

[2]By the end of the first decade of the twentieth century in Europe, foster care under state or district supervision had become customary. Institutions were but observation centers, not permanent homes. See H. J. Gerstenberger, "The Methods or the System Employed in Caring for Institutional Infants Abroad--More Especially in Germany and Austria-Hungary," American Association for the Study and Prevention of Infant Mortality, Transactions of the Fifth Annual Meeting, November 12-14, 1914, Boston, pp. 142-43.

[3]Baker, Fighting for Life, pp. 118-19; Knox, "The Care of Institutional Children Outside of Institutions," p. 135; Henry D. Chapin, "Are Institutions for Children Necessary?" American Association for the Study and Prevention of Infant Mortality, Transactions of the Fifth Annual Meeting, Boston, November 12-14, 1914, pp. 128-29, 131-32.

[4]Chapin, "Are Institutions Necessary?" pp. 128-29.

from home and mother. Chapin believed that the multiplication of large infants' hospitals was antithetical to proper treatment. When an infant must be hospitalized, Chapin insisted that discharge follow immediately upon the remission of acute symptoms. Infant hospitals should be constructed in small units, he urged, with one nurse to every three or four infants; convalescing infants should be boarded out.[1]

Chapin spoke from an experienced perception. As medical director of the Speedwell Society, an organization established in 1902 for the boarding out of sick infants, he witnessed the results of foster-care treatment. The first Speedwell unit was in Morristown, New Jersey; in July 1917, another unit opened in Yonkers, New York, followed in 1918 by one in New Rochelle, New York, the latter designed especially for abandoned Jewish children. In sixteen years, Speedwell boarded out 3,169 children. Its work consistently demonstrated a mortality never exceeding 18 percent. With no institutions to maintain, the system operated less expensively. It also facilitated permanent adoption, through daily intercourse between child and foster parent.[2]

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[1]Ibid., pp. 126-28.

[2]Henry D. Chapin, "Systematized Boarding Out vs. Institutional Care for Infants and Young Children," reprinted from New York Medical Journal, June 2, 1917 (New York: A. R. Elliott Co., 1917), pp. 4-8; Speedwell Society,

Although boarding-out never became as prevalent in the United States as in Europe, infant life-saving agencies adopted the practice here as an adjunct to institutional care.

New York City's Infant Asylum (established in 1866), on Randall's Island, housed foundlings (infants of unknown parentage, simply "found"); dependent, homeless mothers with their babies; orphans (defined as any child without its mother); and poor infants surrendered by parents unable or unwilling to provide for them. Among the bottle-fed orphans, mortality was extremely high. In 1885, 129 of 601 children with their mothers died, while 329 of 570 orphans died. In 1886, 70 of 526 mothered children died, while the orphan toll was 267 deaths of 475. In 1884 the city began to "farm out" a selected number of bottle-fed infants, with striking results. Mortality among this group was 66 percent in 1884. In 1885, it dropped to 58 percent; the next year it stood at 56 percent and in 1887, the figure was 54 percent. These data prompted greater experimentation with boarding-out in New York City.[1]

Fourth Annual Report, 1905, pp. 2, 8; Henry D. Chapin, "The Speedwell Plan of Child Saving in Theory and Practice," The Survey 41 (October 26, 1917):88-91.

[1]Committee on Vital and Social Statistics, "Mortality in so-called Foundling Institutions," p. 171; Department of Public Charities and Correction, 26th Annual Report of the Commissioners of Public Charities and Correction of

In 1898, the New York Association for Improving the Condition of the Poor and the State Charities Aid Association established the Joint Committee on the Care of Motherless Infants to assist the Department of Public Charities with a systematic boarding-out program. In its first year of operation the Committee either permanently boarded or placed out to Italian immigrant wet nurses some one hundred infants, with only twelve deaths. Between 1898 and 1906, the Committee boarded-out or placed one thousand foundlings. In October 1906, the State Charities Aid Association began to operate the program unilaterally.[1]

The White House Conference meeting on January 25, 1909, provided national endorsement for the deinstitutionalization of dependent children. Theodore Roosevelt wrote to Lillian Wald three weeks before the Conference, declaring, "surely nothing ought to interest our people more than the care of children who are destitute and neglected

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the City of New York for the Year of 1885, p. 68; Department of Public Charities and Correction, 27th Annual Report of the Commissioners of Public Charities and Correction of the City of New York for the Year 1886, p. 61; Department of Public Charities and Correction, 28th Annual Report of the Commissioners of Public Charities and Correction of the City of New York for the Year of 1887, p. 52.

[1]New York Association for Improving the Condition of the Poor, Fresh Air Work (New York: AICP, 1905), pp. 30-31; "Infant Mortality, A Review of the Annual Report of the State Charities Aid Association's Subcommittee on Motherless Infants," Charities and the Commons 19 (December 28, 1907): 1300.

but not delinquent,"[1] thereby forecasting the tenor and resolutions of the Conference.[2] The twin principles that poverty alone should not cause familial break-up and that foster care should be supplied when dissolution became unavoidable remained basic notions of social work through 1930.[3]

In 1902, the city abandoned the Infant Asylum and increased its aid to private institutions placing out or caring for dependent children. The Department of Public Charities (which supervised all of the city's charitable

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[1]Theodore Roosevelt to Lillian D. Wald, 5 January 1909. Lillian D. Wald Papers, Box 10 (1896-1915), New York Public Library, New York.

[2]White House Conference on Child Health and Protection, Addresses and Abstracts of Committee Reports (New York: The Century Co., 1931), pp. v-vi; Harold A. Jambor, "Theodore Dreiser, The Delineator Magazine, and Dependent Children: A Background Note on the Calling of the 1909 White House Conference," Social Service Review 32 (March 1958):33, 35, 38-39.

[3]These principles stood the test of time. In 1924, the State Charities Aid Association published a study of foster children whom they had placed and who had reached age eighteen by January 1, 1922. The group consisted of 910 children. Tested by standards of ordinary prudence, self-reliance, and educational achievement, the study measured how these children had grown up. It found that adult performance directly correlated with the speed with which the child was removed from the institutions; the younger the removal, the better he performed as an adult. More importantly, results demonstrated that the children who were taken from their homes, rather than from institutions, no matter how devastating the home conditions, did better than those placed from asylums. See State Charities Aid Association, Fifty-third Annual Report for the Year Ending September 30, 1925, pp. 2, 14, 115-16, 135, 150-52.

institutions except Bellevue and Allied Hospitals and the hospitals for contagious diseases under Department of Health jurisdiction) did some boarding-out. For its major activity in this field, however, it distributed per capita allowances to private organizations.[1]

The State Charities Aid Association continued to aid destitute children through its placement program, and within a few years of the creation of the Bureau of Child Hygiene in 1908, the Department of Health began to board-out selected foundlings it would otherwise have supported in private institutions. S. Josephine Baker, head of the Bureau of Child Hygiene, described this work:

> We started taking these foundlings, every other one of whom was doomed to die before the year was out and boarded them with tenement mothers. . . . Poor mothers, who had already had experience in raising families under supervision of the Bureau of Child Hygiene, were paid ten dollars a month to become foster mothers of foundling babies. . . . In four years we had only one foundling in three dying where one in two had died earlier, the decrease would probably have been much sharper if we had had funds and facilities for boarding them all out.[2]

Although Baker later induced the Russell Sage Foundation to supply another five dollars a month to foster mothers,

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[1]In 1920, the Department of Public Charities and Correction helped support 338 private organizations. Among those funded were 105 homes for children and 19 boarding-out agencies. See Lina D. Miller, The New York Charities Directory, A Reference of Social Service in or Available for Greater New York (New York: Charities Organization Society, 1920), p. 57.

[2]Baker, Fighting for Life, pp. 119-20.

the city could never afford to abandon completely its policy of funding private agencies which had no intention of making foster placements. Indeed, public support of private institutions often worked to discourage placing out as payments fed the interests of voluntary groups, thereby encouraging the retention of children in institutions.

In 1916, the Department of Public Charities reorganized its Children's Home Bureau, which formerly placed orphans and other dependent children in private child welfare facilities, to do its own placing-out work of children under age eight. The city had annually committed six thousand children to private agencies, four thousand of whom were under the age of eight.[1] Department policy now forbade city payments to private child-caring groups unless institutions could show that prospective inmates were proper public charges and that the mother was legitimately unable to support the child. This seemingly hard-hearted policy sought to discourage the "no questions asked" attitude of private agencies which encouraged maternal abandonment and put the city in the cruel paradox of supporting institutions where babies were dying.[2]

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[1]"Family Homes for New York Dependents," The Survey 36 (July 8, 1916):384; see also Humanizing the Greater City's Charity, the Work of Public Charities in the City of New York (New York: Public Welfare Committee, 1917), p. 22.

[2]"Family Trees for New York Foundlings," The Survey 37 (March 17, 1917):698.

A new administration in 1918 dissolved the Bureau,[1] but the Department of Public Charities continued its efforts on a smaller scale through a new Bureau of Investigation, Boarding Out and Inspections.[2] Nonetheless, New York State and City tailed behind other jurisdictions, especially Massachusetts, which had boarded out state-dependent children since 1895, and Boston, which followed the practice from 1898.[3]

Workers in the first phase of the child welfare movement attributed high infant mortality rates to diarrheal diseases. They emphasized breast feeding, clean milk, and education. The movement had international implications in which broad patterns of development followed similar lines in European and American urban communities. Reputations crossed political boundaries, as projects and eminent child welfare workers in one nation were reported and known in other countries. It was not unusual to find Americans citing French infant-welfare spokesmen, or, for example, H. Llewellyn Heath, a Fellow of the Royal Institute of Public Health and a member of the Royal Sanitary Institute,

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[1]Winthrop D. Lane, "Monitored by the City: An Appraisal of the Child-Placing Work of the New York Children's Home Bureau," The Survey 39 (January 19, 1918):435-36.

[2]Miller, New York Charities Directory, p. 57.

[3]Chapin, "The Speedwell Plan," The Survey 41 (October 26, 1918):85.

quoting Americans Henry Dwight Chapin and L. Emmett Holt.[1] Although the effort to save infants' lives carried a sense of international solidarity, the second stage of the movement highlighted greater variations in national priorities. While the approaches among different nations paralleled each other, some demonstrated greater commitment (measured by willingness to endorse programs with public monies) than others, and results reflected the degree of commitment.

Advocates' primary aims, at this early stage of the child welfare movement, included the encouragement of breast feeding, the education of the public for the need for pure milk, the supervision of dairymen, the modification of cow's milk according to infants' needs, the medical observation of poor infants, and the education of mothers in child care.[2] Health workers overemphasized milk in this first period of

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[1]Heath, Infant, Parent and the State, p. 21. Chapin, as already mentioned, was an expert on the boarding-out of infants, and L. Emmett Holt was one of America's foremost pediatricians in the early twentieth century. For discussions of the international quality of the infant life-saving effort, see Transactions of the Fifteenth International Congress on Hygiene and Demography, Vol. 6: The World-Wide Effort to Diminish Infant Mortality--Its Present Status and Its Possibilities, Edward B. Phelps, ed. (Washington, D.C.: Government Printing Office, 1913); Elizabeth S. Chesser, Woman, Marriage and Motherhood (New York and London: Funk and Wagnalls Co., 1913), pp. 109-10, 158-59, 161-63. For the purposes of this dissertation, infant is defined as a child one year or under. Unless otherwise stated, infant mortality rates will be calculated and reported on the number of deaths per thousand live births.

[2]See Heath, Infant, Parent, State, p. 159.

attack against "cholera infantum," as they waged a seemingly relentless battle against artificial feeding and dirty milk.[1]

Federal documentation of the problem came in 1906, when the Census Brueau published mortality statistics for the five years between 1900 and 1904. These data--accurately compiled--were the first of their kind to study child mortality as a separate and important division of overall mortality.[2]

The conclusions of a government study of women and child wage-earners in the United States, published in 1912, typified the emphasis of the early stage of infant welfare work. The thirteenth volume of the published report followed the Congressional mandate of January 1907 to analyze the relationship between wage-earning status and childbearing.[3] Researchers undertook a study of Fall River,

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[1]For examples of this emphasis on milk, see New York Diet Kitchen Association, Thirty-Second Annual Report of the New York Diet Kitchen Association for the Year 1904, p. 11; Charles E. North, "Milk and Its Relation to Public Health," in Ravenel, ed., A Half-Century of Public Health, p. 254; American Association for the Study and Prevention of Infant Mortality, Save the Babies, p. 3.

[2]Meyer, Infant Mortality in New York City, pp. 81-83; Phillip Van Ingen, "The History of Child Welfare Work in the United States," in Ravenel, ed., Half Century of Public Health, pp. 291-92.

[3]U.S., Congress, Senate, Report on Condition of Woman and Child Wage-Earners in the United States, S. Doc. 645, 61st Cong., 2d sess., vol. 13: Infant Mortality and Its

Massachusetts, in response to emerging views, especially from England, that high infant mortality had definite correlations to away-from-home employment of mothers.

Fall River, a textile city, had a population of 112,300 in 1908. Thirty-nine percent of its female population had employment; of these women, 30 percent worked in cotton mills. About one-third of the female workers were married or widows.[1] With a high infant death rate and ratio of female employment, the government research team seized upon Fall River as an ideal site for investigation.

Edward Phelps studied the city during the year 1908, investigating every death and stillbirth. In 1908, there were 4,835 births and 859 deaths of children under one year of age, making an infant death rate of 178 per 1,000 live births.[2] Investigators gathered background information on only 580 of the dead infants; of the 227 stillbirths, they recorded material on 165. The study found that among the

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Relation to the Employment of Mothers, Part 1, A Study of Massachusetts, by Edward Bunnell Phelps (Washington, D.C.: Government Printing Office, 1912).

[1] Ibid., p. 71.

[2] Ibid., pp. 71-72. Between 1900 and 1909, for every 100 deaths in Fall River, 38.4 were infants; the general death rate of this ten-year period is unknown, but between the years 1900 and 1903 it was 20.3 per 1,000 population. In 1910, the infant mortality rate in Manhattan was 135; in Boston, it was 126. In England and Wales, the rate was 120 in 1908.

580 deaths investigated, 266 (or 46 percent) of the women working outside the home, 314 dead infants had non-working mothers. Outside employment was thus not the major cause of infant death, or so the study asserted.

Instead, Phelps concluded that the high proportion of foreign-born (French-Canadians were in the majority, followed by Irish, English, and Portugese), high rate of female illiteracy, and high birth rates were more important. He insisted upon the importance of ignorance of proper methods of care, especially feeding.[1]

> The high infant mortality of Fall River as a whole clearly is not due . . . to the excessive rate among the children of mothers at work outside the home. For the proportion of deaths due . . . to diarrhea, enteritis, and gastritis, 38.6 percent for all, for the city as a whole, only falls to 34.6 when the children of mothers at home are taken separately.[2]

The study found insufficient nursing and poor care and feeding as reasons for high death rates among infants of women at home.

Yet among the children of working mothers, the study demonstrated (but failed to analyze) that only 1 percent were nursed exclusively, compared to 34 percent of the infants of unemployed mothers. The differential continued; 40 percent of working mothers' children who died received solid food in

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[1]Ibid., pp. 48, 72, 74.

[2]Ibid., p. 74.

their first months of life, while only 24 percent of the children of mothers at home who did not survive were given solids. Condensed milk was the principal food for 16 percent of infants with mothers at home and for 31 percent of infants of working mothers.[1]

While the study stands as a condemnation of prevalent methods of infant care and their commensurate reflection in death rates, it avoids essential facts the second phase of the infant-welfare movement would not readily ignore. First, notwithstanding the study's assertions, the statistics illustrate that the principal causes of death were prenatal conditions. Almost one-quarter of the deaths occurred in the first month of life, with 41 percent in the first three months. These data demand that wage-earning status prior to birth, not after, should have been the factor studied.[2] Next, mentioned in the study but not adequately analyzed, was the reality that "the two classes of mothers at work and mothers at home, are not sharply defined and that the group at home includes a considerable number of women who were formerly engaged in mill work and whose

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[1]Ibid. "In over one-third of the cases where solid food was given, its use was begun during the first week."

[2]Ibid., p. 11. Of the deaths, 11 percent occurred in the first week of life, 3.3 percent in the second week, and 23 percent in the first month.

physical condition may still be affected in some degree by such earlier employ."[1]

The distinction between the two groups of women studied becomes even murkier when it is recognized that the women at home did not luxuriate in the care of their newly born; they were hard at work, usually caring for a number of small children. The report itself described women who had lost their children but did "housework only." One woman worked until the delivery day of her eighteenth child. After the birth, she resumed care of her eleven living children. She had lost six children--three under one year and the remainder under four years. Her story is not atypical for the group of "nonworking" mothers.[2]

Analysts in the second phase of the movement would have viewed the collected evidence differently, urging that solutions lay in institutional redress of women's employment status, rather than their ignorance. While data showed that even some mothers at home failed to nurse, nursing nonetheless took place more among those who did not leave their infants. Non-working mothers resorted to solids less frequently. Research demonstrated that in the group of 264

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[1]Ibid., p. 120.

[2]Ibid., p. 118. For example, another woman, having buried one child, raised seven more while doing dress-making at home. Her ninth child soon succumbed to gastroenteritis.

women who consented to answer questions on feeding, only 29 percent nursed exclusively while 41 percent nursed partially and 30 percent used artificial foods. Yet working mothers adopted improper feeding methods more consistently. Only 24 percent of the mothers who stayed at home reported the use of solids, against 40 percent of the working mothers. Necessarily, the infants of working women suffered greater intestinal difficulties.

Diarrheal diseases caused the deaths of 63 percent of working mothers' children who perished, but only 38 percent of the deaths of infants of mothers at home. Before 1915, infant workers interpreted these data with calls for educational propaganda; they perceived ignorance as the cause of deaths from the absence of mother's milk, from unbottled cow's milk, from infrequently washed bottles, from condensed milk, from long-tube bottle feeding, and from soothing syrups. "The causes of the excessive infant mortality in Fall River may be summed up in a sentence as the mother's ignorance of proper feeding, of proper care, and of the simplest requirements of hygiene."[1] Workers in the second part of the movement would analyze the data, recognizing that education alone would be insufficient, and call for economic and structural changes.

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[1]Ibid., pp. 150-55, 169.

Critical evaluation of the first stage of the infant-welfare movement may be slightly unfair, and is employed here only to contrast it to the second stage. Public health leaders stressed infant feeding and maternal education, in part because they considered infant deaths from prematurity and congenital weakness, determined by antenatal condition, unavoidable.[1] Since the infant death rates demanded attention, proper feeding was the logical first step. In New York City, in 1870, 236 infants under a year died for every 1,000 infants born alive.[2] Between 1890 and 1892, 32,916 infants died in New York City; deaths of children under one year comprised 26 percent of the total mortality of 128,136 for these three years. Another 10,547, or 8 percent of the deaths, occurred among children between one and two years old. This meant that over one-third of the deaths in New York City between 1890 and 1892 occurred in children under two years of age.[3] In 1900 in Manhattan, 9,000 infants a year or under died.[4] That summer alone, in

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[1]McCleary, The Maternity and Child Welfare Movement, p. 48.

[2]Wain, History of Preventive Medicine, p. 253.

[3]L. Emmett Holt, Diseases of Infancy and Childhood: A Catechism for the Use of Mothers and Children's Nurses (New York: D. Appleton and Co., 1894), p. 3. Another 7 percent of the total deaths occurred among children between two and five years and an additional 5 percent of the victims were children ages five to fifteen.

[4]Phillips, "The Mother and the Baby," p. 627.

the whole city among children under five years of age, 6,000 died simply from diarrhea.[1]

For two reasons, New York City offers an ideal case study of the development of infant-welfare work in the United States. First, its history reflects the evolution from voluntary private work to centralized municipal efforts. Second, the city set precedents imitated by cities throughout the country.

Pivotal dates in infant life-saving work begin in 1874, when the New York City Health Department issued and distributed leaflets on infant care through the city's tenement districts. In 1876 it sent a corps of doctors into the slums to treat infants suffering from gastrointestinal diseases, and in 1879 the Department allocated $10,000 annually to make this group of physicians and nurses permanent in poverty sections. The New York Diet Kitchen Association established New York's first milk station in 1872; by 1888 it operated five stations the year round. In 1890, the Good Samaritan Dispensary (formerly the Eastern Dispensary) opened a summer milk depot.[2] But the impetus for the

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[1]New York Diet Kitchen Association, Thirtieth Annual Report for the Year 1902, pp. 9-10.

[2]Chapin, "History of State and Municipal Control of Disease," in Ravenel, ed., A Half Century of Public Health, p. 150; Sam Shapiro, Edward R. S. Schlessinger, and Robert E. L. Nesbilt, Jr., Infant, Perinatal, Maternal and Childhood Mortality in the United States, American Public Health

movement for pure, modified cow's milk as the only substitute for breast milk began only when Nathan Straus organized his extensive system of pasteurized milk distribution in 1893.[1]

The years between 1900 and 1910 were formative ones, in which private, voluntary agencies directed the first large-scale work. In these years such organizations as the Diet Kitchen Association, the Henry Street Nurses' Settlement, and the New York Association for Improving the Condition of the Poor helped focus public attention on

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Association: Vital and Health Statistics Monographs (Cambridge, Mass.: Harvard University Press, 1968), p. 223, Rosen, History of Public Health, p. 353; Meyer, Infant Mortality in New York City, p. 114.

[1]Straus respected Abraham Jacobi, who advocated the boiling of milk as early as 1873. By 1902, the Straus stations distributed 250,000 bottles of milk each month. See Rosen, History of Public Health, p. 355. In the summer of 1906, Straus operated seventeen stations, located at 151 Avenue C, 47 Monroe Street, 441 West 33rd Street, 329 East 59th Street, 303 East 111th Street, 38 Macdougal Street, Battery Park, City Hall Park, Tompkins Square, Central Park, Mt. Morris Park, the Hebrew Educational Alliance (East Broadway and Jefferson Street), East 3rd Street Recreational Pier, East 24th Street Recreational Pier, Barrow Street Recreational Pier, West 15th Street Recreational Pier, and East 112th Street Recreational Pier. See "Nathan Straus Milk Depots," Charities and The Commons 18 (June 29, 1907): 341. In 1897, Rochester established the first municipal milk depot in the country. In Europe, Germany's first depot opened in Hamburg in 1889; the first in Paris was established in 1892 and the first opened in England in 1899. See North, "Milk and Its Relation to Public Health," in Ravenel, ed., A Half Century of Public Health, pp. 277-78; see also Wain, History of Preventive Medicine, p. 255; Rosen, History of Public Health, p. 355.

possible remedial steps to prevent unnecessary infant deaths.[1]

The qualitative reform of milk supply and the mastery of its distribution to the poor families represent the great achievements of the years between 1900 and 1912. The evolution from loose to certified to pasteurized milk bears significance from more than the hygienic standpoint, since it resulted from the consciously directed effort of public health workers to ensure that new health standards no longer remain the privilege of a few.

Before certified and pasteurized milk, consumers could buy milk either bottled or loose. While either form was risky, loose milk posed far greater dangers, sitting unrefrigerated in open cans, usually in dirty crowded groceries in immigrant districts. Indeed, the poor, whose incomes precluded the purchase of bottled milk, had no choice but to buy loose milk, often contaminated. Poor women carried the milk home in pails and, if financially able, tried to preserve it with a nickel or dime's worth of

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[1]In 1905, for example, the New York A.I.C.P. established a summer camp for sick babies at the East River and 65th Street, property adjacent to the Rockefeller Institute (now University) which John D. Rockefeller had lent. Infant life-saving work, however, lacked coordination and organization during this early stage. See Clean Milk for New York City Report of the Milk Conference Called by the NYAICP Jointly with the Department of Health (New York: AICP., 1906), p. 4; Lillian D. Wald, Windows on Henry Street (Boston: Little, Brown and Co., 1934).

ice a day. Many families could not even afford this daily extravagance, and the June 17, 1911 issue of The Survey offered them cooling suggestions. The magazine recommended a makeshift refrigerator box filled with sawdust, which would not conduct heat and therefore kept milk cool for a day, provided it had not been allowed to become warm.[1]

Milk Committee investigators called grocery stores in New York's Lower East Side notoriously bad, "reeking with filth, foul smelling, and swarming with flies." Stores often connected directly to tenement homes, "with the living-rooms of the proprietor . . . in the rear, and, in cases of sickness in the family, the milk is likely to become contaminated." The sanitary condition of retail shops posed only one problem. Uniform control of producers seemed almost impossible, when in 1911 New York City imported 2,000,000 quarts of milk each day from 44,000 different dairies in 6 different states. Changes in the milk's condition would involve middlemen as well, since milk often arrived in the city in railroad cars without ice.[2]

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[1]"A Home-Made Refrigerator," The Survey 26 (June 17, 1911):434. In 1914, the American Association for the Study and Prevention of Infant Mortality recommended an ice box made from a wooden box and a tin can filled with crushed ice. See The Care of Baby (Pittsburgh: Bureau of Child Welfare, 1914), p. 5.

[2]New York Milk Committee, Committee Investigation of East Side Groceries, Fifth Annual Report of the New York Milk Committee for the Year ending December 31, 1911, p. 18; New York Diet Kitchen, Thirtieth Annual Report, 1902, p. 9;

Although Pasteur's experiments on wine fermentation in 1860 led to the realization that organisms could be destroyed with high temperatures, and while Koch's discovery in 1881 of mechanisms to isolate and study distinct bacteria through culture media made it possible to locate epidemic-producing microbes in milk,[1] pasteurization of milk did not immediately become popular. Public prejudice against "cooked milk" (which, until the process was perfected, literally tasted as if it had been boiled) encouraged a profit-oriented dairy business to balk at the expense involved in new equipment and supervision which pasteurization would require.[2]

While Straus continued to distribute pasteurized milk, the first stage in milk reform involved modified cow's milk for infant use and certified milk for those who could afford it. Milk modification sought to adapt cow's milk as close to mother's breast milk as possible. Cow's milk contained almost three times the protein (with curd, very difficult for infants to digest) and only half as much sugar as mother's milk. In order for artificial feeding composition

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New York Milk Committee, Fifth Annual Report, 1911, p. 16; New York Milk Committee, Seventh Annual Report for the Year Ending December 31, 1913, p. 22.

[1]North, "Milk and Its Relation to Public Health," in Ravenel, ed., A Half Century of Public Health, p. 238.

[2]Baker, Fighting for Life, pp. 127, 130-31.

to resemble the natural product, reformers told women to dilute cow's milk with water and to add sugar. Dilution followed the child's development; an older infant would gradually be given less water and more milk.[1]

With the certified milk movement, reformers took the first important step in preventing the sale and use of milk from diseased animals (the biggest danger came from cows infected with bovine tuberculosis).[2] Henry L. Coit of

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[1] Holt, Care and Feeding of Children, p. 25; L. Emmett Holt, "Artificial Feeding," in Diseases of Infancy and Childhood, p. 3; Abraham Jacobi, "The History of Pediatrics and Its Relation to Other Sciences and Arts," reprinted from American Medicine 8 (November 5, 1904):19; Walter B. Jennings, The Hygiene of Pregnancy (New York: Medical Review of Reviews, 1908), pp. 31-34. In 1891, Boston established the first laboratory for milk modification; large cities in the country quickly followed Boston's example. These laboratories bought milk from selected farms where hygienic rules were strictly enforced (with cow's food, stabling, and pasture closely supervised, milker's hands and nails scrubbed, and cow's udders clean). If laboratories were not available, or if the price was too high, advisors urged home modification. See Jennings, Hygiene of Pregnancy, pp. 36-37.

[2] Germs grow more rapidly in milk than in water, so milk is the more dangerous medium of contamination. As Harry Wain wrote: "Milk is the chief vehicle for the conveyance of bovine tuberculosis from cow to man. The bacilli get into the milk, either directly as a result of T.B. of the udder, or indirectly from milk contaminated by saliva and hence, those with pulmonary tuberculosis infect their intestinal tracts and pass living tubercle bacilli in their feces. Bovine tuberculosis generally produces extra-pulmonary infection in man. It is the chief cause of scrofula or glandular tuberculosis, and tuberculosis of the bones and joints. It occurs chiefly among children in the preschool age group and to a lesser extent to older children and adults." In History of Preventive Medicine, p. 258.

Newark, New Jersey, inaugurated the movement with the establishment of the first milk commision in 1892; manufacturers produced the first bottles of certified milk in 1894.

The movement sought the production of milk under strict sanitary conditions. To be certified, regulations required milk to be produced under the supervision of medical commissions chosen by county medical societies. The milk had to come from healthy cows (tuberculen-free) and healthy employees. Barns, water, waste facilities, and pastures were subject to sanitary inspection. The finished product could contain no more than 10,000 bacteria per cubic centimeter and must arrive for retail marketing less than 24 hours old, preserved at temperatures between 48 and 50 degrees Fahrenheit.[1]

The movement won immediate popularity. New York City established a medical milk commission in 1896 and Philadelphia followed the next year. Between 1892 and 1906, thirty-six such commissions were formed to supervise milk production. Certified milk proponents, who united in 1907 to form the American Association of Medical Milk Commissions and set national standards, campaigned vigorously for their

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[1]"Purity of the Milk Supply," Charities 3 (August 19, 1899):2, 3; North, "Milk and Its Relation to Public Health," in Ravenel, ed., A Half Century of Public Health, pp. 239, 267; Manfred J. Wasserman, "Henry L. Coit and the Certified Milk Movement in the Development of Modern Pediatrics," Bulletin of the History of Medicine 46 (July-August, 1972): 361-65.

cause. They charged that resort to pasteurized milk would allow the continuance of unsanitary dairy practices; they insisted that pasteurization would simply cloak dirty milk.[1]

By 1910, circumstances put the proponents of certification on the defensive. Whatever the individual merits of certified milk, it lay beyond the purchasing power of the poor, since its retail price ranged from ten to fifteen cents per quart above the price of plain bottled milk.[2] The last factor added another element, by increasing the incentives for fraud. The New York Diet Kitchen Association reported in 1909 that "seventy-five per cent of our poor population do not purchase even the cheapest bottled milk but rely upon loose store milk or condensed milk."[3] It is obvious why certified milk consumption never rose above half of one percent of fluid milk consumed.[4]

The final downfall of the certified milk movement came when critics demonstrated that danger of infection

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[1]North, "Milk and Its Relation to Public Health," pp. 267-68; Wasserman, "Coit and the Certified Milk Movement," reports that in 1912, there were sixty-three medical milk commissions, pp. 366, 370, 372; Wain, History of Preventive Medicine, p. 257.

[2]North, "Milk and Its Relation to Public Health," pp. 267-68.

[3]New York Diet Kitchen Association, Thirty-seventh Annual Report for the Year Ending October 31, 1909, p. 22.

[4]North, "Milk and Its Relation to Public Health," pp. 267-68.

still lurked in even the highest grade of raw milk. After investigators discovered tuberculosis among certified dairy herds, and traced an epidemic of typhoid fever in New York City in 1909 to a specific milk supply and back further to a dairy man who was a chronic carrier, public health authorities turned increasingly to pasteurization as the only sure safeguard.[1]

The New York Milk Committee played an instrumental role in convincing laymen and professionals that pasteurized milk must be substituted for raw milk production, even raw milk of the highest grade. Its founders established the Committee in 1906, under the aegis of the New York Association for Improving the Condition of the Poor, to examine milk supplies to the city and the connection with infant death rates, and to formulate a program of action. The Committee remained an adjunct to the AICP for two and a half years; it then became a voluntary independent organization.[2] Paul E. Taylor, secretary, and Dr. Philip Van Ingen, medical director, provided active direction to the Committee, whose members consisted of philanthropists, physicians, and a few interested milk producers and dealers. With Franklin D. Roosevelt, Mrs. Henry Villard, and Mrs. Arthur M. Dodge on

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[1]Rosen, History of Public Health, pp. 359-60.

[2]New York Milk Committee, Ten Years of Work, 1907-1916 (New York: New York Milk Committee, 1916), p. 9.

its advisory committee, and Dr. Abraham Jacobi as chairman of its medical council, voluntary funding encountered few difficulties.[1]

Although Abraham Jacobi and L. Emmett Holt, the nation's most prominent pediatricians, had actually shown the sanitary effects of pasteurized milk in reducing infant intestinal diseases,[2] direct results followed the New York Milk Committee's demonstration of economical and safe pasteurization in Homer, New York in 1907.[3] The Committee showed that raw milk, whatever its quality, risked death for infants. "Dirt, bacteria, harmless to adults, irritate and inflame the intestines of children." Pasteurization, the Committee claimed, would kill 99 percent of bacteria in milk.[4] The Committee demonstrated that even the best

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[1]New York Milk Committee, Fourth Annual Report for the Year 1910, p. 2.

[2]In 1903, Holt experimented with two groups of tenement-house babies, feeding one group raw milk and the other pasteurized milk. The latter showed a markedly lower death rate from diarrheal causes. See Wain, History of Preventive Medicine, p. 262.

[3]"The experiment was carried out under the auspices of physicians and business men and financed independently of the Committee. The demonstration . . . proved conclusively that clean milk of very high quality can be produced by the ordinary dairy farmer under careful laboratory control when payment is made to the producer on the basis of the sanitary character of the product." New York Milk Committee, Ten Years of Work, p. 13.

[4]Charles E. North, Safeguarding Nature's Most Valuable Food--MILK (New York: New York Milk Committee, 1915), p. 11.

certified milk caused outbreaks of scarlet fever, diphtheria, typhoid, and tuberculosis. Raw milk could also convey septic sore throat to adults. "Bacteria in sore udders of cows closely resemble bacteria found in these sore throats."[1]

In 1908, Chicago became the first city to require pasteurization. In 1910, after the American Public Health Association established uniform methods for testing bacterial counts in milk, the New York City Board of Health issued orders that all drinking milk be pasteurized.[2]

In 1910, the New York Milk Committee gathered in conference a group of milk producers, dealers, and experts, who called collectively for milk guidelines. Consequently, in 1911, the Committee set up the National Commission on Milk Standards, composed of twenty nationally respected milk experts. The Committee began work in May 1911 and completed its first report in January 1912. The federal government published the study in August 1912; public hearings in Chicago for milk dealers and health authorities followed in October 1912.[3]

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[1] Ibid., pp. 11, 16.

[2] Wasserman, "Coit and the Certified Milk Movement," p. 376; North, "Milk and Its Relation to Public Health," p. 241; Wain, History of Preventive Medicine, pp. 262-63; Rosen, History of Public Health, pp. 359-60.

[3] New York Milk Committee, Ten Years of Work, p. 13; New York Milk Committee, Sixth Annual Report of the New York Milk Committee for the Year ending December 31, 1912, p. 69.

The Commission's report acknowledged that even pasteurized milk could be produced in varying degrees of quality. It recommended that labels distinguishing between defined levels of standards be adopted. New York thus became the world's first city to adopt milk grading.

The grading of pasteurized milk dealt the final blow to the certified milk movement by depriving it of its chief ammunition--that pasteurization was a facade covering uncleanliness. Grade A milk had to pass minimum requirements of safety for infant feeding. Health officials required Grade B to ensure milk's safety for household use, while they designated Grade C for cooking or commercial use.[1]

The battle for clean milk had been fought successfully. With a clean feeding substitute for babies, infant-welfare workers could plunge headlong into other aspects of more equitable food distribution and health reform.[2]

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[1]New York Milk Committee, Seventh Annual Report for the Year Ending December 31, 1913, pp. 12, 14; New York Milk Committee, Ten Years of Work, p. 14; North, "Milk and Its Relation to Public Health," p. 241.

[2]In 1933, New York City banned the sale of loose milk. In 1940, the Board of Health adopted a single standard (grade) of milk. See E. H. Lewinski Corwin and Elizabeth V. Cunningham, Thirty Years in Community Service, 1911-1941. A Brief Outline of the Work of the Committee on Public Health Relations of the New York Academy of Medicine (New York: New York Academy of Medicine, 1942), p. 87.

Through 1908, infant-welfare work in New York City was largely voluntary. Significant drops in infant mortality rates came after 1908 with the creation of the Bureau of Child Hygiene in the New York City Department of Health. Municipal participation resulted in the centralization and coordination of previously cacophonous and unharmonized private activity. Nonetheless, the private projects set the blueprints, developing small programs which the city would assume and enlarge.

In fact welfare centers pose a prime example of private initiative in laying the foundation and outlining goals and policy of future city involvement. New York City did not operate baby health stations until 1911. Then, the city simply adopted the pattern which voluntary agencies had developed. What had begun as simple milk-dispensing depots grew into clinical examining centers for infants and schools for mothers.

Through 1907 in Manhattan, only the New York Diet Kitchen Association, the Good Samaritan Dispensary, and the Straus centers offered pure milk in poor districts, in scattered locales. In that year the New York Milk Committee opened seven of its own depots.[1] While the Straus stations

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[1]The Diet Kitchen ran six year-round stations, Good Samaritan Dispensary maintained one. Nathan Straus's organization operated seven permanent and ten summer milk depots. See Meyer, Infant Mortality in New York City, p. 116.

continued as one-function milk-dispensing stations, both the New York Diet Kitchen and New York Milk Committee facilities grew into integrated health service units.

The Diet Kitchen began work in 1873 on East 23rd Street at the request of physicians servicing the Demilt Dispensary, who recognized that physical recovery was impossible without proper nourishment. The Diet Kitchen set out to relieve the "destitute sick." Upon a note of authorization from the dispensary doctor, the kitchen furnished "gruel, rice, tea, broth and milk" to patients. Since the founders had particular empathy for the physical vulnerability of women and children, the kitchens always distributed milk heavily. In 1874, a second kitchen opened at 408 West 36th Street; by 1888, the organization operated five kitchens, and in 1892, its name changed from the New York Diet Kitchen to the New York Diet Kitchen Association.[1]

By 1904, the kitchens honored only requisitions from dispensary physicians ordering milk. The Association saw the need for quality milk as so important that it discarded

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[1]New York Diet Kitchen Association, First Annual Report for the Year Ending March, 1874, p. 3; New York Diet Kitchen Association, Forty-Third Annual Report for the Year Ending October 31, 1915, p. 3; New York Diet Kitchen Association, Second Annual Report for the Year Ending March, 1875, p. 4. In 1903, the Association ran six kitchens, located at 423 West 41st Street, 137 Centre Street, 158 East 7th Street, 335 East 21st Street, 301 East 49th Street, and 89 Christopher Street. See New York Diet Kitchen Association, Thirty-First Annual Report for the Year Ended 1903, p. 3.

all other foods. In 1908, the Association supplied 334,802 quarts of milk to needy families.[1]

The Association made other changes as well. In 1906, the kitchens began distributing free booklets to mothers on the care of babies, in several languages. The Association's annual report in 1909 restated the group's objective as preventive, rather than curative. In 1910, the kitchens held mothers' conferences and began to examine babies. The Diet Kitchen established liaison between other organizations, as it cooperated with fresh-air charities and the New York AICP to send mothers and babies on day excursions or to convalescent homes.[2]

In addition to the Association's educational and infant medical supervisory work, by 1912 it serviced expectant mothers with milk and medical advice. In 1913, Diet Association nurses observed over 300 pregnant women. In 1915, the Association employed nine full-time nurses; fifteen doctors gave time voluntarily, and the Department of Health supplied another seven doctors to the organization.

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[1]New York Diet Kitchen Association, Thirty-sixth Annual Report for the Year Ending October 31, 1908, p. 8.

[2]New York Diet Kitchen Association, Thirty-third Annual Report of the New York Diet Kitchen Association for the Year 1905, p. 11; New York Diet Kitchen Association, Thirty-seventh Annual Report for the Year Ending 1909, pp. 7, 19-20; New York Diet Kitchen Association, Thirty-eighth Annual Report for the Year Ending 1910, p. 12.

Also in 1915, the Association began to hold conferences for mothers of children between two and five as well. Two years later, it ran eight stations, conducted prenatal work, baby-welfare work (including dispensing of milk, baby conferences, demonstrations for mothers, home visits, and emergency care to sick babies), and general health work. This included supervising entire families' health by securing dispensary and hospital treatment when necessary, aiding mothers who sought admissions for children in schools, day nurseries, or philanthropic vacation programs, and cooking classes for mothers. In 1917 the Association had registered 6,407 babies, 6,204 mothers, 1,043 expectant mothers, and 976 children between 2 and 6.[1]

When first established, the New York Milk Committee depots dealt only in milk, pasteurized, modified, and bottled in a central laboratory and distributed daily to mothers. By the end of 1908, the Committee's policy changed, reflecting the belief that home modification of milk would not only ensure the best adaptation of milk to individual infant needs but would also secure mothers' independence from the milk station. Home modification meant that babies

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[1]New York Diet Kitchen Association, Fortieth Annual Report for the Year Ending 1912, p. 12; New York Diet Kitchen Association, Forty-first Annual Report, 1913, p. 11; New York Diet Kitchen, Forty-third Annual Report, 1915, pp. 3, 9; New York Diet Kitchen Association, Forty-fifth Annual Report for the Year Ending October 31, 1917, pp. 3, 21.

had to be checked weekly. Thus, depots began to hire doctors and nurses; they subordinated the distribution of milk to "the bringing of education and training to the mothers."[1] Depot physicians served without pay; to evaluate feeding results, they held weekly classes in which the staff examined and weighed babies. Time could then be spent in the instruction of infant hygiene. The Committee used the price of milk to attract women to the centers. While the retail price of certified milk ran between fifteen and twenty cents a quart, the Committee sold its milk at eight cents.[2]

The stage had been set for municipal participation. The city's milk supply was sanitary and graded and the rudimentary framework of district health service had been created. In 1911, the Bureau of Child Hygiene opened fifteen baby health stations; in 1912, it operated fifty-five.[3]

Infant mortality began to plummet. Although there were 5,462 more births in New York City in 1911 than in 1910, 1,198 fewer babies died in 1911 than in the previous year. In 1910, there were 16,215 deaths of infants under

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[1]New York Milk Committee, Fourth Annual Report, 1910, pp. 23-24.

[2]Phillips, "The Mother and the Baby," The Survey, p. 626; New York Milk Committee, Fourth Annual Report, 1910, pp. 12, 23-24. This became the way to lure women into milk stations. The Committee did not distribute milk without charge unless absolutely necessary, but always sold it under the retail price.

[3]Meyer, Infant Mortality in New York City, pp. 117-18.

a year; in 1911, there were 15,017 such deaths. The trend continued. In 1910 the death rate among infants under a year was 125 per 1,000 live births. In 1911 it fell to 111, and in 1912 it dropped further to 105.[1] Indeed, New York City led the nation in infant life-saving work with mortality statistics commensurate with the great effort. Ultimately, the city served as a national model for progress.

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[1]New York Milk Committee, Fifth Annual Report for the Year 1911, p. 15; New York Milk Committee, Sixth Annual Report for the Year Ending 1912, p. 3.

CHAPTER V

MUNICIPAL MANAGEMENT

> There are three things necessary for stopping war and for controlling maternal morbidity and mortality and reducing the mortality rate from congenital diseases--education, education, and more education.
>
> --Jacob Sobel, 1919

> What's the matter with the poor is their poverty! The more ignorant racial groups, the lowest paid, those herded most in congested slums, have the largest preventable infant death rate.
>
> --The Survey, 1919

New York City began its most effective work in infant welfare, through which it became a model for other cities, by 1908. The establishment of the Bureau of Child Hygiene was the first official admission that children's health deserved separate and unique attention in a municipal health department, and also set the trend for national unification of theretofore disjointed child agencies. The significant shift of emphasis from education to broad legislative and governmental change marked the transition from the first stage of the infant welfare movement to the second. Centralization of agency efforts and remedies would ultimately predominate, as would the notion of government as the focus of assistance.

The establishment of the American Association for the Study and Prevention of Infant Mortality mirrored New York's evolution on a national scale. The Association emerged in 1909 from a conference on infant mortality held that same year in New York under the auspices of the American Academy of Medicine. This voluntary organization represented the first national organization endeavoring to save infant life. Together with its successor, the American Child Health Association, founded in 1919, the Association was crucial in underscoring national shame at the preventable loss of human life and prompting national policy for remedial efforts.[1]

The next pivotal date in the second phase of the infant welfare movement came in 1911, when the New York

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[1]Phillip Van Ingen, "The History of Child Welfare Work in the United States," in Mazyck P. Ravenel, ed., A Half Century of Public Health. Jubilee Historical Volume of the American Public Health Association in Commemoratory of the Fiftieth Anniversary Celebration of Its Foundation, New York City, November 14-18, 1921 (New York: American Public Health Association, 1921; reprint ed., New York: Arno Press, 1970), p. 292, 320-21; S. Josephine Baker, Fighting for Life (New York: The Macmillan Co., 1939), p. 143; "The Significance of the Study of Infant Mortality in United States Cities in 1926," American Journal of Public Health 17 (September 1927):934; "The Campaign against Infant Mortality," Modern Medicine 2 (September 1920): 615. The objects of the American Association for the Study and Prevention of Infant Mortality were to study infant mortality, to disseminate knowledge concerning its causes and prevention, and to encourage methods of prevention. See "Constitution of the American Association for the Study and Prevention of Infant Mortality," in Transactions of the Fifth Annual Meeting, Boston, Mass., November 12-14, 1914, p. 360.

Academy of Medicine established its Public Health Committee. Earlier, the Academy sheltered itself from civic involvement under a scholarly and esoteric aura beyond the comprehension of laymen. The Public Health Committee became central to the Academy's work and reputation, serving as the Academy's voice in community affairs, advising governmental agencies, initiating health surveys, and conducting conferences and lectures on specific health problems and issues.[1]

The formation of the United States Children's Bureau in 1912 affirmed the federal government's commitment to the special protection of children. New York State's Division of Child Hygiene, established in 1914 within the Department of Health, followed the first state allocation of special machinery and funds for child welfare work. When federal law established the Birth Registration Area (consisting of states which reported reliably at least 90 percent of all births) in 1915 and the Census Bureau published accurate birth statistics for that area the same year, whatever national complacency or equivocation which existed faded. The public found infant

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[1]E. H. L. Corwin and Elizabeth V. Cunningham, Thirty Years in Community Service, 1911-1941. A Brief Outline of the Work of the Committee on Public Health Relations of the New York Academy of Medicine (New York: New York Academy of Medicine, 1942), pp. 3, 5, 63. In 1924, the Committee's name became the Public Health Relations Committee.

mortality rates, compiled from birth statistics, shockingly high.[1]

The second half of the infant life-saving movement (the change came between 1912 and 1915) produced statistical data as well as more accurate analysis. Social investigators, statisticians, and public health workers began to correlate mortality to class. They no longer viewed ignorance as the determinant of infant mortality, as they demonstrated high deaths to be a function of poverty.

In 1915, the New York Association for Improving the Condition of the Poor conducted a study which illustrates the more sophisticated direction of the second phase. The assumption of the first phase of the movement --that improper feeding methods, especially artificial feeding (that is, anything but mother's milk), led to infant mortality--seemed to implicate the mother individually. Remedy began with the woman rather than in social environment or municipal policy. But results of the AICP's study of the connection between diarrhea among young children and the prevalence of dirt (and particularly

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[1]Van Ingen, "History of Child Welfare Work," pp. 292-93, 318. Prior to the creation of the New York State Division of Child Hygiene, a survey showed that in only 12 localities--all of which were cities--was there any organized infant welfare work.

flies) drew attention from individual blame toward social irresponsibility.

Between June 9 and September 15, 1915, the Association analyzed the health of 480 infants. It divided the subjects into two groups, with one protected with fly netting, tanglefoot fly paper, and fly literature, supplemented with lessons from a visiting nurse who came to homes weekly to encourage the application of sanitary prophylaxis. The second, or control, group received none of these safeguards. Although a nurse visited these homes weekly, there was no specific discussion program.[1]

The results shed new awareness on the causes of infant death and disease. Public health workers no longer attributed diarrhea solely to artificial feeding. In the fly-exposed group, twice as many infants had diarrhea than those in the fly-protected group. Morbidity or disease rates proved more significant than actual mortality. In the protected group, twenty children contracted diarrhea, while sixty fell ill with intestinal disease in the control group. Where there were fewer flies there was less

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[1]New York Association for Improving the Condition of the Poor, Flies and Diarrheal Disease, Second Year's Investigation, publication no. 91 (New York: AICP, 1915), pp. 4, 11, 34. The experimental district was in the southwest Bronx, a poor Italian neighborhood with unsanitary conditions and high infant mortality. The two groups studied came from the same population group, shared the same types of housing, and had the same ethnic characteristics.

disease; no children in the protected group contracted whooping cough in the four months studied, while twenty became infected in the unprotected homes. Total days of sickness among children without protection aggregated 984, compared to 273 within the aided group. When dirt and artificial feeding were combined, the incidence of diarrhea soared to three and a half times that of infants who were breast-fed in clean homes.[1] The final points of the study underscored the new emphasis. The Association noted the facilitation of favorable health patterns through environmental manipulation, a result more widely to be expected with even ordinary enforcement of the municipal Sanitary Code.[2]

The dictates of the infant welfare drive gained new meaning as the public health movement matured. The demand for breast feeding remained constant as health workers reminded the public that infants develop basic immunities through breast milk. Statistics bore out these warnings. An average of thirty infants of one hundred bottle-fed babies died in their first year, while only seven of every hundred breast-fed babies so perished.[3]

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[1]Ibid., pp. 18, 20, 21, 29, 34.

[2]Ibid., p. 14.

[3]American Association for the Study and Prevention of Infant Mortality, The Care of the Baby (Pittsburgh: Bureau of Child Welfare, 1914), p. 3.

But fresh analysis would demonstrate that the infant's protection was not isolated from the mother's, that the reason why women often did not nurse was because they were unable to, and that poverty posed a greater factor than seeming ignorance.

That infant mortality was a symptom of class, a product of tenement life, had revolutionary implications in an American milieu which historically placed its faith in education as the propellant for upward mobility and general social betterment. The initial notion that inability to nurse stemmed from woman's hereditary debilities or disease, or from tuberculosis, syphilis, or even the alcoholism of her father, meant a progressive step away from personalizing blame. Inquiry went even further when health workers recognized that the adjuncts of poverty--insufficient diet, hard work, and excessive worry--could underly women's inability to produce good or sufficient breast milk:

> The tenement baby enters life already handicapped through generations of half-starved ancestors. Even when the mother can nurse her infant it is very difficult for her to keep up a really good milk supply because the food she can afford is not the kind that will produce good milk.[1]

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[1]New York Diet Kitchen Association, Thirty-Sixth Annual Report for the Year Ending October 31, 1908, p. 19.

Research findings implied clearly that women could nurse, that babies might live, if women might have an extra quart of milk each day, or a steady portion of meat and vegetables each week.[1]

The second phase of the movement questioned the relationship of women in industry to healthy motherhood and babyhood. Communities with industries which employed unskilled female workers invariably fell at the high end of the infant death scale.[2] Contributors to The Survey, a professional journal for social workers, became less concerned with educating women than in improving their social conditions. One such contributor maintained: "The two main reasons for this maternal impotency [inability to nurse], are physical disability, due to improper nourishment and disease, and industrial employment, due principally to abject poverty."[3] Public health workers

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[1]Abraham Jacobi, "The History of Pediatrics and Its Relation to Other Sciences and Arts," reprinted from American Medicine 8 (November 4, 1904):19; Arthur W. Calhoun, A Social History of the American Family. From Colonial Times to the Present, 3 vols. (New York: Barnes and Noble, 1945, originally published 1919), 3:253.

[2]Julius Levy, "The Reduction of Infant Mortality by Economic Adjustment and by Health Education," Proceedings of the National Conference of Social Work. 46th Annual Session, June 1-8, 1919, p. 205; Calhoun, A Social History of the American Family, 3 vols., 3:73.

[3]Wilbur C. Phillips, "The Mother and the Baby," The Survey 22 (1909):624. See also L. Emmett Holt, "Infant Mortality and Its Reduction, Especially in New York City," The Journal of the American Medical Association 54 (February 19, 1910):685.

discovered that not only did the babies of the affluent weigh more at birth than those of employed mothers, but infants of working women who rested two weeks before birth weighed almost as much as the babies whose mothers never worked.[1]

The ultimate realization of the new class approach, rather than educative or individualistic outlook, was that even knowledge must be purchased.[2] Ignorance, merely a mild handicap for the middle class, becomes an insurmountable obstacle for the poor. "Both mothers in the past have commonly been ignorant. But the ignorance of the working-class mother is more dangerous, because it is associated with relative social helplessness."[3]

After Dr. S. Josephine Baker was graduated from the Medical College of the New York Infirmary for Women and Children in 1898 and completed her internship the next year at the New England Hospital for Women and Children, she returned to New York City. She and another woman doctor opened a private practice which hardly paid

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[1]"Prenatal Care and the Infants of Poor Mothers," The Survey 31 (January 17, 1914):470.

[2]Wilbur C. Phillips, "Community Planning for Infant Welfare Work," Proceedings of the National Conference of Charities and Correction at the 39th Annual Session Held in Cleveland, Ohio, June 12-19, 1914, p. 40.

[3]Arthur Newsholme, Fifty Years in Public Health. A Personal Narrative with Comments (London: George Allen & Unwin Ltd., 1935), p. 374.

their office rent.[1] Accidentally, she saw a notice in the morning paper for civil service examinations for the position of school medical inspector in the Department of Health; her real career thus began in 1901.[2]

Baker subsequently transferred to a program, operated by the city each summer since 1876, in which the physicians canvassed the city's tenement districts, inquiring after and treating sick babies. Baker worked in Hell's Kitchen every morning from 7:00 to 11:00 and again from 4:00 until 6:00 each evening. The heat, squalor and misery combined to make her feel completely helpless, as an average of 1,500 babies died each week that summer in the city.[3]

Change came in the summer of 1908. On the recommendation of the Bureau of Municipal Research, Baker led an experiment with thirty-one public health nurses who were employed to do preventive health work among the infants of Manhattan's Lower East Side. The results were astounding. The simple visits of nurses to mothers and their clear instructions on proper care, dress and feeding

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[1]Baker, Fighting for Life, pp. 46-47. (She earned $185.00 her first year in practice.)

[2]Ibid., p. 54.

[3]Ibid., pp. 57-58. See also S. Josephine Baker, "Address," Transactions of the Fifth Annual Meeting of the American Association for the Study and Prevention of Infant Mortality, Boston, November 12-14, 1914, p. 271.

appeared to cut infant mortality by 1,200 lives in that area alone, as infant death rates in other poor neighborhoods in the city remained stationary. City officials were convinced: "Heat did not necessarily kill babies."[1] In August 1908 the Department of Health created the Division of Child Hygiene, with Dr. Baker as its head, to continue this special work with children.

Baker began the Bureau's intensive work with the city's infants the following summer on the preventive premise that "healthy people do not die. That sounds like a completely absurd and witless remark, but at that time it really was a startling idea."[2] With the objects of keeping babies well, of seeking out their mothers and instructing them concerning the importance of breast feeding, ventilation, bathing, proper clothing and fresh air, all before children became ill, Baker hired school nurses, free for the summer, and sent them into the slums. The nurses received word of each birth and promptly visited the home of every newborn. New York City's infant death rate receded. The period between 1909 and 1914 saw the survival of eighteen thousand infants, who, by the

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[1]Baker, Fighting for Life, pp. 86-87. See also 50 Years of Better Health for New York's Mothers and Babies, 1908-1958 (The City of New York: Department of Health, 1958), pp. 7-8.

[2]Baker, Fighting for Life, p. 83.

standards of 1908, would have died.[1]

Until 1911, the city had no involvement in milk depots. Then, following the proposal of the New York Milk Committee, the Bureau of Child Hygiene assumed control of fifteen stations. The city agreed to operate the milk stations temporarily and, if results were successful, to assume permanent control.[2] The results proved so remarkable (the infant mortality rate for the city fell from 125 per 1,000 births in 1910 to 111 per 1,000 births in 1911; that is, in a single year, the rate fell by more than 10 percent) that the city appropriated $300,000 in 1912 for the operation of the original 15 stations and an additional 40 which the Department now supervised.[3]

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[1]Ibid., p. 86; Baker, "Address," p. 27. In 1914, with approximately 135,000 babies born each year in New York City, the Bureau of Child Hygiene cared for 60,000. The work of the Bureau resulted in the fall of the summer death toll from 1,500 per week to 60 per week in the early twenties.

[2]In 1911, with an allocation of $40,000, the Department of Health opened 15 municipal infant stations: nine in Brooklyn, five in Manhattan, and one in the Bronx. See New York Milk Committee, Ten Years of Work, 1907-1916, p. 12; New York Milk Committee, Fifth Annual Report, 1911, p. 7; John Duffy, A History of Public Health in New York City: 1866-1966 (New York: Russell Sage Foundation, 1914), p. 466.

[3]New York Milk Committee, Ten Years of Work, p. 12; Duffy, History of Public Health, p. 466. In 1921, the city operated 68 baby health stations while private agencies ran an additional 25. See Charles E. North, "Milk and Its Relation to Public Health," in Ravenel, ed., Half Century of Public Health, pp. 279-80.

The infant milk depot adopted a new name to reflect the revised content of its work. The municipal facilities, now called baby health stations, provided complete physical examination of the child each visit, distributed individual formulas for milk modification, sold Grade A pasteurized milk below the retail price, and routinely sent nurses to the homes to see if women understood formula instructions and to supplement hygienic lessons of the weekly clinic. Doctors visited homes when necessary.[1] Apparently, the stations truly exercised a wide influence upon the infant population. In 1915, the city's 59 stations dealt with 37,197 infants under a year old, although some mothers merely used the stations to tide themselves through the hot summer months. Nonetheless, this figure represents 26.9 percent of the city's total infant population that year.[2] The intensive, individual treatment that poor children could not normally afford paid dividends. By 1920, the death rate among infants cared for under the municipal program was forty-one per thousand, while the "rate among those not cared for, but belonging to the same age-group and living under

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[1]Ernest C. Meyer, Infant Mortality in New York City, A Study of the Results Accomplished by Infant-Life Saving Agencies, 1885-1920, Publication No. 10 (New York: The Rockefeller Foundation, 1921), pp. 63-64.

[2]Ibid., pp. 46.

conditions approximately similar, was found to be about 84 [per thousand live births]."[1]

In 1911, the Department of Health and the New York Milk Committee collaborated in the creation of the Milk Station Association of New York. Its members included all agencies engaged in the distribution of pure milk.[2] Baker immediately recognized the virtue of centralization. In evaluating the infant welfare movement in the city, she saw that New York did not lack effort or sincerity but sorely missed coordination. Duplication of effort, founded upon an unawareness of what different agencies were doing plagued child-life-saving work and frustrated dedicated attempts to reduce the city's infant mortality rates. Upon Baker's urgings, the Babies Welfare Association began in 1912 as a federation of agencies actively engaged in infant welfare work.[3] "To save babies by saving wasted effort" became the motto of the Association, which functioned as a clearing house and information center for all matters relating to the welfare of infants. For the first

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[1]Ibid., pp. 49, 58-59.

[2]New York Milk Committee, Fifth Annual Report, 1911, pp. 10, 12. From June 30 to September 30, 1911, the Association coordinated the efforts of seventy-nine milk stations in the city.

[3]Children's Welfare Federation, Twenty-Five Years of Service, 1912-1937 (New York: Children's Welfare Federation, 1937), p. 1; New York Milk Committee, Ten Years of Work, p. 16.

three years of its existence, the Association received most of its money from the New York Milk Committee; in 1915, the Bureau of Child Hygiene as well as the subsidiary agencies assumed financial support.[1]

By 1915, the Bureau serviced a membership of seventy-nine milk stations, six research agencies, ninety-two day nurseries, twenty institutions and homes, seventy-seven dispensaries, sixty-eight hospitals, thirty-five outing facilities, and fifty-four relief agencies, representing eighty different institutions.[2] The Bureau facilitated the work of social workers, district nurses, and welfare groups with the publication of large maps depicting the location of milk stations, the preparation of an infant welfare directory, and regular publication of morbidity and mortality statistics. It saved public health workers' time by handling all referrals for hospital accommodations, wet nurse care, aftercare or convalescent supervision for mothers and babies discharged from maternity hospitals, and fresh air trips, day nurseries, foster

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[1] Report of the Babies Welfare Association, 1912-1915 (New York: Russell Sage Foundation, 1915), p. 1; New York Milk Committee, Ten Years of Work, p. 16.

[2] Report of the Babies Welfare Association, 1912-1915, p. 1. In 1922, when membership included 220 agencies, its name became the Children's Welfare Federation. See Children's Welfare Federation, Twenty-five Years of Service, p. 1.

homes, and adoption.[1] Upon calling the central office, for instance, a social worker would receive immediate information concerning hospital vacancies or the names of homes for mothers who were temporarily ill, as well as homes which would simultaneously care for any children for whom shelter was necessary while the woman was hospitalized.[2]

The Babies Welfare Association also printed weekly articles on baby care, published in the summer in Die Wahreit, Ill Progresso, and The Evening Journal. It consolidated its milk station map into a pocket card, and distributed it among policemen, churches, charities, and social workers.[3] The Association established a wet nurse bureau in 1917. Maternity hospitals reported all women having stillbirths who were willing to let themselves out as baby nurses. Officials gave Wassermann tests, and sent women whose test results were negative to employment.[4]

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[1]Report of the Babies' Welfare Association, 1912-1915, pp. 7, 16; Report of the Babies' Welfare Federation of New York City, 1921, p. 1.

[2]Report of the Babies' Welfare Association of New York City, 1912-1915, p. 6; Report of the Babies' Welfare Association of New York City, 1917, pp. 3, 5.

[3]New York Milk Committee, Sixth Annual Report, 1912, p. 40.

[4]Report of the Babies' Welfare Association of New York City, 1917, p. 5.

The group converted the traditional baby show into a baby competition, not dissimilar to a cattle contest. Now, however, judges evaluated infants on their weight and general health, instead of cosmetic characteristics. The unusual nature of the contest attracted women and the congregation of mothers suited welfare workers, who conducted lectures and distributed health leaflets after the competition.[1]

Baker's efforts in the city gained momentum and snowballed. Inspiration for the establishment of Little Mothers' Leagues came after she read John Spargo's The Bitter Cry of Children. He described young girls, prematurely burdened with maternal responsibilities, caring for younger siblings while mothers worked to support their families. Unprepared for those custodial roles, the girls were "a fertile source of infant mortality."[2] Baker began a program of childcare education in the public schools, which practically every other major urban area engaged in infant welfare work adopted. Children twelve years or older met in neighborhood schools--usually during the summer--and received demonstrations on the management of

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[1]New York Milk Committee, Ten Years of Work, p. 16; Report of the Babies' Welfare Association, 1912-1915, p. 10.

[2]Baker, Fighting for Life, p. 132.

babies.[1] The Bureau's effort gave the girls a sense of pride, and they reciprocated:

> These youngsters were among our most efficient missionaries, canvassing tenements for us, cajoling mothers of their acquaintance into giving the baby health stations a trial . . . telling every mother they met all about what they were learning.[2]

Again, Baker initiated what other cities would imitate. In 1911, New York City had its first Child Welfare Exhibit. The exhibition was similar to a business convention, with displays aimed instead to sell health and not goods. The show included exhibits on food, with demonstrations of milk modification, on infant clothing, on dentistry, on prenatal care, on nursing hygiene, and on summer protection of young infants. As the idea spread to other parts of the country, it led to traveling health exhibits in rural areas as well.[3]

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[1]Ibid., p. 133; Van Ingen, "The History of Child Welfare Work," pp. 305-06; U. S., Department of Labor, Children's Bureau, Baby-Saving Campaigns. A Preliminary Report on What American Cities are Doing to Prevent Infant Mortality, Bureau Publication No. 3 (Washington, D.C.: Government Printing Office, 1913), p. 30.

[2]Baker, Fighting for Life, p. 134.

[3]U.S., Department of Labor, Children's Bureau, Child-Welfare Exhibits. Types and Preparation, Bureau Publication No. 14, by Anna L. Strong (Washington, D.C.: Government Printing Office, 1915), pp. 7-10, 12-13. Kansas City, Buffalo, Indianapolis, Providence, Rochester, St. Louis, Louisville, Seattle, Toledo, and Montreal followed.

New York City and Chicago led in setting aside one week a year (called "baby week") and devoting a massive advertising campaign to all aspects of infant welfare work. Movie theatres showed health slides between films, department stores and drug stores distributed pamphlets on baby care, schools held special programs, and newspapers contributed free publicity space. The grand display and excitement in New York prompted the Children's Bureau to call for a national Baby Week, which was celebrated the week of March 4-11, 1916 with 2,100 communities participating. The week provided valuable community instruction and proved an impetus to permanent work. State and city divisions of child hygiene followed, as did little mother's leagues in the public schools, milk stations, and better birth registration.[1]

By 1916, the New York City tenement baby had greater chances of survival than the child born in a rural district or small town. Baker's work with infants proved that many more children could live. As infant mortality declined, so did deaths of children between two and five.[2]

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[1]Ibid., pp. 16-17; U.S., Department of Labor, Children's Bureau, Baby-Week Campaigns, Bureau Publication No. 15 (Washington, D.C.: Government Printing Office, 1917), pp. 9-10, 64, 69.

[2]Baker, "Address," p. 2. While deaths of infants under one year declined from 164.0 per 1,000 live births to 144.0 in 1908, 110.0 in 1912, 98.2 in 1914, to 94.6 in

Perhaps as a natural progression, the Bureau then moved to undertake the health supervision of public school children. In New York City, municipal intervention in public school children's health began before the creation of the Bureau of Child Hygiene; once the Bureau was established, however, the school health program expanded in a significant shift of emphasis. Medical inspection of school children began in the United States in the 1890s. In 1897, the New York City Health Department appointed 150 medical inspectors to the schools. They received a salary of $30.00 per month, and the Department expected them to work an hour each day, visiting three or four schools.[1] Their assignment sought to eradicate communicable diseases.

1915, 93.1 in 1916, 88.8 in 1917, 91.7 in 1918, and 81.6 in 1919, deaths of children between two and five years per 1,000 living children dropped from 17.9 in 1904 to 13.1 in 1908, 9.4 in 1912, 9.2 in 1914, 8.9 in 1915 and 6.9 in 1919. See Meyer, Infant Mortality in New York City, pp. 128-29.

[1] 50 Years of Better Health for New York's Mothers and Babies, p. 25; Van Ingen, "History of Child Welfare Work," p. 294. Boston was the first city in the country to provide physicians' examinations in school, in 1894. The next year, Philadelphia and Chicago followed. New York City, then, was the fourth city in the country to have such a program. See George Rosen, A History of Public Health (New York: Medical Publications, 1958), p. 366. In this area, the United States lagged behind Europe. In 1904, Abraham Jacobi wrote: "The office of school physicians is relatively new. Whatever we have done in establishing it in America has been preceded by countries to which we are not in the habit of evoking for our models. Bulgaria and Hungary have no schools without physicians." In Jacobi, "The History of Pediatrics," p. 25.

The program proved disappointing in many respects. Since salaries were not compelling and one hour's time was hardly sufficient to canvass one school, the service tended to be perfunctory. Baker, whose first civil service appointment was as school medical inspector, learned that many inspectors simply telephoned the school each morning.[1] The most serious deficiency, however, put responsibility for detection of contagious diseases with untrained teachers. The Health Department merely expected visiting doctors to examine those children whom a teacher had suspected of illness; if the doctor confirmed disease, the school sent the child home. Thus not only did the program operate on a certain degree of luck or prescience, it also fostered a considerable amount of truancy.[2]

In 1902, when the city elected Seth Low Mayor and he appointed Dr. Ernst J. Lederle as Commissioner of Health, the new administration reduced the school medical staff, raised the salary to $100.00 a month, and required doctors to work three hours a day. Orders from the new commissioner stipulated that every child receive a

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[1]Baker, Fighting for Life, p. 56.

[2]Lillian D. Wald, The House on Henry Street (New York: Henry Holt and Co., 1915), pp. 49-50; Letter, Lillian Wald to Dr. Abbot E. Kitridge, 29 October 1903, Lillian Wald Letters, New York Public Library, Lillian Wald Papers, Box 2, 1893-1917; Baker, Fighting for Life, p. 56.

physical examination. Results shocked the public, when workers found over six thousand public school children suffering from trachoma alone.[1]

Lillian Wald played an important role in the next step in school health supervision, arguing that the exclusion of children from schools did not solve the problem, since all disease could not be eliminated with such crude screening procedures. She noted as well that for children sent back to homes which could not afford medical treatment, the exclusion forced the double handicap of disease and no education. The city succumbed to her pressure for the hiring of school nurses, and in 1902 became the first American municipality to employ nurses in schools.[2] Now children could remain in school under medical treatment. "Ninety-eight and a half percent of the children who were excluded from school on account of various diseases," Wald recalled, "before the advent of the school nurse, are now kept in school and treated daily by the nurse."[3]

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[1]Baker, Fighting for Life, p. 57; Wald, House on Henry Street, p. 50; Wald Letter to Kitridge, p. 2.

[2]Wald, House on Henry Street, p. 52. The Board of Estimate and Apportionment appropriated $30,000 for the program, and the nurses were paid $75.00 per month. See Norman Barnesby, The Mother and the Child (New York and London: Mitchell Kennerley, 1913), p. 165.

[3]Wald letter to Kitridge, N. Y. Public Library, p. 2. By 1921, contagious skin and eye conditions--

When the Bureau of Child Hygiene assumed control of the Health Department's school medical services, the Bureau expanded the program into a preventive screening for physical defects--physical, visual, nutritional, and dental. The search for and discovery of enormous physical handicaps quieted derogatory claims that immigrant children were somehow mentally incapacitated. Workers found children, on whom educators often gave up as hopelessly ignorant, suffering from curable physical problems which interfered with learning concentration.[1]

In the school year September 1908-June 1909, the first in which the Bureau directed school health examinations, it found that among the 322,344 children examined some 242,048 children needed treatment. Of these, 183,862 required immediate dental attention, 38,329 needed vision care, 73,058 suffered from nasal breathing difficulties (tonsils, adenoids), and 86,688 had hypertrophied tonsils.[2]

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ringworm, scabies, impetigo and trachoma--were unusual. See 50 Years of Better Health for New York's Mothers and Babies, 1908-1958, p. 25.

[1]James J. Walsh, History of Medicine in New York, Three Centuries of Medical Progress, 5 vols. (New York: National Americana Society, Inc., 1919), 2:293.

[2]Henry Moskowitz, "The Place of the Immigrant Child in a Social Program," in The Child in the City. A Series of Papers Presented at the Conferences Held During the Chicago Child Welfare Exhibit, May 11-25, 1911, ed., Sophonisba P. Breckinridge (Chicago: The Department of Social Investigation, 1912, reprint ed., New York: Arno Press, 1970), pp. 260-61.

Almost all exhibited some degree of malnutrition.

Undernourishment remained a basic problem among New York City's school children through the 1930s. Working among the Italians in a pilot health project in the Mulberry district, the Association for Improving the Condition of the Poor reported that even among the 2,181 "well" children there were 656 (or 30 percent) suffering from malnutrition.[1] Health workers urged that height and weight tables not be the only source of measuring individual nutritional levels, since careful physical examination often revealed severe undernourishment even when the patient was of purportedly normal weight.[2]

Malnutrition is poverty's offspring; it plagues tenement populations. In New York City in the early twentieth century, it affected many of the city's immigrants with particular tragedy. Immigrants often had little else but good health in their European homelands. Most came from peasant backgrounds and spent much of their time in open air and sunlight, with diets of fresh food and milk. In New York, however, with congestion, indoor employment and unfamiliarity with foods and

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[1]Lucy H. Gillett, Adapting Nutrition Work to a Community, Publication No. 134 (New York: AICP, 1924), p. 215.

[2]Louis I. Dublin and John C. Gebbart, Do Height and Weight Tables Identify Undernourished Children? (New York: AICP, 1924), pp. 17, 19.

American preparation habits, children grew up "thin, pale and hollowed-eyed."[1]

The movement to provide free lunches to public school children started in 1908, but until 1918 such programs remained largely the function of private organizations working in specific areas of the city. In 1918, the City Council appropriated $50,000 to the Bureau of School Lunches in the Department of Education, but by 1920 only fourteen schools offered free lunches.[2] Most of the nutritional work in this period was educative, through the public schools, visiting nurses, or community health center workers. Nutritional workers decried the lack of meal regularity and fresh air, and insufficient sleep. They were anxious to refine the immigrant diet, and to eliminate the excess of meat, eggs, fats, sweets, tea, and coffee. The nutritionists propagandized for more water, milk, cereals, vegetables, and fruits.[3]

Of all the nutritional problems in the beginning of the century, rickets posed the most serious in urban areas. The ailment is essentially a disease of infancy,

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[1]Gillett, Adapting Nutrition Work, p. 6.

[2]Duffy, History of Public Health, p. 503; Van Ingen, "The History of Child Welfare Work," p. 301. Van Ingen reported that in 1921, twenty-six schools fed three thousand children hot lunches received from the Department of Education.

[3]Gillett, Adapting Nutrition Work, p. 18.

attacking babies between the fourth and eighteenth months. Although it increases a child's susceptibility to disease, it rarely proves fatal. Its legacy lies in bone deformities and arrested growth caused by softening bones. Rickets also leaves its mark on girls, who often develop deformed pelves, adding to childbed mortality by requiring cesarean section.[1] Italian children suffered especially from the retardation of skeletal growth; the AICP found the incidence of rickets obviously higher among Italians in the Mulberry district, where "they are both shorter and lighter than the run of children throughout the country."[2] Generally, a Vitamin D deficiency causes rickets. Until the 1920s and the development of ultraviolet radiation therapy, doctors usually treated the disease with sunlight and cod liver oil to compensate for the vitamin deficiency.

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[1]Carolyn C. Van Blarcom, Getting Ready to be a Mother: A Little Book of Information and Advice for the Young Woman Who is Looking Forward to Motherhood (New York: The Macmillan Co., 1922), p. 231; Newsholme, Fifty Years in Public Health, p. 262; Arthur Newsholme, "Values in Public Health," in American Health Congress, Proceedings of the General Sessions, Atlantic City, N.J., May 17-22, 1926, pp. 12-13. Rickets also increases the victim's susceptibility to whooping cough, measles, and diarrhea.

[2]John Gebhart, The Growth and Development of Italian Children in New York City, Publication No. 132 (New York: AICP, 1924), pp. 10, 17-18. "Even a casual observer cannot fail to note the twisted bodies and bowed legs of the toddlers on the streets of this district," p. 16.

The decision to employ nurses within the schools, as well as the recognition that the distribution of milk alone without medical examination and consultation was comparatively meaningless, boosted the nascent specialty of pediatrics. Although Abraham Jacobi established the first pediatric clinic in the United States in 1860 and became America's first clinical professor of pediatrics at the New York Medical College, by the turn of the century most medical curricula still included the diseases of children with obstetrical and gynecological training.[1] In 1903, Professor Williams expected his apprenticing obstetricians to be responsible for after-care of the infant as well as the mother.[2]

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[1]The New York Medical College on East 13th Street reorganized its facilities in 1860 and established a children's clinic under the leadership of Jacobi. When the Civil War forced the college to close in 1865, the clinic shifted to the New York University Medical College. In 1870, Jacobi transferred his work to the College of Physicians and Surgeons. Jacobi then went on to found and head Mt. Sinai's department of pediatrics in 1878. See Jacobi, "History of Pediatrics and Its Relation to Other Sciences and Arts," p. 3; Jacobi, "History of Pediatrics in New York," p. 38; "Historical Exhibit, Commemorating the Ninetieth Anniversary of the Founding of the Mt. Sinai Hospital," reprinted from Journal of the Mount Sinai Hospital 9 (September-October 1942), p. 198; Claude E. Heaton, The New York Obstetrical Society. An Historical Sketch, 1863-1963 (New York: F. A. Davis Co., 1963), p. 18.

[2]J. Whitridge Williams, Obstetrics. A Text-Book for the Use of Students and Practitioners (New York: D. Appleton and Co., 1903), p. 321.

While leading hospitals and medical schools created pediatric wards and professorships in children's pathology,[1] Holt reported in 1900 that "not half a dozen men practiced pediatrics exclusively as a specialty. No medical school in the United States had a separate department of pediatrics."[2] In 1894, W. S. Christopher, Professor of Pediatrics in the Chicago Polyclinic and the College of Physicians and Surgeons, complained of the specialty's immaturity:

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[1]In 1886, both the Polyclinic and the Post-Graduate Hospitals, each founded in that year, opened special hospital sections for children and offered clinical instruction in pediatrics. Also in 1886, Bellevue Hospital established a children's ward. See Jacobi, "History of Pediatrics in New York," p. 12. In 1887, Babies' Hospital was incorporated in New York City for the care of poor sick children under two years of age. The hospital provided clinical training for medical students at the College of Physicians and Surgeons. L. Emmett Holt served as the hospital's attending physician. See Babies' Hospital of the City of New York, First Annual Report, 1888, p. 10; Babies' Hospital of the City of New York, Twenty-second Annual Report October 1, 1909-September 30, 1910, p. 5; Jacobi, "History of Pediatrics in New York," p. 16; Walsh, History of Medicine, 5 vols., 3:850. In 1888, Harvard established its first professorship of pediatrics, and in 1889 the American Pediatric Society was founded. See Jacobi, "Pediatrics and Its Relation to Other Arts and Sciences," p. 11.

[2]L. Emmett Holt, "American Pediatrics. A Retrospect and a Forecast," reprinted from the Journal of the American Medical Association 81 (October 6, 1923):4; also see Theodore Von Escherich, "The Foundation and Aims of Modern Pediatrics," reprinted from American Medicine 9 (January 14, 1905):1; W. S. Christopher, "A Plea for the Study of Pediatrics," The American Journal of Obstetrics and Diseases of Women and Children 29 (January 1894):50.

> So long as all the ills of infancy are referred to teething as the great causative factor, and the troubles of childhood are satisfactorily explained by worms, so long we may expect stagnation in this important branch of our work.[1]

The infant welfare movement must be viewed against a pattern in which parents of all classes did almost nothing on a regular ongoing basis about the medical surveillance of their infants and children.[2] (Even in wealthy homes, parents called in the family physician only when children became sick.) Thus, the development of child health centers, which necessarily required staffs of doctors with expertise in infant health, gave impetus to pediatrics and the better health of children of all socioeconomic classes.

Abraham Jacobi, Prussian born, became the central American figure in the importation of a new methodology, largely developed in Germany. The raison d'etre of the new German school of child health was the realization that disease unfolded uniquely in the child. The new pediatricians objected that the status quo in medical subspecialties, which lumped children's diseases with internal

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[1]Christopher, "A Plea for the Study of Pediatrics," p. 49.

[2]Escherich, "The Foundation and Aims of Modern Pediatrics," p. 23. He wrote: "I admit that nowadays this function of the pediatrist is employed only exceptionally and under particularly favorably conditions, and that even in the future only a limited number of families will have it accessible."

medicine, assumed that the child was simply a miniature adult.[1]

The notion that the immature anatomy and physiology of the baby and child modify and differentiate the pathological manifestations of disease in infants and children became the manifesto of the new pediatric movement. Champions of the specialty claimed that the distinguishing physiological feature of young children is their requirement for growth and development. The "physiologic peculiarities of the childish organism" mandated that it be studied separately.[2]

Early German students of pediatrics emphasized the relatively raw and unfinished state of the infantile digestive system; the nutrition of infants, particularly, required special study and medical observation. In spite of the relative backwardness of the infants' alimentary system, sustenance needs required that it "assimilate a sufficient quantity of food for the body weight to treble itself" in a year.[3] This meant that any administration of artificial food demanded precise analysis of the infant's capacity to accept and digest the substance.

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[1]Christopher, "Plea for the Study of Pediatrics," p. 50.

[2]Escherrich, "Foundation and Aims of Modern Pediatrics," p. 3.

[3]Ibid., p. 19. See also Christopher, "Plea for the Study of Pediatrics," pp. 54-55.

New guiding principles arose from the initial investigation into infants' health. Diet must be tailored according to the developmental stage of the child, and his functional maturation determines his capacity to digest various food. Holt wrote in 1905 that "the nutrition of the growing child, whether sick or well, should be the first concern of the physician to whose care the young lives are entrusted."[1] Doctors trained in this new specialty urged changes of diet, sleeping habits, and ventilation, rather than the customary reliance on drug treatment of illness.

Because of this concern with digestive immaturity and necessity for precision in calculating food intake, infant care advise observed extreme caution with food; doctors told mothers to delay giving solid foods until at least the tenth month of an infant's life. The Children's Bureau's Publication No. 8, Infant Care, first issued in 1914, became the U.S. Government Printing Office's most popular publication. Its delineated dietetic routine reflects the period's conservatism toward solid foods.

According to the pamphlet, a child must remain on breast milk until the seventh or eighth month. He could then be given strained fruit juice. After the ninth month,

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[1]L. Emmett Holt, "Address on the Therapeutic Outlook in Pediatrics," reprinted from The Medical News (December 23, 1905):2.

a mother might try beef juice, or mutton or chicken broth. Only after the tenth month should a soft boiled egg or crisp toast or zwieback be added to the diet.[1]

Notwithstanding the demonstrated life-saving benefits of the nutritional education campaign, economics still determined dietary habits. Despite health worker's emphasis upon the benefits of milk and the purification of its supply, by 1919 the price of milk had risen so much that the poor in New York City were again substituting coffee for milk. In 1920, Dr. Royal S. Copeland, New York's Health Commissioner, published the results of a survey. After investigating 11,007 city families with 19,037 children between the ages of one and seven, the study found that the children consumed an average of two cups and one ounce of milk each day, an amount health workers considered completely inadequate for normal growth and development. These same youngsters drank a daily average of one cup of coffee or tea, which the workers viewed as causing nutritional disorders. The study concluded that "the reason for this was found not to be

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[1]U.S., Department of Labor, Children's Bureau, Infant Care, by Mrs. Max West, Bureau Publication No. 8 (Washington, D.C.: Government Printing Office, 1914), pp. 37, 49. Advice continued: at fifteen months a child might start with scraped beef, mutton or chicken. At eighteen months, a baked potato could be tried, and at two years, mashed fresh vegetables may be introduced into the diet.

ignorance of the parents but the high price of milk."[1]

As a concomitant to the drive to keep infants alive, infant health physicians played a key role in bucking resistance to the emerging field of bacteriology. Since infectious diseases are the particular scourge of childhood, pediatricians took up the cause of bacteriology with vigor.[2]

Among the deadly children's diseases, this period witnessed especially an enormous diminution in mortality from diphtheria. The disease, which is practically nonexistant in the United States today, struck twelve thousand children in New York City in 1900.[3] It begins gradually, without obvious prostration. As it develops, a membrane covers the throat, obstructing breathing. Unfortunately, when the indications of illness become apparent

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[1]"Two Milk Bills," The Survey 43 (February 21, 1920):602.

[2]For pediatricians, the explanation of childhood deaths and disease justified a new area of study. See, for example, Escherich, "Foundation and Aims of Modern Pediatrics," p. 11: "No other period of life shows so large a number of sicknesses and deaths as the first year of life; during these years [sic], about a quarter of those born perish. . . . The cause of this unnatural fatality . . . is that the organs necessary for the support and protection of life processes are at this time so undeveloped that the slightest injury already suffices to produce an irreparable function and thus destruction of life."

[3]Samuel Karelitz, When Your Child is Ill. A Guide to Infectious Diseases in Childhood, 2d ed. (New York: Random House, 1968), p. 3.

to the untutored eye, the time for favorable treatment has passed. (Even today, when someone not previously immunized contracts the disease, chances of recovery drop from 99 to 75 percent if the antitoxin is not administered until the fifth day of illness.)[1] The virulence of diphtheria can cause death from asphyxiation, impairment of the heart, or nerve paralysis.

The discovery of the etiological cause of diphtheria in the 1880s, and the development and successful use of an antitoxin and immunization in the 1890s put bacteriology on a respectable footing and began the preventive health movement.[2] In 1895, the New York City Health Department appropriated $30,000 for the manufacture of diphtheria antitoxin and its distribution among the city's indigent population.[3] Once the antitoxin was provided, health authorities assumed they had conquered the disease. Researchers then discovered that the antitoxin

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[1]Ibid., p. 121.

[2]When the diphtheria bacteria invades the body it generates a poisonous toxin. If this substance is removed and injected into animals, they produce an antitoxin in their blood which, if extracted and innoculated in humans, has immunization powers. Emil Von Behring discovered the antitoxin. See William G. Rothstein, American Physicians in the Nineteenth Century. From Sects to Science (Baltimore: The Johns Hopkins University Press, 1972), p. 275.

[3]Ibid., p. 277; Charles V. Chapin, "History of State and Municipal Control of Disease," in Ravenel, ed., Half Century of Public Health, p. 153.

was not truly effective unless administered during infancy. Given to children over the age of nine months, it insured immunity for only two or three weeks. After that, the patient remained as susceptible to the disease as before.[1] In large measure, the prevention of diphtheria became a problem of pediatrics; it depended upon parents' willingness to allow their infants as well as school-aged children to be checked regularly and to receive preventive therapy. (Dr. Bela Schick's development of the skin test measuring individual immunity to diphtheria--the Schick test--aided control of the disease, and expanded the willingness of parents to allow their children to receive the antitoxin.)[2]

Despite the discoveries relating to diphtheria in the early part of the century, medicine did not vanquish the disease until the late 1920s, when the New York State Department of Health and voluntary organizations mobilized massive drives for immunization. During the decade, morbidity rates dropped steadily and increasingly. Between 1920 and 1924, the death rate from diphtheria in New York

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[1] Eradicate Diphtheria, An Intensive Five-Year Effort to Wipe Out Diphtheria in New York State by the End of 1930, through the Immunization of Children by Means of Toxin-Antitoxin (New York: State Charities Aid Association, 1926), pp. 7-8.

[2] Ibid., pp. 8-9; Harry Wain, A History of Preventive Medicine (Springfield, Ill.: Charles C. Thomas, 1970), p. 357.

City went from 18.4 per 100,000 to 11.9 per 100,000. This diminution coincided with the immunization of approximately 350,000 children in the same years.[1]

Notwithstanding these demonstrations of the successful prevention of diphtheria, the public failed to take universal advantage. Significantly, the slum child, and especially the infant, received the benefits of the revolution in preventive medicine through his exposure to the health centers. Until American mothers at large accepted pediatric supervision, it was principally the urban poor who took advantage of the medical achievements of the early part of the century--the prevention of infection through bacterial antigens, the control of diarrheal diseases, and the supplementation of artificial formulas with vitamins and carbohydrates.[2] In the early 1920s,

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[1]In 1924, in New York State (outside of New York City) there were still 5,885 reported cases of diphtheria, with 368 deaths. Over half the deaths were among children under five years. See Eradicate Diphtheria, pp. 3-4, 7, 18. In 1929, the death rate fell to 6.75 per 100,000 and the tide had been turned. See Duffy, History of Public Health, pp. 559-60. (In 1950, the death rate was 0.1).

[2]Pediatricians had greatest success among infants. School children received some medical supervision in the schools. During this period, preschoolers, between the ages of two and five, made up the bulk of neglected children. The Children's Bureau reported that while mothers might bring their infants to health centers, they were reluctant to attend medically to their older children. Part of the problem lay in convincing parents that normal children also required medical supervision. Another difficulty was that "older children are generally outgrowing

advice literature directed to a middle-class audience began to counsel the mother to see a children's doctor every week until the infant was three months old, and then every month until it reached a year's age.[1] Still, in 1928, the Quarterly Bulletin of the Medical Women's National Association reported that "the American mother is only just beginning to discover the existence of the pediatrist and the wide range of his powers."[2]

By 1915, New York City boasted the most extensive infant welfare work in the country, and its mortality figures were the lowest among large cities. In 1913, the infant mortality rate in Manchester, New Hampshire was 165, against 101.8 in New York City, "with all its congestion and large foreign element."[3] Between 1885 and

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the period when their food and their activities differ from those of the older members of the family, and as their expression of feeling . . . can be more easily understood than the infant's, the mother feels more confident in her ability to judge of their medical care." U.S., Department of Labor, Children's Bureau, Nutrition Work for Preschool Children, by Agnes K. Hanna, Bureau Publication No. 138 (Washington, D.C.: Government Printing Office, 1924), pp. 4, 8.

[1]Van Blarcom, Ready to Be a Mother, p. 160; Maternity Center Association, A Fair Chance for Your Baby and You. Twelve Helpful Talks (New York: MCA, 1922), p. 2; Mary L. Read, The Mothercraft Manual (Boston: Little, Brown and Co., 1921), p. 117.

[2]Quarterly Bulletin of the Medical Women's National Association (April 1928):10.

[3]U.S., Department of Labor, Children's Bureau, Infant Mortality, Results of a Field Study in Manchester,

1915, in spite of the population increase in New York City, efforts arguably saved 23,830 infant lives, since in these years the death rate among 1,000 living children under one year dropped from 273.6 to 94.6.[1] Systematic education concerning hygiene, sanitation and feeding paid dividends.

The most striking change in the first fifteen years of infant life-saving work was the decline of diarrheal diseases in children under five years. This followed largely from persistent educational work, as well as municipal intervention in private milk production. When Baker retired in 1923, after seeing fulfillment of her goal of working child bureaus in forty-eight states, she reflected that "changes in diet, plenty of fresh air, simple clothing, adequate bathing and regular schedules worked wonders."[2] Yet while the baby death rate fell to

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N.H. Based on Births in One Year, by Beatrice Sheets Duncan and Emma Duke, Bureau Publication No. 20 (Washington: Government Printing Office, 1917), p. 117.

[1]In 1920 the American Child Health Association published comparative infant mortality statistics for the nation's largest cities. St. Louis showed the lowest rate of 77 per 1,000 live births; New York was next with a rate of 85, followed by Philadelphia with 89, Boston with 101, Baltimore with 104, and Pittsburgh with 110. (Chicago's rates were not listed because the city failed to report all infant births.) See North, "Milk and Its Relation to Public Health," in Ravenel, ed., A Half Century of Public Health, p. 255.

[2]Baker, Fighting for Life, p. 124. When Baker resigned, the city's seventy baby health depots had

less than sixty-six per thousand births in New York City by 1923, certain causes of death resisted educational efforts. The mortality rates among babies dying in their first month of life remained practically static through the initial fifteen years of municipal infant welfare work in New York City.[1]

In the birth registration area of the United States in 1923, 105,000 babies died before they were a month old and an equal number were stillborn.[2] Education

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between thirty thousand and forty thousand babies registered. In 1922, the Bureau employed about six hundred people and had a budget of $989,328.

[1]The four major causes of infant mortality were contagious, diarrheal, respiratory, and congenital diseases. Between 1910 and 1919, the mortality rate from contagious diseases fell from 4.7 to 1.9; diarrheal infant deaths fell from 39.7 in 1910 to 15.9 in 1919; respiratory deaths declined from 27.1 in 1919 to 15.5 in 1919, but congenital diseases causing deaths in infants merely fell from 40.2 in 1910 to 37.2 in 1919 (all per 1,000). From Meyer, Infant Mortality in New York City, p. 131. Still, in 1940, prenatal and natal conditions caused 58 percent of all infant deaths (17 percent of infant deaths were caused by respiratory diseases, 9 percent by gastrointestinal illnesses, and 3 percent by epidemic and communicable diseases, with 13 percent attributed to diverse and unknown causes). See U.S., Department of Labor, Children's Bureau, Births, Infant Mortality, Maternal Mortality, 1940, Bureau Publication No. 228 (Washington, D.C.: Government Printing Office, 1943), p. 12A.

[2]Public Health Committee of the New York Academy of Medicine, The Hospital Situation in Greater New York, Report of a Survey of Hospitals in New York City, prepared by E. H. Lewinski-Corwin (New York: G. P. Putnam's Sons, 1924), p. 317; see also Lee K. Frankel, "The Present Status of Maternal and Infant Hygiene in the United States," American Journal of Public Health 27 (December 1927): 1211-12.

would not suffice. If any significant progress were to be made in these data, pregnant women would have to be approached medically.

CHAPTER VI

BETTER HEALTH FOR MOTHERS--A RELUCTANT DISCOVERY OF THE INFANT WELFARE MOVEMENT

> I nursed her. They feel that's important nowadays. I nursed all the children, but with her, with all the fierce rigidity of first motherhood, I did like the books then said. Though her cries battered me to trembling and my breasts ached with swollenness, I waited till the clock decreed.
>
> --Tillie Olsen
> I Stand Here Ironing

Until now, health workers saw the mother principally as the conduit to her children. Ironically, though, the agency created to deal with children had the greatest impact upon opening the infant welfare movement to issues of mothers' health. When the movement sought maternal well-being, it added a dimension which made government intrusion vital to further progress in public health.

After the White House Conference in 1909, it took three years of vigorous campaigning before Congress approved the creation of the federal Children's Bureau. In 1912, President Taft signed the bill creating the Bureau, with an initial appropriation of $25,640. The original legislation placed the Bureau in the Department of Commerce and Labor; in 1913 Congress transferred it to the new Department of Labor and today it is part of

the Department of Health, Education, and Welfare.[1] Congressional authorization designated the Bureau strictly as an investigative body. The Bureau's mission was not to perform child welfare services, but to report on all aspects of child life, with special attention to the

> . . . questions of infant mortality, birth rate, orphanages, juvenile courts, desertion, dangerous occupations, accidents and diseases of children, employment, legislation affecting children in the several states and territories.[2]

The Children's Bureau devoted its first projects and publications to stimulating the states to make accurate compilations of all births in the state. In 1915, after the government created a national birth registration area under the jurisdiction of the Bureau of Census (as noted previously, for which states qualified when they reported accurately on 90 percent of their births), the Census Bureau's first report revealed a registration area of only eight states.[3] The United

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[1]Josephine Goldmark, Impatient Crusader, Florence Kelley's Life Story (Chicago: University of Illinois Press, 1952), pp. 9-10; Walter I. Trattner, From Poor Law to Welfare State: A History of Social Welfare in America (New York: The Free Press, 1974), p. 183.

[2]Julia Lathrop, "The Children's Bureau," Proceedings of the National Conference of Charities and Correction at the 39th Annual Session held in Cleveland, Ohio. June 12-19th, 1912, pp. 30-31.

[3]In 1915, the registered states included the New England states, Pennsylvania and Michigan. See Goldmark, Florence Kelley's Life, p. 101; Robert S. Barrett, The

States lagged behind European countries, which generally maintained national records of births and deaths.[1]

On the premise that a total birth picture was fundamental to child welfare work--without birth statistics, infant mortality can not reliably be calculated--the Children's Bureau continued to propagandize for state registration action through the 1920s. The drive became an elemental part of the administration of the Sheppard-Towner Act of 1921. Still, in 1926 only 35 states, covering 76.8 percent of the nation's population, qualified for membership in the registration area.[2] Yet by 1929, largely by the persistent efforts of Sheppard-Towner workers hired through the Children's Bureau, all but four states lay within the area.[3]

The Bureau's researchers embarked first upon comprehensive, comparative studies of infant mortality in

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Care of the Unmarried Mother (Alexandria, Va.: by the Author, 1929), pp. 3-4.

[1]For example, in August 1907, Parliament passed the Notification of Births Act, requiring birth registration within 36 hours. See U.S., Department of Commerce and Labor, Children's Bureau, Birth Registration. An Aid in Protecting the Lives and Rights of Children. Necessity for Extending the Registration Area, Bureau Publication No. 1 (Washington, D.C.: Government Printing Office, 1913), p. 11.

[2]"The Significance of the Study of Infant Mortality in United States Cities in 1926," American Journal of Public Health 12 (September 1927):935.

[3]Barrett, Care of the Unmarried Mother, pp. 3-4.

selected American cities. Agents conducted research between 1911 and 1915, and surveyed eight communities.[1] Bureau agents--all women, since their work depended on successful contact with mothers--went into each district with standard schedule samples, from which they summarized the social, civic, sanitary, and industrial conditions of every community. Working with this outline, staff members then visited each home in which there had been a birth.[2]

Julia Lathrop, who served as the Children's Bureau's head until 1921, reversed the usual method of infant mortality compilation. Instead of studying death records, staff members began with birth certificates and

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[1]Workers first studied Johnstown, Pennsylvania, an iron and steel city. The sample group of babies was born in 1911 and 1912. They next chose Montclair, New Jersey, a suburban community, to see what contrasts, if any, existed between urban and suburban areas. The Children's Bureau staff then continued its work: they surveyed Manchester, New Hampshire, in which textiles were the principal industry, in 1912-1913. Saginaw, Michigan, chosen because it lay in the midst of rich agricultural lands, came under study between November 30, 1912 and November 30, 1913 to determine if mortality diminished where the foreign population was lower. New Bedford, Massachusetts, another textile city, was studied in 1913, together with Brockton, Massachusetts, a shoe factory city. Workers surveyed Akron, Ohio, where rubber was the principal industry, between June 30, 1913 and June 30, 1914, and Waterbury, Connecticut, between 1914 and 1915.

[2]Grace Abbott, Ten Years' Work for Children (Washington, D.C.: Government Printing Office, 1923), pp. 2-3; see also Goldmark, Florence Kelley's Life, p. 102.

followed each child through one calendar year subsequent to birth, or through whatever part of that year in which he lived. Statisticians' ordinary procedures compared all births in one year to all infant deaths occurring in that same year. At best this approximated the actual situation, since children born in one year might die in the next before reaching a year's age, and some babies dying were undoubtedly born in different areas.[1]

Bureau workers did not visit the child's home until a year after his birth. At that point, whether the child was alive or dead, agents would request an interview with the mother, collecting data concerning every aspect of the child's life, the feeding methods and hygienic surroundings, the home conditions, the neighborhood, the previous or current employment of the mother, and the earnings of the father. Although each of the cities studied varied, with different population and industrial bases, the basic causes of infant mortality remained persistently identical.

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[1]U.S., Dept. of Labor, Children's Bureau, Infant Mortality. Results of a Field Study of Johnstown, Pa., Based on Births in One Calendar Year, by Emma Duke, Bureau Publication No. 9 (Washington, D.C.: Government Printing Office, 1915), p. 11; U.S., Dept. of Labor, Children's Bureau, Infant Mortality. Montclair, N.J. A Study of Infant Mortality in a Suburban Community, Bureau Publication No. 11 (Washington, D.C.: Government Printing Office, 1915), p. 8.

The studies corroborated speculation that the midwife as birth attendant was less a custom and more an economic necessity. While the uniform finding was that native mothers usually employed physicians at birth, while foreign-born mothers used midwives, analysis demonstrated that the more prosperous foreign mothers departed from tradition and turned to doctors for childbirth. Poor American-born mothers, on the other hand, relied on midwives.[1] Yet the research in no way implicated the midwife as a cause of the heavy infant death toll. Even where few mothers employed the midwife, as in Saginaw, Michigan, the mortality pattern remained the same as in eastern industrial centers.[2]

In each city surveyed, the infant mortality rate stood consistently and markedly higher among the immigrant population than it was for children of native mothers.

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[1]Children's Bureau, Infant Mortality. Johnstown, Pa., p. 32. See also U.S., Department of Labor, Children's Bureau, Infant Mortality. Results of a Field Study in Waterbury, Connecticut Based on Births in One Year, by Elizabeth Hunter, Bureau Publication No. 29 (Washington, D.C.: Government Printing Office, 1918), p. 99.

[2]U.S., Department of Labor, Children's Bureau, Infant Mortality, Results of a Field Study in Saginaw, Michigan. Based on Births in One Year, by Nila F. Allen, Bureau Publication No. 52 (Washington, D.C.: Government Printing Office, 1919), p. 18. In Saginaw, 91.6 percent of the births were attended by physicians and 9.5 percent by midwives; 1.9 percent of the women had no birth attendants.

Although Saginaw had a relatively small foreign representation among its population--35.7 percent of the births involved German-born mothers--infant mortality was highest in this group. While less than one-fourth of the births were to immigrant mothers, three-eighths of the deaths fell among infants of this group. Results showed the infant mortality rate for the native births at 70.5 per 1,000 live births, contrasted to the rate of 127.6 for infants born to foreign-born mothers.[1]

In New Bedford, Massachusetts, the study examined 2,587 live births. While general infant mortality for the group as a whole was 130.3, foreign and native rates of 138.9 and 108.4, respectively prevailed.[2] Disparities continued even among foreign groups. In Manchester, New Hampshire, for instance, the native infant mortality was 128.1 per 1,000 live births, while the foreign rate rose to 183.5. But French-Canadians suffered a higher rate--

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[1]Children's Bureau, Infant Mortality, Saginaw, Michigan, pp. 21, 34, 61.

[2]U.S., Department of Labor, Children's Bureau, Infant Mortality, Results of a Field Study in New Bedford, Massachusetts. Based on the Births in One Year, by Jassamine S. Whitney, Bureau Publication No. 68 (Washington, D.C.: Government Printing Office, 1920), p. 66; U.S., Department of Labor, Children's Bureau, Infant Mortality. Results of a Field Study in Akron, Ohio. Based on Births in One Year, by Theresa S. Haley, Bureau Publication No. 72 (Washington, D.C.: Government Printing Office, 1920), p. 67. The foreign infant mortality rate in Akron was 109 per 1,000 live births, with the native rate 70.

224.7--than the Polish rate of 189. And the infant mortality rate among babies of English, Irish and Scottish mothers dropped as low as 66.[1] In Waterbury, Connecticut, the component nationality groups showed infant mortality rates of 207.7 for Lithuanians, 184.6 for Irish, and 109.9 for Italians, all against 97.9 for natives.[2] Analysts saw that the group's place in the specific socio-economic geography of the city, rather than the particular ethnicity, was the responsible agent for high rates.

Again, mortality contrasts followed differentials in sanitary conditions. Johnstown had only 41 miles of sewers and 36 outlets for 135 miles of streets and alleys. In homes in which the water had to be pumped from outside wells, infant mortality was 198 per 1,000, compared to a rate of 118 per 1,000 in houses where water was piped in.[3]

The findings concerning black infant mortality were more important than the revelations contrasting immigrant and native death rates, if only because in the early part of the twentieth century the plight of the immigrant poor received serious attention while child welfare discussions almost never mentioned blacks. In

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[1]Children's Bureau, Infant Mortality, Manchester, N. H., p. 56.

[2]Children's Bureau, Infant Mortality, Waterbury, Conn., p. 98.

[3]Children's Bureau, Infant Mortality, Johnstown, p. 8.

studying the five wards of Montclair, bureau agents discovered that the black district, or fourth ward, suffered a rate almost twice as high as the rest of the jurisdiction (130.4 compared to 84.6 for the town as a whole in 1912). While native babies died at the rate of 49 per 1,000 live births and the rate for infants of foreign-born mothers was 88.1, mothers lost black babies at the rate of 151.5.[1] Black mortality compared unfavorably to every group. Yet until the Sheppard-Towner Act became law and federal agents organized child welfare agencies

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[1]Children's Bureau, Infant Mortality, Montclair, pp. 13, 16. The New York Association for Improving the Condition of the Poor was unique in its attention to the black community. In 1916, the Association conducted an infant welfare demonstration in a black district and in the 1920s it did prenatal work among black women. The Association's discoveries were similar to every other group which bothered to work among blacks: mortality, no matter the measurement, was two times as great among blacks. For example, in 1916, the death rate for infants under one month for all of New York City was 37.2 per 1,000 births; the same rate for black infants was 75.2. See John C. Gebbart, "Filling in the Gaps of the Child Life," The Survey 43 (December 27, 1919):313; see Health Work for Mothers and Children in a Colored Community, Publication No. 131 (New York: AICP, 1924). In 1927, the mortality rate for white infants stood at 61; for black babies it was 100. In Alabama the white-black rate was 55 compared to 82; in Illinois, 62 against 105; in Maryland, 68 to 134; in New Jersey, 58 compared to 113; in New York, 57 against 109; and in the District of Columbia, 49 compared to 109. See U.S., Department of Labor, Children's Bureau, The Promotion of the Welfare and Hygiene of Maternity and Infancy. The Administration of the Act of Congress of November 23, 1921, for the fiscal Year Ended June 30, 1928, Bureau Publication No. 194 (Washington, D.C.: Government Printing Office, 1929), pp. 174-75.

in the South, attention to and work with the black population proved a major gap and flaw in the entire child welfare movement.

The coincidence of high infant mortality and mothers' employment represents one of the most important findings of these studies. This result directly contradicted the conclusions of the earlier government study of Fall River. The employment of women after the birth of their children posed obvious difficulties, through deprivation of maternal care and the necessity for artificial feeding, but up until this point researchers had not quantified the risks or the result. In New Bedford, mortality among infants whose mothers were gainfully employed during their lifetime rose to one and a half times the average. In Manchester, mortality stood at 277 for infants whose mothers worked after giving birth, as against 156 for infants whose mothers stayed home.[1]

At the same time, Children's Bureau agents confirmed what social workers were discovering; the pin money

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[1]Children's Bureau, Infant Mortality, New Bedford, pp. 67-68; Children's Bureau, Infant Mortality, Manchester, p. 53. In Manchester, 119 new mothers returned to work before the babies were four months old. Among their infants, 33 died before reaching a year, for a death rate of 27 percent. Among the remaining 1,445 infants, there were 225 deaths, or only 15 percent. This breakdown is also typical for Montclair. See Children's Bureau, Infant Mortality, Montclair, p. 21.

saga was purely myth. Women worked not to save for a dress or to regain the economic independence they enjoyed before marriage, but because their husbands did not earn enough to support the family. In Manchester, in families in which the husbands earned less than $450.00 a year, 73 percent of the mothers found outside employment some time during the first year of the baby's life.[1]

Bureau agents made yet another connection between the employment of women--now before birth--and high infant mortality rates. The first phase of the infant life saving movement had concentrated attention where deaths were most painfully obvious. To stem the thousands of infant deaths which struck each summer, infant welfare workers initially attacked gastrointestinal diseases. Yet by 1915, deaths in the first month of life became the highest area of infant mortality. Prematurity, congenital weakness, and birth injuries made up the primary causes of infant deaths.[2]

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[1]Children's Bureau, Infant Mortality, Manchester, p. 47.

[2]In Manchester, 17.8 percent of all infant deaths occurred in the first week of life, 28 percent in the first month, and 47 percent in the first three months. Ibid., p. 21. In Saginaw, there were 83 deaths among 981 live born infants, yielding a mortality rate of 84.6 per 1,000. Of the 83 deaths, 71 percent occurred in the first three months. See Children's Bureau, Infant Mortality, Saginaw, p. 14. In New York City in 1919, congenital diseases rated first among baby-killers, with

These conditions were prenatal and natal. They had nothing to do with postpartum care, events, or knowledge level of the mother, but related instead to the mother's condition before birth, to her ability to purchase medical care during pregnancy, and to her willingness to receive it. A baby's ability to survive depended in large measure on his mother--on what she ate, on how much she slept, on how much leisure she enjoyed, and on her freedom from heavy industrial employment and her ability to rest at least a few weeks before the birth. In all the cities, researchers found that where mothers worked before birth, the infants suffered greater mortality. In New Bedford, the mortality of infants with mothers who worked before delivery was 154.5, against a rate of 108.8 for infants whose mothers did not work.[1] In Manchester, the breakdown between infants of working and non-working mothers revealed respective mortality rates of 312.9 and 122.[2]

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respiratory ailments next and diarrheal disorders third. See Jacob Sobel, Instruction and Supervision of Expectant Mothers in New York City (New York: Department of Health, Monograph No. 21, 1919), p. 4.

[1]Children's Bureau, Infant Mortality, New Bedford, pp. 67-68.

[2]Children's Bureau, Infant Mortality, Manchester; U.S., Department of Labor, Children's Bureau, Save The Youngest. Seven Charts on Maternal and Infant Mortality, with explanatory comment. Bureau Publication No. 61 (Washington, D.C.: Government Printing Office, 1919), p. 14. In Akron, for mothers who worked during pregnancy,

Each study ultimately focused on one issue, the common element in all. That was the matter of poverty. While the conclusions today appears abecedarian and utterly logical, the implications of the accumulated findings that mortality and poverty were distinctly related opened new avenues to health reformers and directly challenged the existing medical and social structure. The Children's Bureau's samples showed conclusively that it was far more dangerous to be born into a home which could not afford basic medical, nutritional, and sanitary safeguards. Scientists had provided the technology to secure healthy life, but planners had not worked out an equitable system of distribution.

In every city, researchers produced evidence illustrating the greater hazards to babies born in homes of unskilled workers. As fathers' earnings increased, infant death rates dropped. In New Bedford, one-fifth of the fathers earned less than $450.00 a year with an infant mortality rate of 201.9, compared to 59.9 for infants with fathers earning $1,250.00 or more.[1] Applying the figures $450 and $1,250 consistently as the bottom

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their infants died at a rate of 107.4 compared to a rate of 77.2 for babies whose mothers did not work. See Children's Bureau, Infant Mortality, Akron, p. 68.

[1]Children's Bureau, Infant Mortality, New Bedford, p. 67.

and top income levels, high mortality in each city coincided with low income. In Saginaw, the rates ranged from difference 179.5 for the lowest earning group to 22.2 for the highest. In Waterbury, for the occupational group earning under $450.00, infant mortality stood at 153; the rate did not fall below 100 until income exceeded $850.00. In Manchester, the poorest infants' death rate quadrupled that in the homes of families in the highest income bracket.

Simultaneous research projects in various rural districts demolished any lingering vision of an idyllic pastoral setting in the United States. Cities were overwhelmingly healthier than the countryside. Studies showed infant mortality greater in rural areas than in cities, with similar results for lung and heart disease, nutritional deficiencies, and health defects (the most common of which was rotten teeth).[1] Rural children suffered five times more ear trouble than did urban children, as well as four times as many eye maladies, three times the adenoid problems, and four times more tonsil difficulties.[2]

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[1]U.S., Department of Labor, Children's Bureau, The Child-Welfare Special. A Suggested Method of Reaching Rural Communities, Bureau Publication No. 69 (Washington, D.C.: Government Printing Office, 1920), pp. 5-8, 13.

[2]Frances S. Bradley, "Suggestions for the Teaching of Child Hygiene," Proceedings of the National Conference of Charities and Correction, 41st Annual Session

Backers of the Sheppard-Towner Act of 1921, which Lathrop originally proposed in 1917, intended the legislation primarily to service rural women without access to medical personnel, clinics, and hospitals.

The Children's Bureau studies had profound impact on the infant welfare movement. They redirected the focus of the movement to women and to economic condition, and called attention to European social legislation. The reports gave impetus to the movement for widows' and mothers' pensions. They provided ammunition for those advocating national health insurance, and they forced health workers to take a new look at pregnant women, paving the way for comprehensive studies of maternal mortality as well as the movement for prenatal care and maternity insurance.

The statistical portrait which emerged from the studies increased national concern. Americans found the unfavorable infant mortality standing of the United States, as compared to Europe, particularly alarming. Nations which Americans rather chauvinistically considered less civilized had lower mortality rates. In 1910, infant mortality in the birth registration area of the United

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held in Memphis, Tennessee, May 8-15, 1914, p. 154. Lathrop appointed Dr. Bradley as special agent servicing rural districts.

States, which comprised 58.3 percent of the population and 33.6 percent of the land area, was 124 per 1,000 live births, or one in eight.[1] In 1911, New Zealand's rate was 76 per 1,000 with Norway's at 86, while the approximate figure for the United States' registered and unregistered areas stood at 165 per 1,000.[2] In 1917, the United States placed eighth among eleven nations. New Zealand had the world's lowest infant mortality rate of 48, with Australia next with 56, followed by Norway with 68, Sweden with 70, Switzerland with 78, Holland with 85, Ireland with 88, the United States with 94, Denmark with 95, England and Wales with 96, and Scotland with 107.[3] America's maternal mortality showing was even worse.[4]

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[1]Children's Bureau, Infant Mortality, Manchester, p. 5.

[2]"Saving Babies," The Survey 26 (September 2, 1911):769.

[3]These rates are based on 1,000 live births. See Children's Bureau, Save the Youngest, p. 5. In 1926 the infant mortality of these nations showed the United States with 73, New Zealand with 40, Australia with 54, Norway with 46, Sweden with 55, Switzerland with 57, Denmark with 84, England and Wales with 70, and Scotland with 83. In U.S., Department of Labor, Children's Bureau, The Promotion of the Welfare and Hygiene of Maternity and Infancy, for the Fiscal Year Ended June 30, 1928, Bureau Publication No. 194 (Washington, D.C.: Government Printing Office, 1929), p. 176.

[4]Save the Youngest, p. 3. In 1916, 16,000 American women died from causes relating to pregnancy and childbirth. Proportionally, more women died from this cause than in any other developed nation in the world besides Spain and Switzerland.

Again, largely from the work of the first Children's Bureau's studies, infant welfare workers recognized that mothers must be dealt with independently, and not always seen as agents aiding others through newly acquired instruction.

Deaths attributed to diarrheal and nutritional ailments, as well as to respiratory and contagious diseases, showed marked reduction by 1915.[1] Yet the stillbirth rate and infant deaths in the first four weeks of life resisted organized effort. These data drew public health workers' attention to mothers.

Reformers discovered the mother through her infant. The genesis of prenatal care lay in efforts to protect the infant, rather than the mother. Workers recognized that unless they gave attention and care to the mother before and during pregnancy, infant welfare efforts had reached a dead end. Indeed, this conclusion followed simple arithmetic. Among infants who were

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[1]In New York City between 1885 and 1915, death rates from diarrheal diseases fell 75 percent, respiratory disease mortality dropped 53 percent, and contagious disease deaths declined by 88 percent. Yet the death rate from congenital maladies dropped only 1.5 percent in the same period. New York City witnessed a drop in the general infant death rate from 111 to 100 and then to 93 in the years 1911, 1912 and 1913. While the death rate from two to twelve months fell from 72 to 63 and 56 in those years, the death rate under one month of age declined from 39.24 to 37.69 and 37.22, respectively. See Sobel, Instruction and Supervision of Expectant Mothers in New York City, pp. 3-4.

destined to die in their first year, one-third were born dead and another third died in their first month; hence a milk station, no matter what kind of medical care it provided, could ideally reach but a third of the doomed babies.[1]

In 1925, the Children's Bureau estimated conservatively that stillbirths in the United States annually numbered 100,000.[2] In New York State, authorities listed children born without breathing, or showing no signs of life, as stillbirths. With the exception of syphilis, the causes of stillbirths were virtually the same as those which led to death in the first month of life. The solution thus lay in the control of congenital diseases and debility, including prematurity, marasmus (a condition of progressive emaciation, prevalent mostly in young children whose bodies waste away), convulsions, and accidents at birth.

In New York City, congenital diseases caused 41 percent of all deaths of infants under a year, and between 80 and 90 percent of deaths in the first month.

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[1]"Pulling Out," The Survey 43 (November 22, 1919): 139.

[2]U.S., Department of Labor, Children's Bureau, Maternal Mortality. The Risk of Death in Childbirth and from all Diseases Caused by Pregnancy and Confinement, by Robert M. Woodbury, Bureau Publication No. 158 (Washington, D.C.: Government Printing Office, 1926), p. 1.

Thirty-seven percent of the first-year deaths caused by congenital diseases occurred in the first month alone; among them, 27 percent of the deaths occurred in the first ten days of life.[1] The physical condition of the mother during pregnancy and the circumstances of her delivery became crucial elements in further progress.

The realization that the health of women had powerful influence on fetal and post-uterine life led to the creation of prenatal clinics. Maternal health was not the driving force in the first efforts of pregnancy supervision:

> . . . systematic prenatal work, undertaken as a recognizable means of combatting infant mortality and of improving the health of the succeeding generation, is a distinctly new idea.[2]

Yet the realization that infant health depended upon maternal health redirected the focus of the public health movement. Infant welfare broadened to the new field of maternal welfare which would review the incidence of unnecessary childbirth death and call to question the

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[1]Ibid., pp. 2-4. In 1921 in the United States birth registration area, 44.5 percent of all infant deaths occurred in the first month of life. See Children's Bureau, Maternal Mortality, p. 1.

[2]Mrs. Max West, "The Development of Prenatal Care in the United States," American Association for the Study and Prevention of Infant Mortality. Transactions of the Fifth Annual Meeting, November 12-14, 1914, Boston, Massachusetts, p. 70; see also Arthur Newsholme, If I were Unborn (New York: State Charities Aid Association, 1925), p. 1.

current standards in obstetrics, the system of medical distribution in the United States, and the unique hardships of mothers, especially those who held full-time employment.

The early work with mothers, derived from nineteenth century fresh-air work, was a convalescent care, directed at worn-out tenement mothers with sick infants or young children. The idea that a day trip, or even a fortnight's vacation, would bring physical and spiritual restoration to poor women combined attitudes of good-hearted naiveté and complacency. In 1899, Charities magazine abounded with articles describing the magnificence of fresh-air work. "So much is being done," one editorial read,

> that no one in distress or ill-health should feel that there is no place for her, no chance for the recovery that a few days or weeks in bracing air would bring about. It is a beautiful thing to think of the way money is being poured out to benefit, by means of health-restoring nature, the most helpless class of society--women and children --and all in the broad spirit of philanthropy.[1]

Beside the Tribune and Children's Aid Society's fresh-air camps for older children, other agencies sponsored seaside resorts for shorter summer excursions. The St. John's Guild, organized in 1866, maintained a Floating Hospital for sick babies which docked in New

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[1]"Summer Outings for Poor Women & Children," Charities 3 (July 22, 1899):2-3.

York harbor in summer months. Two boats left every day, with mothers and babies selected by physicians working for various charity organizations. The children received medical attention; the mothers heard instruction.[1] The Edgewater Creche, which began operation in 1885, gave rest to the harried factory-working mother who could not leave the city for any length of time. Across the Hudson River in New Jersey, opposite West 130th Street, it allowed half-day trips for women who left work at noon on Saturday.[2]

The New York Association for Improving the Condition of the Poor maintained Sea Breeze, a summer resort in West Coney Island for "sick babies, and exhausted, feeble mothers."[3] With 272 beds and a 20-week season, the Association had to sift through more than 6,000 applications to select women and infants for a 10-day stay.[4] The process required that trained visitors be sent

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[1]Ibid.; Welsh, History of Medicine, 5 vols., 3:838. The Guild also had a permanent hospital in Staten Island where sick children, together with their mothers, could stay until the child's recovery.

[2]"News," Charities 5 (June 16, 1900):9,10; "Summer Outings," Charities, pp. 2-3. Tickets for the ferry were free, as were refreshments.

[3]New York AICP, Fresh Air Work (New York: AICP, 1904), p. 9.

[4]Sixty-second Annual Report of the New York Association to Improve the Condition of the Poor for the

to the homes to judge the neediest and most worthy. For those who failed to qualify for a long stay--in 1903, 2,754 were accepted--the Association ran day excursions as well.[1] Charities reported that in the summer of 1899, some 89,701 persons had been treated to week vacations by philanthropic groups, while another 89,651 participated in day trips "away from the hot walls and walks of the city, which man built, to the fresh air which God made."[2]

As was the case with the infant welfare movement, initial efforts to provide care to pregnant women came from private sources. In New York City, the AICP was the first organization to make separate provisions for the expectant and postpartum mother. On March 18, 1907, the Association opened Caroline Rest, a convalescent home for mothers, in Hartsdale, New York. The facility took women, upon the recommendation of maternity hospitals or charities, who could not withstand normal activities immediately after birth. The following year, the Association established a prenatal service, sending nurses into tenement districts to seek out and aid expectant

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Fiscal Year Ending September 30, 1905, p. 48; AICP, Fresh Air Work, p. 1.

[1]AICP, Fresh Air Work, pp. 1, 6-7; Sixty-third Annual Report of the New York AICP for the Fiscal Year Ending September 30, 1906, pp. 54, 58.

[2]"The Fresh Air Work of 1899," Charities 3 (October 14, 1899):4.

mothers.[1]

The establishment of the first nurses' training school in the country in 1873, after the women of the Local Visiting Committee of Bellevue and Allied Hospitals refused to bury findings of their investigation into the conditions at Bellevue, created a figure who played an indispensable role in the public health endeavor. The public health nurse became a crucial component of the movement to make medicine a preventive science.

In New York, credit for centralizing the position of the nurse belongs to Lillian Wald. Wald, who graduated from the Nurses' Training School of the New York Hospital in 1891, immediately entered a program for medical training at the Women's Medical College, but her intentions of becoming a physician were shortlived. After teaching a nursing course in the Lower East Side and witnessing life there, she decided that the area needed nurses living among the people, rather than doctors who would be sent for in emergencies.[2] She saw the need for nurses who

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[1]Seventh Annual Report of the New York Milk Committee for the Year Ending December 31, 1913, p. 46; Sixty-fourth Annual Report of the New York AICP for the Fiscal Year Ending September 30, 1907, p. 38.

[2]Lillian D. Wald, Windows on Henry Street (Boston: Little, Brown and Co., 1934), p. 72. In 1909, there were 1,413 public health nurses in the country. By 1931, there were 15,865.

would not merely attend the sick, but who would become the spokesmen of the inarticulate poor; who would understand the social environment affecting the health of the tenement population; and who would necessarily become involved in issues of child labor, education, home industry, and sanitation.[1]

In 1893, Wald and a colleague, Mary Brewster, rented a tenement flat and founded the Nurses' Settlement. The philanthropist Jacob Schiff, who supported Wald's plan for home nursing from the beginning, bought a house on Henry Street, to which Wald and Brewster moved in 1895. Although the house provided many features of a settlement, visiting nursing remained the primary function. From the start, maternity care played a central part in the nurses' activities.[2]

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[1]Edna Yost, American Women of Nursing (New York: J. B. Lippincott, 1947), pp. 24, 26-27, 33. See also Edward T. James, ed., Notable American Women. A Biographical Dictionary (Cambridge, Mass.: Harvard University Press, Belknap Press, 1971), pp. 526-29.

[2]Lavinia L. Dock, "The History of Public Health Nursing," in Ravenel, ed., Half Century of Public Health, p. 441; Lillian Wald, Report of the Henry Street Settlement, 1893-1913, p. 14, from the files of the Visiting Nurse Service of New York, 107 East 70th Street, New York, N. Y.; Wald, Transactions of the Third International Congress of Nurses, Pan-American Exposition, Buffalo, September 18-21, 1901, pp. 2, 5, from the files of the Visiting Nurse Service, New York. In 1906, the Nurses Settlement was reincorporated as the Henry Street Settlement; in 1944, the nursing service left the Settlement and became known as the Visiting Nurse Service.

The import of Wald's innovation appreciates when one recalls that Americans, particularly the immigrant poor, carried with them a deep-seated prejudice against hospitals. Hospitals brought associations--not terribly exaggerated--of impersonality, filth and lonely death.

Until Wald's venture, only patients attending dispensaries had access to visiting nurses. Wald's estimate that 90 percent of the sick in the cities throughout the country refused hospital treatment and remained at home--later confirmed, at least with respect to New York City, by an investigation of the Committee of Inquiry into the Department of Health, Charities and Bellevue and Allied Hospitals in 1913-1914[1]--guaranteed that her experiment would show immediate success; it did.[2] Because immigrant women tended to avoid hospitals, they required home attendance in childbirth. Poverty, especially when combined with a dread of hospital confinement, exacerbated enormously the difficulty posed by any absence from

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[1]Wald, Report of the Henry Street Settlement, 1893-1913, p. 14; Wald, House on Henry Street, p. 28.

[2]In 1913, the Settlement nurses treated 22,168 patients, accounting for approximately 200,000 nurses' visits. This may be compared to the combined yearly total of 21,120 patients admitted to Mt. Sinai, Presbyterian, and New York Hospitals. See Report of the Henry Street Settlement, 1893-1917, p. 16. In 1928 and 1929, the service made 778,772 visits to homes. See Report for the Years 1928 and 1929 of the Visiting Nurse Service from the Wald file at the Visiting Nurse Service.

the home. Wald was ready with sympathetic accommodations to social reality:

> Though the hospital can certainly do better than the very best we could do, yet there are occasions when it is the mother whose presence protects and keeps the family, so then we do not urge it.[1]

Wald made maternity care a basic provision of the service. The program divided nurses into three categories, and while general nurses attended normal illness and another group treated patients suffering from contagious diseases, there was a separate obstetrical division. Yet Wald's salutory efforts were limited in effect. While it certainly sought to aid patients, the service had no demonstration component, whereby results could immediately be extrapolated into projected progress for broader populations.

Between August 1911 and November 1913, the New York Milk Committee conducted the State's first controlled demonstration of the value of prenatal care work. Two years earlier, the Women's Municipal League in Boston studied the results of supervised pregnancies of women scheduled for confinement at the Boston Lying-In Hospital.[2] The success of the program spurred similar

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[1]Letter, Lillian Wald to Jacob Schiff, 2 October 1892, Lillian Wald Papers, Box 2, New York Public Library.

[2]In five years, the League provided prenatal nursing to 1,512 women. The infant death rate, as well

efforts in New York.

The Milk Committee's test standards involved infant longevity, stillbirth and miscarriage rates, infant death rates under one month of age, and the number of infants who were subsequently breast fed. The Committee's medical staff managed the pregnancies of 2,644 women in various districts of Manhattan from the sixth month of gestation through the first month of infant life.[1] The work provided convincing proof that prenatal care was a necessary ingredient in infant life-saving work--the stillbirth rate for the project was 16 percent lower than the Manhattan average, and the death rate of infants under a month was 30 percent below the norm.[2] When the Health Department took over the Committee's milk stations, it also incorporated prenatal supervision in a select number of municipal milk depots.

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as the stillbirth rate, dropped to half among this group. See Arthus B. Emmons, 2nd., "The Resources for Giving Prenatal Care," American Association for the Study and Prevention of Infant Mortality. Transactions of the Fifth Annual Meeting, November 12-14, 1914, Boston, Mass., pp. 53-54; see also Lloyd C. Taylor, The Medical Profession and Social Reform, 1885-1945 (New York: St. Martin's Press, 1974), p. 104.

[1]West, "The Development of Prenatal Care in the United States," p. 97; New York Milk Committee, Sixth Annual Report, 1912, pp. 36, 38.

[2]New York Milk Committee, Ten Years of Work, pp. 14-15.

The Bureau of Child Hygiene oversaw the Health Department's work with pregnant mothers. The Bureau operated through seven divisions, with prenatal work falling under baby welfare activities. Since no special funds were allocated for prenatal work, the Bureau reorganized its nursing staff, creating eight positions for obstetrical nurses who worked with the city's fifty-nine milk stations. With approximately 137,000 annual births in New York City, the city's prenatal supervision could perforce be no more than a gesture. At best it provided an outline, an attempt to demonstrate the efficacy of such work and to prompt appropriate efforts by private agencies. Through this experimental period, preservation of the infant's life remained the primary goal.

The Bureau of Child Hygiene's obstetrical nurses canvassed poor neighborhoods for pregnant women and urged them to visit milk stations, and encouraged doctors, midwives, and hospitals to refer poor women for prenatal observation. After a woman agreed to use the program's services, nurses visited her home every three weeks through the fifth month of term in normal cases, and then every ten days until delivery. If the patient showed any signs of complications, nurses visited as often as

necessary.[1] The program continued to emphasize instruction of the mother on the proper care of the child after birth, stressing the importance of breast feeding. When possible, though not at the risk of alienating reluctant women, nurses encouraged them to accept medical aid for confinement, rather than the midwife.[2] Nurses arranged convalescent care for weak postpartum women through the Babies Welfare Association. For the mother who agreed to hospital delivery, nurses found temporary shelter for older children until she returned.[3]

Between 1914 and 1916, city nurses supervised 5,426 women through pregnancy.[4] What the city provided, however, scarcely scratched the surface of need. "If we presume," wrote Jacob Sobel, chief of the Division of Baby Welfare of the Bureau of Child Hygiene,

> that practically all the mothers delivered by midwives--46,487 in 1916--should receive prenatal care, and add to this a goodly proportion of those delivered in institutions, and by physicians

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[1]Sobel, Instruction and Supervision of Expectant Mothers, pp. 6, 8, 12, 24.

[2]Although the number of women in the program increased from 900 in 1914 to 1,853 in 1916, the percentage using midwives declined from 64 percent in 1914 to 52 percent in 1916. See Sobel, Instruction and Supervision, pp. 13, 15.

[3]Ibid., p. 11.

[4]Ibid., p. 16.

> in private practice, it will be no exaggeration to say that 75,000 mothers annually stand in need of such service.[1]

The results of the program replicated other experiments in prenatal care. Infant mortality in the first month diminished each year, comparing favorably to rates in the city at large. Premature and stillbirth rates followed a similar pattern.[2] Aside from the reduction of infant mortality, especially from congenital disease, health officials counted other benefits, such as better supervision of midwives resulting from contact with nurses, the development of more intelligent motherhood, and more confident mothers who would immeidately seek the prophylactic shelter of baby health centers.[3]

Among the many advantages which accrued from intensive prenatal work, Sobel noted the reduction in the

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[1] Ibid., p. 15.

[2] Ibid., p. 14. Of the 1,622 women supervised in 1914, 898 continued through the delivery of their children, resulting in 869 live born infants. Among this group, there were 17 deaths in the first month of life, a rate of 19.5 per 1,000 live births compared to the city rate of 36.6. In 1915, 1,442 women delivered 1,385 living children. Infant deaths in the first month numbered 37, a rate of 2.6 percent. The infant death rate in the first month in the city at large was 35.9. The data for 1916 showed 1,746 live births in a total of 1,841 deliveries, with 24 deaths in the first month, yielding a rate of 13.7 against a city rate of 36.7. Among the control group, the premature death rate dropped from 11.1 per 1,000 in 1914 to 8.1 in 1916. See Sobel, Instruction and Supervision, pp. 13-15.

[3] Ibid., p. 16.

number of maternal deaths and birth injuries. He recognized that as the diminution in still- and premature births increased the number of living children, it also "indirectly [improved] the general health of the mothers."[1] This admission is significant, since it hints at the refocusing of prenatal care to the mother.

Yet the shift would not be developed fully until new agencies entered the public health movement. Indeed, through 1918 only four organizations in New York City, the Department of Health, the Henry Street Visiting Nurse Service, the AICP, and the New York Diet Kitchen, provided prenatal nursing services.[2] The findings of the Children's Bureau's studies of infant mortality, depicting a motherhood operating on a different reality than the rhetorical recitations of maternity manuals, influenced the redirection. Public health leaders became aware of the significance of prenatal care as preventive medicine for obstetrics.

The bifurcation of the infant welfare movement to include the mother began in New York in 1915. Enough evidence had accumulated to suggest that mothers died needlessly in childbirth, or remained permanently injured

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[1] Ibid.

[2] Log, 1915-1963, of the Maternity Center Association (New York: Maternity Center Association, 1964), p. 4.

after birth. In the winter of 1915, Dr. Haven Emerson, the Commissioner of Health, appointed a committee of three public health leaders, Drs. J. Clifton Edgar, Philip Van Ingen, and Ralph W. Lobenstine, to study existing obstetric services in Manhattan and recommend change.[1]

The survey of obstetrical facilities in Manhattan found chaos in maternity care and distribution. Certain districts totally lacked facilities, while others contained institutions duplicating work without coordination. Women who were to deliver in a hospital typically reserved space at the beginning of their pregnancies, and did not return until labor had begun. With approximately 35 percent of the women delivered in hospitals, 30 percent by midwives, 10 percent by private physicians with obstetric experience, and another 25 percent by general practitioners, it was difficult to achieve uniformity in prenatal and obstetrical standards. Needless to say, the committee discovered few obstetrical patients who received any prenatal care.[2]

The fact-finding committee attacked the problem of more equitable distribution of services and suggested that Manhattan be organized into hospital zones. In its

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[1]Ibid., p. 1.

[2]Ibid., pp. 1-2. See also Fifty Years of Health for New York's Mothers and Babies, p. 16.

final report, the committee proposed the division of the borough into ten obstetrical zones, outlining where resident expectant mothers might seek complete--prenatal, delivery and postpartum--care. Hospitals would be urged to accept only maternity patients living within their respective districts, on the theory that prenatal oversight might be frequent or regular if patients came from the immediate area. As a second potential advantage of the plan, permitting residents to stay in the comfortable familiarity of their own areas for medical aid and confinement might encourage hospital use. The group also urged that a maternity center be located in each zone, to function as the coordinating agency for maternity services in the area as well as a prenatal clinic for women who expected to be delivered by midwives.[1]

When the committee disbanded in 1917, it proposed a new voluntary agency to promote quality obstetrical care in the city. In 1918, after the Women's City Club and the New York Milk Committee created three district maternity centers, the several physicians and women formed the Maternity Center Association to continue in the establishment of similar centers throughout the borough.[2]

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[1] Log, Maternity Center, p. 2; Children's Bureau Standards of Child Welfare, p. 183.

[2] Log, Maternity Center, p. 2. The founders were Mrs. J. S. Rogers, Dr. Lobenstine, Dr. Edgar, Mrs. J.

Its founders intended the Maternity Center Association, incorporated in 1919, to be a national, nonprofit health agency. At the time, Americans were first learning that maternal mortality in the United States was the highest of any developed country in the world. Convinced that more than half of childbirth deaths were unnecessary, the Association's backers began with the premise that every mother had the right to quality maternity care.[1] The Association's members included a representative of each of the three city departments dealing with maternity care, i.e., the Department of Bellevue and Allied Hospitals, the Department of Health, and the Department of Charities. Each hospital in the city with a maternity service treating from one hundred to two thousand patients annually chose one representative to the Association from its obstetrical staff; hospitals caring for more than two thousand maternity patients appointed two representatives. Lay organizations participating in maternity-related health efforts also became members. The Association expected each member group to

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Breckenridge, Mrs. W. E. A. Griswald, Mrs. Ray Morris, Mrs. S. W. Lambert, Mrs. A. S. Burden, and Miss Frances Perkins (who became the first woman cabinet member under Franklin Roosevelt).

[1] Maternity Center Association (New York: by the Association, n.d., ca., 1970), pp. 2, 11; Maternity Center Association, 50th Annual Report, 1918-1968, p. 1.

abide by the unofficial zoning plan and to provide and encourage the use of its prenatal services.[1]

By 1920, the Maternity Center Association had established thirty centers and sub-stations in the ten zones in Manhattan. It also assumed the financing of the original centers, begun by the Milk Committee and the Women's City Club. The centers held classes for expectant mothers and fathers, offered prenatal care to women not registered with hospitals or private physicians, and in cooperation with the Henry Street Settlement employed nurses for postpartum observation. As a strategy to direct women to seek medical help during pregnancy, the centers refused delivery care or postpartum nursing to women who had not had at least one month of prenatal care.[2] As prenatal care increasingly gained acceptance in the nation, Maternity Center nurses went into communities to teach obstetrical techniques to other nurses.[3]

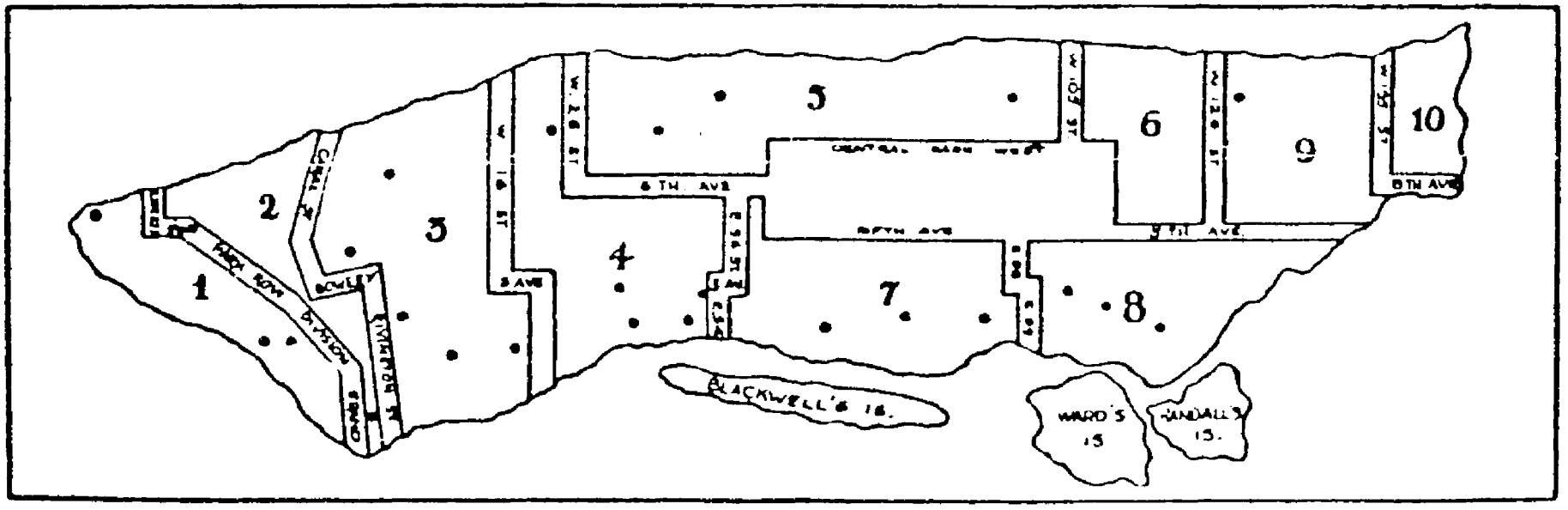
In Manhattan alone, with a population of roughly two and a half million in 1919 and from sixty thousand to

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[1]"Constitution of the Maternity Center Association," in Log, Maternity Center, p. 4; Maternity Center Association, Twenty Years of Nurse-Midwifery, 1933-1953 (New York: by the Association, 1955), p. 12.

[2]Routines of the Maternity Center Association (New York: by the Association, 1922), pp. 2, 7, 9, Log, Maternity Center, p. 3.

[3]50th Annual Report of the Maternity Center Association, p. 2.



Map of Manhattan showing boundaries of zones, suggested by the Maternity Center Association, together with location of maternity centers, ca. 1920.

sixty-five thousand births a year, universal prenatal coverage presented a challenge.[1] At this point, public health leaders urged prenatal supervision on the basis of women's health. With low-grade prenatal care, routine procedures rarely included blood-pressure testing.[2] While pregnancy observation would directly affect an infant's chances for survival, health spokesmen recognized the care as essential to women's health. As an early and persistent theme, the maternity movement urged that eclampsic convulsions could all but be eliminated if toxic symptoms were discovered in pregnancy.[3] Prenatal observation would also diminish the need for emergency cesarean section, as pelvic deformities in women and excessive infant head size could be diagnosed.

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[1]Children's Bureau, Standards of Child Welfare, pp. 181-82. In 1919, one commentator estimated that 90 percent of pregnant women in the United States received no prenatal care whatsoever. See Harry Schwarz, "Painless Childbirth and the Safe Conduct of Labor," The American Journal of Obstetrics and Diseases of Women and Children 79 (January 1919):46-47.

[2]Theodore Cianfrani, A Short History of Obstetrics and Gynecology (Springfield, Illinois: Charles C. Thomas, 1960), p. 41.

[3]J. Whitridge Williams, "The Limitations and Possibilities of Prenatal Care Based Upon the Study of 705 Foetal Deaths Occurring in 10,000 Consecutive Admissions to the Obstetrical Department of The Johns Hopkins Hospital," American Association for the Study and Prevention of Infant Mortality, Transactions of the Fifth Annual Meeting, November 12-14, 1914, Boston, Massachusetts, p. 43.

After World War I, syphilis received greater attention from public health advocates. Before the advent of prenatal care, the disease led to more fetal deaths than any other cause. While the Wassermann test was devised in the teens, physicians found it too expensive to use routinely. Instead, doctors attending pregnant women looked for pelvic lesions. Yet three-fourths of pregnant women with syphilis showed no visible symptoms, so the disease escaped detection until the child was born dead.[1] On one front the battle to make the Wassermann test routine was financial; on the other, it was psychological. Reformers encouraged women not to be "ashamed" to get blood tests, and reminded them that syphilis could be contracted "accidentally." Ideal prenatal care, then, required more than urinalysis and blood pressure testing. Yet as a first step, workers had to convince women that they needed such care.

Public health workers pleaded for women to register with health clinics for prenatal care even if they planned to use midwives. The clinics, in turn, sought to employ women physicians to make immigrant patients more comfortable and to acclimate them to the

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[1]Nicholas J. Eastman, "Obstetrics and Gynecology," in 75 Years of Medical Progress, 1878-1953, Louis H. Bauer, ed. (Philadelphia: Lea and Febiger, 1954), p. 96; Williams, "The Limitations and Possibilities of Prenatal Care," pp. 40-41. Before the discovery of penicillin, physicians used arsenic and bismuth to treat syphilis.

notion of physicians attending in childbirth. Health officials publicized unnecessary deaths in childbirth. "Too many mothers do die each year, far too many."[1] Advocates told women not to become alarmed; instead, they should see a doctor. "The doctor and nurse do for the women what experts at the service station do for the automobile."[2]

The period between 1908 and 1920 is more remarkable for its analysis than for any actual change. The notion that mortality and morbidity were products of class, and that infant mortality decreases as incomes rise, would have been opposed bitterly as radical humbug fifty years earlier. Unfortunately, action responsive to the results of this analysis did not follow, and the issues submerged until their reappearance in new form in the late 1960s and 1970s, still awaiting successful remedial address.

A re-evaluation of the role of government vis-a-vis medicine emerged from the refocusing on mothers' health. The movement to save infants' lives did not lead to this path until public health leaders recognized the mutual necessity of mother and child. The movement from infant

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[1]Ibid., pp. 7, 28.

[2]Maternity Center Association, A Fair Chance for Your Baby and You, p. 2.

to mother demonstrated that one group alone could not achieve good health; that health depended upon social condition; and that in any consideration of the future generation of men and women, the mother could certainly not be ignored. The public health drive realized early that poverty plays havoc with health. A new concept followed--that "it is always the mother in the home who finally bears the brunt of the world's suffering. If she is relieved, the children and the husband are relieved."[1]

Given the mother's condition, health advocates translated and understood prematurity, so common a cause of infant death, as something more than incomplete fetal development precluding extrauterine survival. They asked new questions: Why did pregnancies terminate too early? Why was prematurity more common among infants of black mothers? The propensity to prematurity was not inherent in some mothers and absent in others. It resulted instead from a woman's overwork, her lack of rest, and her faulty nutrition. If poverty was not to cause illness, the government would have to assume a new role:

> We need national, state and municipal action. The machinery must be provided by which the poor can find it possible to raise families without

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[1]West, "The Development of Prenatal Care in the United States," p. 108.

> undue sacrifice of health or unreasonable financial strain.[1]

Government intervention in the area of women's (hence children's) health would mean greater provisions for free obstetrical care, including increased ambulatory maternity clinics for women unwilling to use hospitals for delivery. It presupposed some means of rest before and after birth for working women. Legislation would be necessary to mandate compliance, as would provisions for money stipends to make improved health financially possible for many women. If health were truly a right, it required guarantees--and at least a minimal interference with medicine as free enterprise. "This has been done in France, Russia, and Italy; why not here?"[2] Increasingly, many more public health workers would make this comparison to Europe and ask the same question.

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[1]Children's Bureau, Standards of Child Welfare, p. 184.

[2]Sobel, Instruction and Supervision, pp. 25-26.

CHAPTER VII

RACE SUICIDE, SEXUAL SELF-DETERMINATION, AND MARGARET SANGER: PHYSICIANS' UNDUE INFLUENCE

> Enforced maternity brings into the world wretched infants whom their parents will be unable to support and who will become the victims of public care or 'child martyrs.' It must be pointed out that our society, so concerned to defend the rights of the embryo, shows no interest in the children once they are born.
>
> --Simone de Beauvoir
> The Second Sex, 1949

The myth of race suicide--the romantic notion that sustained child-bearing was necessary to avoid the slow strangulation of the national stock--confronted the reality of shameful American infant and maternal mortality rates. The supreme dehumanization, indeed objectification, of women in the early twentieth century through the relentless demand that they fulfill maternal duties to society accompanied the myth.[1]

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[1]For discussion of race suicide and demands that women bear sufficient children, see George J. Engelmann, "Education Not the Cause of Race Decline," Popular Science Monthly 63 (June 1903):179-180, 184; Ida H. Harper, "The Right of the Child," North American Review, 176 (January 1903):107-08; Solomon Schindler, "Why Race Suicide with Advancing Civilization?" Arena 40 (December 1908):552; Frederick A. Bushee, "The Declining Birth Rate and Its Cause," Popular Science Monthly 63 (August 1903):335; H. Laing Gordon, The Modern Mother. A Guide to Girlhood,

As middle-class women emerged from the docile ennui which had alternately starved and sustained them for decades, and while immigrant mothers slaved ten hours to supplement their husbands' meager incomes, two themes emerged. Cassandras warned of impending population doom, and redoubled efforts to ban the distribution of contraceptive information and devices. At the same time, health workers compiled the data of maternal, infant, and abortion-related deaths, as well as the individual pain and suffering--temporal and emotional--endured by women who in every sense of the phrase worked in factories by day and made babies at home, with predictable annual regularity, in a virtual urban cottage industry.

Yet in the face of apocryphal tidings of the loss of the species, women bore fewer children.[1] One must

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Motherhood, and Infancy (New York: R. F. Fenno and Co., 1909), pp. 91, 98; Andrea H. Proudfoot, A Mother's Ideals. A Kindergarten Mother's Conception of Family Life (Chicago and New York: A. Flanagan Co., 1897), pp. 183-84. In sentencing Mr. Sanger for distributing his wife's pamphlet on birth control, Justice James C. McInerney declared that "'Such persons as you who circulate such pamphlets are a menace to society. There are too many now who believe it is a crime to have children. If some of the women who are going around advocating equal suffrage would go around and advocate women having children, they would do greater service.'" See "Birth Control and the New York Courts," The Survey 34 (September 25, 1915):567.

[1]The average number of children born to white women living beyond menopause was 7.04 in 1800, 6.14 in 1840, 4.42 in 1880, and 3.56 in 1900; see Daniel Scott Smith, "Family Limitation, Sexual Control and Domestic Feminism in

conjecture whether the decline meant that those who read the literature of doom felt guilty, and if so, the extent to which they overcame guilt by personal relief at the realization of the obvious benefits to health of planned, properly spaced pregnancies. Whether the diminution in births was based on the claimed effects of women's education or upon a hedonistic drive for luxury, a similar message transpired. That message mocked the sixteen thousand women who died annually in childbirth.

Childbearing posed far greater risks to women in the United States than in almost any developed nation in the world. In 1910, from any group of 1,000 live births, 7.1 women died in Pennsylvania from childbirth-related causes, 4.6 in France, 4.5 in New Zealand, 3.6 in England,

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Victorian America," in Clio's Consciousness Raised. New Perspectives on the History of Women, ed. by Mary Hartman and Lois W. Banner (New York: Harper and Row, 1974), p. 122. The average native family in 1900 produced three children. "While 1,000 mothers in 1800 had 1,300 children under five years of age, the same number of mothers in 1900 had fewer than 700 such children." See David M. Kennedy, Birth Control in America. The Career of Margaret Sanger (New Haven: Yale University Press, 1970), p. 42. In 1921, Michael M. Davis reported that in 1900, the number of children born to women less than 45 years of age and married 10 to 19 years was 2.7 for native women and 4.4 for foreign. In 1909, old immigrant women gave birth to an average of 3.5 children and new immigrant women to 4.9. See Immigrant Health and the Community (New York: Harper and Brothers, 1921, reprint ed., Montclair: Paterson Smith Publishing Corp., 1971), pp. 184, 427. Davis also cited a 1916 New York State study which determined that the average yearly legitimate births to 1,000 married women 15 to 45 years of age were 137.1 for native-born women and 253.2 for foreign-born women.

3 in Germany, and 2.5 in Sweden.[1] Next to tuberculosis, childbirth remained the largest killer of women between the ages of fifteen and forty-four years. In 1915, in the United States birth registration area,[2] approximately 10,000 women died from causes relating to pregnancy and childbirth; among them, 4,542 women died of childbed fever alone.[3] Survival rates varied among divergent sections of the country. It was better to be a mother in New York City, for instance, than in Tallahassee. In 1929, 5.6 women of 1,000 births died in New York State while in South Carolina the rate was 11.4.[4]

A woman in Sweden fared better than one in America, and in the United States the chances for survival in a large metropolis were greater than in small cities. Yet even a small urban setting offered more life to women than did any

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[1]Elizabeth P. Hunt, Certain Aspects of Public Maternity and Infant Care in Berlin and Stockholm (New York: American Scandinavian Foundation, 1922), p. 6.

[2]The states included in the birth registration area in 1915 were Connecticut, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, New York, Pennsylvania, Rhode Island, Vermont, and the District of Columbia.

[3]U.S., Department of Labor, Children's Bureau, Maternal Mortality from all Conditions Connected with Childbirth in the United States and Certain Other Countries, by Grace L. Meigs, Bureau Publication No. 19 (Washington, D.C.: Government Printing Office, 1917), pp. 14-15.

[4]"Motherhood and Its Risks," The Medical Women's Journal (January 1931):15.

rural region of the country.[1] For instance, between 1916 and 1920, for every ten thousand births, including stillbirths, twenty more women lived through the experience of childbirth in New York City than in upstate New York.[2]

New York City, in fact, set national standards. Based on 1,000 live births, the maternal death rate in 1923 was 4.6 in New York City and 6.7 in the United States at large; in 1924, the city's was 4.9 against 6.6; in 1925, it was 5.1 against 6.5; and in 1926, the rates were 4.5 and 6.6.[3] While the city's maternal death rates proved conspicuously lower than in the rest of the nation, they appeared shamefully poor when compared to other cities in the world. In 1916, for example, upstate New York's maternal mortality rate was 53.4 per 10,000 births and New York City's rate was 45.8. Yet Stockholm reported 35.65, with Birmingham,

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[1]New York State Department of Health, The Geographical Distribution of Maternal Mortality and Stillbirths in New York State, ed. by Otto R. Eichel (Albany: State Department of Health, 1922), p. 3; Ralph W. Lobenstine, "Prenatal Care as Viewed from the Public Health Standpoint," The American Journal of Obstetrics and Gynecology 6 (September 1923): 281.

[2]Florence McKay, "What New York State is Doing to Reduce Maternal Mortality," The American Journal of Obstetrics and Gynecology 9 (May 1925):704. McKay, who was Chief of New York State's Division of Maternal Welfare, reported maternal mortality of sixty-six per ten thousand live births in upstate New York (exclusive of New York City), compared to the New York City rate of forty-six.

[3]1928 Report of the Henry Street Visiting Nurse Service, New York, in Dorothy K. Brown Papers, Box 2, Folder 48, Manuscript Collection, Schlesinger Library, Radcliffe College, Cambridge, Mass.

England, at 33.26. In the peak of the influenza pandemic in 1918, the city's maternal mortality rate was 45.8; upstate New York, excluding the city, had a rate of 82.8, while Birmingham's dropped to 29.26.[1]

What do these data mean? Were the caveats of racial cataclysm reflections of male hostility or indifference toward women, or were they simply reflections of ignorance? Are the arguments against birth control significant in light of the coincidence of moves to deny women's sexual self-determination with new statistical awareness of the magnitude of female death? In 1932, American maternal mortality was still comparatively high. A female physician suggested:

> Since, so far, all of our law making and legislative measures, as well as our education methods, are in the hands of our fathers, husbands, and brothers, they should take proper steps in this all-important matter [maternal mortality]. Instead of sentimental prattle about the "sanctity of motherhood," they should establish proper channels and means for its protection.[2]

As early as 1913, government studies of puerperal deaths in the United States demonstrated the virtual preventability of major causative factors. Yet death rates did not begin a downward trend until after 1933.

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[1]New York State Health Department, Geographical Distribution of Maternal Mortality, p. 4; see also William T. Howard, Jr., "The Real Risk-Rate of Death to Mothers from Causes Connected with Childbirth," The American Journal of Hygiene 1 (March 1921):220.

[2]Rosina Wistein, "Maternal Mortality," The Medical Woman's Journal 39 (February 1932):232.

In 1917, the Children's Bureau published its first study of maternal mortality. The study concluded that fifteen thousand women died annually from childbirth--a low estimate, since unregistered states tended to have greater mortality rates--with seven thousand yearly deaths from septic fever. The second greatest number of deaths resulted from convulsions or eclampsia, the culmination of unregulated toxemia. Simple prenatal care, as well as systematic asepsis, would therefore have saved literally thousands of women's lives.[1] Similar research through the 1920s listed these chief factors, but included in its analysis the role of abortion in septic deaths and the distinct racial, marital and socio-economic patterns into which maternal mortality fell. Despite these revelations, the United States made little progress in the area. In their 1927 annual report, the directors of the Society of the Lying-In Hospital observed that "those who are making a study of available statistics relative to childbirth throughout the world, assure us that for the country as a whole, obstetric results in the United States rank among the worst to be found. Also, that there has been no total improvement during the past quarter of a a century.[2] In rural areas, Mrs. Meigs of the Children's

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[1]Children's Bureau, Meigs, Maternal Mortality, 1917, pp. 7, 10, 12.

[2]The Society of the Lying-In Hospital of the City of New York, Annual Report for the 129th Year, 1927, p. 12.

Bureau staff contended, "the question is not one of good or bad obstetrical care but of the inaccessibility of any care at all."[1]

Maternal welfare advocates continued to parade the evidence of America's poor showing in the 1920s. Among seventeen developed nations, the United States ranked fourteenth on a scale of maternal mortality with only Spain, Belgium, and Switzerland with worse records.[2] If it was more hazardous to be born female in America, it was even less fortuitous to be born a woman, poor and black. Not surprisingly, maternal mortality varied inversely with family income.[3] A combination of poverty, residence, and racism worked to increase black deaths from childbirth. In 1913, white women died at the rate of 15.2 per 100,000 white population (not births) while black women died at a rate of 26.1 per 100,000 black population.[4] In a Children's Bureau study which

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[1]Children's Bureau, Meigs, Maternal Mortality, 1917, p. 26.

[2]George C. Mosher, "The Problem of Mother and Child," The Medical Woman's Journal 34 (August 1927):218-19.

[3]U.S., Department of Labor, Children's Bureau, Maternal Mortality, The Risk of Death in Childbirth and from All Diseases Caused by Pregnancy and Confinement, by Robert M. Woodbury, Bureau Publication No. 158 (Washington, D.C.: Government Printing Office, 1926), p. 36.

[4]Children's Bureau, Meigs, Maternal Mortality, 1917, p. 22. Black and white puerperal death rates continued to be widely disparate. In 1927 in New York City, white women died at a rate of 5.0 per 1,000 live births, while black women died at the rate of 11.7. Among the states in 1927

analyzed all puerperal deaths in fifteen states for 1927 and 1928,[1] black maternal mortality rates almost doubled those for white women.[2]

Ironically, black women often required the most highly sophisticated kind of obstetric skill, since as infants they suffered abnormally from rickets, which stunted the full development of their pelves. For a woman with

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the differential was even more pronounced. On the basis of 10,000 live births, puerperal mortality was 62.5 for white women in Alabama and 111.6 for black women; for whites in Arkansas, it was 72.5 against 151.0 for blacks. In California, the differential was 56.3 against 76.7; in Illinois, it was 53.0 against 110.2; in Missouri it was 63.6 to 130.7; in New Jersey, 59.3 to 109.6; in Pennsylvania, 61.6 compared to 111.6; and in the District of Columbia, the differential stood at 66.0 to 130.5. See U.S., Department of Labor, Children's Bureau, The Promotion of the Welfare and Hygiene of Maternity and Infancy. The Administration of the Act of Congress of November 23, 1921, for the Fiscal Year Ended June 30, 1928, Bureau Publication No. 194 (Washington, D.C.: Government Printing Office, 1929), pp. 170-71.

[1]U.S., Department of Labor, Children's Bureau, Maternal Mortality in Fifteen States, Bureau Publication No. 223 (Washington, D.C.: Government Printing Office, 1934), p. 2. The fifteen states were Alabama, Kentucky, Maryland, Michigan, Minnesota, Nebraska, New Hampshire, North Dakota, Oregon, Rhode Island, Virginia, Washington, Wisconsin, California, and Oklahoma.

[2]Ibid., p. 163. In the two years in the 15 states, there were 7,537 deaths, amounting to 26 percent of the 29,298 puerperal cause deaths in the United States birth registration area. In the same sample, there were 1,176,603 live births. The 7,537 deaths reflected a maternal mortality rate of 64 per 10,000 live births; the maternal mortality in the birth registration area (in which were included all but 4 states and in 1928 all but 2) was 67 for the 2 years.

a contracted pelvis, childbirth is an operative procedure.[1] Successful performance of a cesarean section rests on the capacity to forecast its indications as much as on the surgeon's ability. Without the means to afford proper prenatal and delivery care, pregnancy and death's terror would be a constant component of black women's psychological make-up.

The Children's Bureau's investigation of 1927 and 1928 into the death histories of the 7,537 women revealed that only 2,611 had any prenatal observation. In most cases the care was mediocre; only 1 percent of the women received quality supervision. (For instance, only 16 percent, or 427 women, who had prenatal care received Wassermann tests.[2]) The fact that toxemia caused 30 percent (2,221) of the deaths--1,000 due to eclampsia--becomes sadly comprehensible, in light of inadequate care during pregnancy.[3] "There are far too many doctors practising this branch of medicine," complained the directors of the Society of the Lying-In Hospital in 1928, "who do not believe in or do not realize the importance of close supervision of women during

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[1]Children's Bureau, Woodbury, Maternal Mortality, 1926, pp. 26-27. Dr. J. Whitridge Williams observed 3,837 consecutive pregnancies in the obstetrical division of The Johns Hopkins Hospital. Of the total, 8.5 percent of the white women and 36.6 percent of the black patients had contracted pelves.

[2]Children's Bureau, Maternal Mortality in 15 States, 1934, pp. 44, 63.

[3]Ibid., p. 139.

pregnancy."[1] Although the death rate from eclampsia dropped only 1.7 percent per year between 1917 and 1924--from 178 per 100,000 to 165 per 100,000--this rate of decline still exceeded the decrease in septicemia deaths (1.4 percent per year),[2] the most controllable of all puerperal fatalities.

The nineteenth-century medical world was an uncentralized cacophonous milieu of competing sects. In this atmosphere, the achievement of therapeutic uniformity was difficult. Invariably, medical advances and their application filtered down unevenly among practitioners. In obstetrics, the dissemination rate appeared particularly slow. As early as 1887, Dr. Julius Hoag, an obstetrician, pleaded for antiseptic precautions: "Vaginal examinations should be avoided as far as possible, and it is the writer's conviction that in many cases these examinations are wholly unnecessary." Hoag continued that women were subject to further threat of infection when, through the physician's haste, "his anxiety to terminate labor," he introduced his hands in the woman's uterus instead of allowing the natural

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[1]The Society of the Lying-In Hospital of the City of New York, Annual Report for the 130th Year, 1928.

[2]Lee K. Frankel, "The Present Status of Maternal and Infant Hygiene in the United States," American Journal of Public Health 27 (December 1927):1210. Mortality from sepsis in 1917 was 276 per 100,000 live births; in 1924, the rate was 241 per 100,000.

contractions to expel the afterbirth--Credé's methods.[1] Theoretically, then, septicemia should have become a peripheral cause of puerperal fatalities. Yet it did not. The Children's Bureau 1927-1928 survey of maternal mortality found antiseptic procedures appallingly poor. Physicians rarely substituted rectal examinations for vaginal intrusions during labor, and questionnaires to doctors revealed that they routinely performed vaginal examinations without gloves.[2] This pattern persisted, even though septic deaths in 1927 amounted to almost half of maternal deaths from puerperal causes.[3]

The most startling revelation of the 1920s concerning septic deaths in obstetrics was the connection of infection to attempts at induced abortion.[4] The Children's Bureau research in the fifteen states found that approximately one-quarter of maternal deaths followed abortion.[5]

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[1]Julius C. Hoag, "Puerperal Fever and Its Treatment," The American Journal of Obstetrics and Diseases of Women and Children 20 (September 1887):952-53.

[2]Children's Bureau, Maternal Mortality in 15 States, 1934, p. 64.

[3]Frankel, "The Present Status of Maternal and Infant Hygiene," p. 1210.

[4]Mosher, "The Problem of Mother and Child," p. 218; "Motherhood and Its Risks," p. 15; Frankel, "The Present Status of Maternal and Infant Hygiene," pp. 1209, 1214.

[5]The Children's Bureau defined abortion as the termination of pregnancy before the seventh month. It could be a spontaneous miscarriage or a deliberate attempt to end the pregnancy.

Of all the deaths, septicemia caused three-quarters and of these, almost half (1,825) were caused by women's desperate and illegal attempts to rid themselves of unwanted pregnancies.[1] Indeed, maternal mortality figures often appeared inflated in urban areas, as pregnant women from rural sections sought refuge in the hands of city abortionists.[2]

By the turn of the century, physicians knew of the bodily havoc and death which abortion brought. In 1900, Dr. Rufus B. Hall questioned the propriety of sexual instruction to young maidens. Admittedly, he conceded, a proper balance between chastity norms and information was difficult to achieve, yet he insisted that "enough ought to be taught to emphasize the danger of septic infection following retained decidua [placenta] in abortion." For Hall, the life-threatening implications of abortion would prevent any reasonable woman, once informed, from ever consenting to deliberate obstruction of pregnancy.[3] Awareness of the

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[1]Children's Bureau, Maternal Mortality in Fifteen States, 1934, pp. 35-36, 103, 114.

[2]Ibid., p. 38. Moreover, urban death rates often seem higher because women delivered inadequately in rural sections were frequently rushed to urban hospitals.

[3]Rufus B. Hall, "The Education of the Laity upon Sexual Matters: When Shall They Be Taught, and to What Extent?" The American Journal of Obstetrics and Diseases of Women and Children 42 (November 1900):583.

hazards of abortion--sepsis, hemorrhage, invalidism, displacement, sterility, or the proclivity for future abortions or miscarriages--seemed merely to prompt more tedious lectures on the irrationality of such recourse; birth control remained taboo.[1] Despite doctors' wise counsel, women continued to ingest home-brewed concoctions which almost always contained a fair amount of turpentine. They battered themselves physically, hoping to dislodge the fetus. If especially brave, they became their own surgeons, using knitting needles as their tools. Otherwise, they engaged the "trained" abortionist. At least 250,000 women chose this avenue each year.[2]

The demand that lecture cease and remedy commence, the insistence that abortion manifested a misogynous sexual system, was largely the contribution of Margaret Sanger. Recent historical attention to Sanger's life has focused

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[1]See Frank H. Jackson, "Criminal Abortion. Its Prevalence, Results and Treatment," The American Journal of Obstetrics and Diseases of Women and Children 58 (October 1911):668.

[2]Margaret Sanger, The Case for Birth Control. A Supplementary Brief and Statement of Fact Prepared by Margaret Sanger to Aid the Court in Its Consideration of the Statute Designed to Prevent the Dissemination of Information for Preventing Conception (New York: M. Sanger, 1917), p. 6. Indeed, the decision to abort or carry to term was often based upon such simple criteria as economic factors and the immigrant's bargaining nature. The writer's great-aunt, an immigrant from Turkey in the early years of the twentieth century, elected to bear a son in 1925 because she wanted to pay the abortionist only $50.00, while he would settle for no less than $75.00.

on negative aspects of her ideological presentation and on her leadership.[1] Historians have utilized Sanger's adherence to the Malthusian theory, albeit adjusted to suit her purposes,[2] and her discussions of the social maintenance costs of "defectives" and the "feeble-minded" to demonstrate the similarity between her efforts and those of Charles B. Davenport and other contemporary eugenists.[3] Her dreams of

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[1]See, e.g., Kennedy, Birth Control in America. He portrays Sanger as a woman with a desire for "historical uniqueness" (p. 19), with no "inner commitment" to radicalism (p. 111). Kennedy cites her intense competition with Mrs. Mary Ware Dennett for control of the movement as a prime example of her desire for unquestioned and unilateral control. See also pp. 15, 17-19, 109-10.

[2]Instead of continence, as Malthus proposed, Sanger urged birth control. See Sanger, Case for Birth Control, p. 250.

[3]Sanger did discuss the danger of overproduction of defectives in close nexus to reference to the poor. For example, see Case for Birth Control, p. 69: "If we consider the example of Holland we may be assured that a further fall in the birth-rate among the poorer classes will be accompanied by an immediate and progressive improvement in their conditions, by a checking of the output of physical and mental defectives and by a gain in the national efficiency, and probably also in the rate of increase of our population." Her urgings that the feeble-minded be instructed how not to reproduce also sounds similar to the words of the eugenists. Davenport, Director of the Station for Experimental Evolution at Cold Spring Harbor, New York, derided the social costs of maintaining what he perceived as hereditary defective strains: "Now, just as we have strains of scholars, of military men, of lazy sots, so, too, we have strains of sex offenders, strains of feebleminded of other sorts, strains with epilepsy, strains with strong tendencies towards larceny, assualt, lying, running away; strains with a lack of resistance to tuberculosis, to cancer, to excessive nervous strain." He felt that inferior strains should not be allowed to reproduce. See Charles B. Davenport, Proper Care

the panacea of birth control--its abilities to conquer poverty, famine, and war[1]--and her persistent drive for unilateral control of the birth control movement have exposed her to claims of opportunism.[2]

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for the Socially Inadequate, Reprint of Address at the Thirteenth New York State Conference of Charities and Corrections, Syracuse, November 20, 1912 (New York: AICP, 1912), p. 4.

[1]In lieu of class analysis, Sanger believed that overpopulation led to labor surplus and strike breakers, and hence, to low wages. It also led to the necessity for geographic expansion, resulting in wars. See Margaret Sanger, The New Motherhood (London: Jonathan Cape, 1922), p. 173. Also see p. 12: "War, famine, poverty and oppression of the workers will continue while woman makes life cheap. They will cease only when she limits her reproductivity and human life is no longer a thing to be wasted." Charlotte Perkins Gilman also shared this view. "Unquestionably," she wrote, "the pressure of population is a basic and permanent cause of war." On this premise, she advocated birth control. See Charlotte Perkins Gilman, "Progress through Birth Control," North American Review (December 1927):624. This view appeared relatively common after World War I, a conflict which was most plausibly explained by population pressures. See "Address" of Dr. Sidney Goldstein, March 15, 1922 to the Women's Medical Association of New York City, in Collected Papers of the Women's Medical Association of New York City, Manuscript Collection of the New York Academy of Medicine, Box 1: Minutes of Meetings, 1902-1931.

[2]Before Sanger returned from Europe, Mary Ware Dennett dissolved the old National Birth Control League and created the Voluntary Parenthood League, with the aim of repealing federal anti-contraceptive laws as inconsistent with the First Amendment. Sanger believed that simple repeal would permit anyone to distribute birth control devices. She sought instead new interpretations of the law, i.e., that doctors be permitted to give out birth control information and devices. On this basis, Sanger split from Dennett and established the American Birth Control League in 1921. In 1928, Sanger peremptorily resigned from the American Birth Control League when the majority resisted her desires. See Margaret Sanger, An Autobiography (New York:

Setting aside the salience of these assertions, or their relevance to Sanger's overall contribution, it is sufficient simply to note that the sort of elitism she demonstrated appeared common among her generation of reformers.[1] Indeed, they did not limit their application of the concept of social control to the reduction of ethnic or lower-class populations. The argument for social control could be employed as easily against the birth control movement. For

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W. W. Norton & Co., 1938), pp. 395, 414. For a negative interpretation of her behavior see Kennedy, Birth Control in America, p. 106: "For all her altruism and humanitarianism, one of Sanger's goals was complete and exclusive control of the birth control movement. However hard others might work for the cause, she nevertheless insisted on the major part of the glory. She spurned any organization she could not dominate." Kennedy insisted that it was Sanger's obsessive personality which made accommodation with the Catholic Church impossible. He depicts her as uncompromising, ready to exploit Catholic opposition to birth control. She, wrote Kennedy, "cared more for polemics and for baiting the Church than she did for strategic compromise," p. 153; see also pp. 76, 198.

[1]Elitism and reform were never totally disengaged in American intellectual history. For example, Robert Hunter, author of Poverty (New York: Grosset and Dunlap, 1904), a moving and emotional portrayal of the life of the poor, also urged curbs on unlimited immigration, fearing the rising birth rate of southern European immigrants: "In the United States the peasantry from other countries, degraded by foreign oppression, are supplanting the descendants of the original stock of this country. This is the race-suicide, the annihilation of our native stock, which unlimited immigration forces upon us," p. 314. See also Richard Hofstadter's description of the equivocal nature of reform mentality in this era, The Age of Reform. From Bryan to F.D.R. (New York: Vintage Books, 1955). One wonders who was in fact elitist, when Kennedy writes: "The real enemy of her [Sanger's] movement was neither church nor state but the ignorance and psychology of the masses themselves," Birth Control in America, p. 274.

example, George Kosmak, who was attending physician to the Lying-In Hospital, editor of the American Journal of Obstetrics and Diseases of Women and Children, an active member of the New York Academy of Medicine, and an instrumental figure in maintaining the Academy's obdurate position against the birth control movement, wrote:

> I sincerely believe that it is necessary for the general welfare and the maintenance of an economic balance, that we have a class of population that shall be characterized by "quantity" rather than by "quality." We need the "hewers of wood and drawers of water," and I would like to ask what our good friends who believe in family limitation would say if the "quantity" factor in our population had diminished as the result of their efforts to such an extent that they would have to perform these laborious tasks themselves.

Kosmak added that "it is from this quantity element that the quality is obtained."[1]

Hence when analyzing the birth control movement, which could not avoid the racism of its founding generation, it becomes necessary to sort and evaluate the movement's various strains. Did, for example, the elements of social control eliminate all genuine humanitarianism in the birth control movement? Did they diminish the impact of Sanger's message? Was the racism dormant or dominant? Where was Sanger's emphasis? She can be portrayed as didactic,

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[1]G. W. Kosmak, "Birth Control. What Shall Be the Attitude of the Medical Profession toward the Present-Day Propagandas?" Medical Record 9 (February 17, 1917):269. Kosmak insisted that the use of contraceptives would subsequently cause sterility in women.

uncompromising, and egocentric, but did she merely react to the painful suffering of women and children in a society which was deaf, indifferent, and recalcitrant to her message? What would Margaret Sanger have been like had medical, religious, and political leaders responded to her rational, sensitive, and timely demands that birth control be available to all women?[1] Was the essence of Sanger's message--woman's right to sexual self-determination, her right to enjoy sex independently of maternity, and her right to good health and motherhood[2]--entirely dissolved once Sanger flirted with the eugenists?

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[1]Sanger's movement for birth control began in 1914. In 1921, the New York Academy's Public Health Committee, which E. H. Lewinski-Corwin chaired, went on public record "emphatically opposed to the methods and principles of the so-called birth control movement." See Collected Papers of the Public Health Committee, New York Academy of Medicine. In January 1928, the Kings County (Brooklyn) Medical Society opposed a bill in the New York Legislature legalizing birth control; Ibid. Not until 1930 did the New York Academy of Medicine sanction doctors giving contraceptive advice. In 1934, the House of Bishops of the Episcopal Church approved birth control. Sanger, An Autobiography, p. 410. In 1936, the United States Circuit Court of Appeals ruled in Sanger's favor. Her aim had finally been achieved. The court reinterpreted the law to allow physicians to import birth control devices, to send them through the mail, and to prescribe them for patients' general well-being. In 1937, the American Medical Association resoved in favor of doctors' right to distribute contraceptives. Sanger, An Autobiography, pp. 427, 430.

[2]Kennedy finds the essence of the movement to be different. Birth Control in America, pp. 112-13: "Birth control was not intended as a weapon for the lower classes to use against the system that oppressed them. On the contrary, the artificial restriction of fertility was seen as an instrument with which the dominant classes could check the threatened social disruption."

Sanger was the most vocal, if not the first, advocate of the right of women to choose the destiny of their biology. She provided a practical solution to the dilemma of women's physiology. Without judging the relative merits of motherhood against outside careers, she insisted that a woman without birth control was a human being without options. As "a slave to maternity,"[1] woman served neither herself nor her children. If woman was a "producing machine,"[2] "an incubator,"[3] Sanger queried the value of suffrage or economic or social liberation. Ultimately, each woman must have access to birth control, and must define the outline of her motherhood, for only she "goes through the vale of death . . . each time a babe is born. As it is the right of neither man nor the state to coerce her into this ordeal, so it is her right to decide whether she will endure it."[4] The denial of women's sexual autonomy, which the opposition to the birth control movement symbolized (police raids, jailings, and the scatological tone of the press[5])

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[1]Sanger, New Motherhood, p. 8.

[2]Sanger, Case for Birth Control, p. 8.

[3]Sanger, New Motherhood, p. 236.

[4]Ibid., p. 125.

[5]In 1914, Margaret Sanger was indicted and charged with sending obscene material--Woman Rebel--through the mails. The next year the government charged and convicted William Sanger, her husband, of giving a copy of Family Limitation, his wife's pamphlet, to a Comstock undercover

represented the supreme male arrogance which increasingly infuriated Sanger and provides the explanation for her emotionalism.

In a society supposedly child-centered, did the illegitimacy of birth control work in children's favor? By interlocking the mutual necessities of mother and child, Sanger replied no. The notion that child advocacy necessarily included women's advocacy was implicit in her demands. Sanger frankly discussed the stereotypic "nervous housewife," the irritability which often accompanied motherhood. She was among the first to see child abuse and battering as the unfortunate result of the overstrained woman. Poor mothers, especially, often pressured with outside employment and too many children, lost "the time and strength to let mother love develop and express itself. . . . We forget that under the stress of caring for many children, under the strain of helping to earn bread for hungry mouths and clothing for bodies . . . in rags, the strongest mother love may turn bitter and cruel."[1]

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agent. In 1916, Margaret Sanger and her sister, Mrs. Byrne, were arrested at their Brownsville, Brooklyn birth control clinic. In 1929, the police raided Sanger's Clinical Research Bureau. For details, see "Birth Control and the Courts," Survey 34 (July 17, 1915):567; "Trials of Birth Control Advocates," Survey 37 (February 10, 1917):555; "Films and Births and Censorship," Survey 34 (April 3, 1915): 4-5; Sanger, An Autobiography, pp. 404-05; Sanger, New Motherhood, p. 227.

[1]Sanger, New Motherhood, p. 62. Even if the letters in Bondage of Motherhood (New York: Brentano's, 1928) are

Sanger's compilation of letters she allegedly received from men and women across the country[1] bears sad testimony to the accumulated burdens of children born haphazardly, without rational attention to women's health or family income. These confessions sound strikingly similar to the letters on maternity which the Women's Cooperative Guild in England collected from working-class women. For instance, one British woman spoke of her disillusion and physical degeneration:

> A year after our marriage the first baby was born, naturally and with little pain or trouble. I had every care, and motherhood stirred the depths of my nature. The rapture of a babe-in-arms drawing nourishment from me crowned me with glory and sanctity and honour. Alas! The doctor who attended me suffered from eczema of a very bad type in his hands. The disease attacked me, and in twenty-four hours I was covered from head to foot . . . finally leaving me partially and sometimes totally crippled in hands. Fifteen months later a second baby came . . . and again I was in a fairly good condition physically and financially, but had incurred heavy doctor's bills and attendance bills, due to my incapacity for work owing to eczema. Both the children were delicate and dietary expenses ran high. . . .[We were] ill-prepared financially and physically to meet the birth of a third baby born sixteen months later.

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fabricated, they reflect Sanger's sensibilities. One letter read: "How ashamed I get of myself. I go all to pieces at the children at the least little thing, when I know afterwards the poor little kids didn't do anything, but it is just my own nervous state. I had always planned I'd be a companion to my kiddies, read and play with them, but when evening comes, I'm so tired I just roll in, dead to the world." p. 81.

[1]See Motherhood in Bondage. Apart from this published volume, the separate letters were destroyed and are not among Sanger's papers in the Library of Congress.

> Motherhood ceased to be a crown of glory, and became a fearsome thing to be shunned and feared. . . . I confess without shame that when well-meaning friends said: "You cannot afford another baby, take this drug," I took their strong concoctions to purge me of the little life that might be mine. They failed, as such things generally do, and the third baby came. . . . I fed them as long as I could, but I was too harassed, domestic duties too heavy and the income too limited to furnish me with a rich nourishing milk. . . . Nine months later I was again pregnant and the second child fell ill.[1]

Similarly, a woman ruefully wrote Sanger: "I long to feel well one more time, just so my children might know their mother as she would be if she was only well and had the strength to be a mother."[2] Sanger underscored the double burden (what she called the "double slavery") of women who worked, raised children, and took full household responsibility.

Nagging fears of pregnancy, Sanger contended, interfered with humanistic sexual intercourse. Sex became women's enemy, and the male embodied sex. To eliminate the repugnance which so many women had for sex (which fostered the categorization of women into two groups, sensual prostitutes and parlor wives), Sanger demanded that sex be freed from automatic maternity.[3] In her volume of collected

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[1]The Women's Cooperative Guild, Maternity Letters from Working Women (London: G. Bell & Sons, Ltd., 1915), pp. 44-45.

[2]Sanger, Motherhood in Bondage, p. 157.

[3]Margaret Sanger. Happiness in Marriage (New York: Brentano's, 1926), p. 198; "Few of us realize . . . how many human beings are conceived in fear and even repugnance by young mothers who are the victims of undesired maternity."

letters, a disheartened husband confided:

> During the earlier years of marriage my wife displayed no antipathy for our unions and it was not until the fear of additional children began to prey upon her mind that she developed a dislike for me. At present her state of physical and mental make-up is such that almost barely the mention of sex upsets her and she has developed a distinct loathing for anything of that kind.[1]

Sanger also claimed women's right to sexual fulfillment. On this basis, she deplored the practices of "male continence," "Karezza" or coitus interruptus, for in sex so highly controlled, virtually no woman could achieve orgasm.[2]

The foundation of Sanger's arguments for birth control lay in women's health, or perhaps more properly lack of health. In any discussion of the historical development of obstetrical care in the United States, her principal role is her association between the high death rate of women

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[1]Sanger, Motherhood in Bondage, p. 333. A woman spoke on the same subject: "I am a mother of four living children, and one dead, the oldest ten and baby 22 months. I am very nervous and sickly after my children. I would like you to advise me what to do to prevent me from having any more, as I would rather die than have another. I am keeping away from my husband as much as I can, but it causes quarrels and almost separation. All my babies have had marasmus in the first year of their lives." Sanger, New Motherhood, p. 88.

[2]Sanger, Happy Marriage, pp. 6-7; Sanger, New Motherhood, pp. 126, 138, 192; Sanger, Case for Birth Control, p. 185. Kennedy could not understand why coitus interruptus posed more stress to women than to men: "Mrs. Sanger disapproved of the method not, significantly, because of its impracticality or inefficiency but because of its damaging neurological and psychological effects on women." Birth Control in America, p. 130.

between the ages of fifteen and forty-four and their inability to control their reproduction. Sanger ascribed much of women's poor health to the frequency with which they bore children. Women suffered and died not only as a direct result of pregnancy and childbirth, but also from diseases of the lungs, heart, or kidneys which pregnancy hastened and exacerbated.[1] Sanger confronted the irrationality of a system which refused to allow tubercular women to prevent conception. She pointed to the contradictions of a social order whose leading obstetrician, without thought of birth control, called the effects of tuberculosis on pregnant women "almost always harmful. Moreover, the strain incidental to labour and the extra drain upon the system, if the mother nurses the child, pull such patients down still further so that the final result is usually hastened."[2]

Why, Sanger asked, were not birth control devices available to syphilitic couples, when a succession of miscarriages or stillbirths usually drained women suffering from the disease?[3] She linked women's good health to a two- or three-year interval between births. Children, too,

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[1]Sanger, Case for Birth Control, p. 155.

[2]J. Whitridge Williams, Obstetrics. A Textbook for the Use of Students and Practitioners (New York: D. Appleton and Co., 1903), p. 438.

[3]Sanger, Case for Birth Control, p. 218.

suffered from maternal disability; infant mortality rose among later children of women whose bodies could not rest between pregnancies.[1] Children born after five or six preceding births who survived were liable to be weak and prone to disease, especially tuberculosis.[2] What too was the emotional toll of infant death on women?

As her major contribution to maternal welfare work in the 1920s, Sanger highlighted the problem and the prevalence of abortion. For Sanger, without birth control, abortion followed inevitably. She depicted abortion in part as an expression of women's indelible instinct for self-development. Infanticide was women's initial statement; child murder declined only as abortion techniques became widespread. Ironically, abortion signaled both woman's death agent and her cry of freedom: "No adult woman who is ignorant of the means to prevent conception can call herself free. No woman can call herself free who cannot choose the

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[1]Sanger, cited data from the Children's Bureau study of infant mortality in Johnstown, Pennsylvania:

Number of Pregnancies	Infant Mortality Rate
1 and 2	108.5 per 1,000
3 and 4	126 per 1,000
5 and 6	152.8 per 1,000
7 and 8	176.4 per 1,000
9 or more	191.9 per 1,000

In Case for Birth Control, p. 96.

[2]S. Adolphus Knopf, "Birth Control. Its Medical, Social and Moral Aspects," Survey 37 (November 18, 1917):161.

time to be a mother or not as she sees fit.[1] Whether by default or in the only available affirmation of the hidden spirit of freedom, "the harassed mother"[2] tried to abort the life within her. Unfortunately, very often she, too, died. (Sanger referred to an unnamed "authority" who estimated total abortions at one million annually. In 1905, Elizabeth Crowell, commissioned to investigate the midwife situation in New York City, estimated conservatively that there were 100,000 abortions in the city each year, with approximately a third ending in the mother's death.)[3]

Sympathetic physicians corroborated Sanger's assertions.[4] Dr. Morris K. Kahn, who headed the cardiac clinic at Mt. Sinai Hospital and also served at a Department of Health tuberculosis center, directly violated Section 1142 of the Penal Code by distributing contraceptive information to poor women.[5] Kahn collected data on 464 women and

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[1]Sanger, Case for Birth Control, p. 8.

[2]Ibid., p. 85.

[3]Sanger, New Motherhood, pp. 25-27; F. Elisabeth Crowell, "The Midwives of New York," Charities and the Commons 17 (1907):674.

[4]Physicians friendly to the birth control movement included Abraham Jacobi, W. J. Robinson, S. A. Knopf, Alice Hamilton, and Robert L. Dickinson.

[5]The Comstock laws made it illegal to publish practical information on the methods of birth control. Section 1142 of the New York State Penal Code provided that no one could give contraceptive advice for any reason, although the statute did allow doctors to prescribe birth control for

discovered abortion nearly twice as prevalent among women who were totally ignorant of contraception, against those who knew of one or more preventive methods. Among 464 women, 192 were ignorant. Of these, more than half (104) had undergone abortions. Abortions totaled 202, almost two abortions for each woman. In the group of 272 women with some contraceptive knowledge, only 72, or about a quarter of the group, reported abortions.[1]

Sanger's correspondents depicted an even bleaker situation. One woman wrote: "I am just up out of bed from an abortion, the twelfth one, and four children, making a total of sixteen in 17 years, and am only a little past 36."[2] Where was the logic in the law which permitted legal termination of pregnancy if women suffered seriously from tuberculosis, nephritis, or heart disease, but did not allow doctors or health workers to teach methods to avoid the pregnancy? How were women to trust doctors who warned of the health hazards of another pregnancy but failed to give

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the cure and prevention of disease (to prevent men from contracting venereal maladies). Sanger wanted the law to be amended, permitting doctors to prescribe birth control for the cure or prevention of disease (including diseases contracted or made riskier by pregnancy).

[1]"Clinic Families and Birth Control," Survey 38 (April 28, 1917):98-99.

[2]Sanger, Motherhood in Bondage, p. 400.

practical advice?[1] A discouraged and confused husband wrote to Sanger:

> My wife cannot carry pregnancy through a birth. She has had to be aborted twice 'according to the law' in order to save her life. This has ruined her health, and more, has almost destroyed our home. The doctors and hospitals are very willing to make big charges for these operations, but will not give any information regarding the prevention of pregnancy, although they say it must not happen again.[2]

In the recent attack on Sanger's leadership qualities, historians have claimed that the middle class practiced birth control nonetheless, mooting much of Sanger's struggle. They hint that Sanger exaggerated the cause in her desire for the public limelight.[3] As a central point,

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[1]One woman wrote: "I have consulted several different doctors and they have told me not to have children, that I was too small. They have told me of no preventives." See Sanger, Motherhood in Bondage, p. 65.

[2]Sanger, Motherhood in Bondage, p. 225. See also Ira S. Wile, "Birth Control," Survey 37 (December 23, 1916): 346.

[3]Kennedy wrote: "By the time Margaret Sanger decided to make birth control a public issue, it was already very much a private one." He also claimed that Sanger's ideal method of birth control, the diaphragm, was impractical for the poor, since it required the privacy of a bathroom which tenement-house living did not provide. Birth Control in America, pp. 44, 186. Professor James W. Reed of Rutgers University, speaking at the Sidney Ditzion Conference in New York on June 8, 1976, contended that Sanger's followers came not from the poor, but from the middle class. Reed used Kinsey's unpublished data on the sex habits of married white women between 1899 and 1930 to demonstrate the prevalence of birth control, including the diaphragm. He concluded that while the middle class used birth control prior to Sanger's efforts, her movement resulted in a better method, as the diaphragm replaced withdrawal, the condom, and douching.

however, Sanger noted that disease and death in pregnancy affected primarily working-class women.[1] She attacked a medical double standard which somehow permitted the dissemination of advice among the wealthy, but kept the poor in ignorance. The product of the birth control movement may simply have been the provision of a new method of contraception (the diaphragm) for middle-class women,[2] but this was hardly Sanger's aim. Did fault lie with Sanger, or with an obstreperous social order and medical distribution system serving wealthy clientele?

Sanger recognized the class nature of the American medical system. Even if her published letters were bogus, they highlight the kind of sympathies to which she was attracted. In the early part of the movement she wrote: "A few years of this work brought me to a shocking discovery--that knowledge of the methods of controlling birth was accessible to the women of wealth while the working women were deliberately kept in ignorance of the knowledge."[3] Unlike most of her generation, Sanger saw the ill effects of the usual aborting drugs on unborn children as well as

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[1]Sanger, New Motherhood, pp. 74-76.

[2]James Reed, paper presented to Sidney Ditzion Conference, New York City, June 8, 1976. The Mensinga diaphragm first appeared in the 1880s but did not enjoy widespread use in America until Sanger overcame barriers against birth control.

[3]Sanger, Case for Birth Control, p. 6.

mothers. Since attempts to purge pregnancies often failed and women carried to term, children also bore the scars of women's lack of sexual self-determination.[1] Careful reading of Sanger's works demonstrates clearly her understanding that the poor carried the primary burden.

Contradictions abound in this period, but none stands out as forcefully as Sanger's simple attempt to give women the opportunity for sexual self-determination. Here, the medical establishment's performance underscored its real attitude toward women, especially the poor. Notwithstanding the abundant availability of data demonstrating the risks of illegal abortion, as well as the inescapable economic impossibility of raising too many children, medical leaders spurred the opposition to Sanger. Even with the evidence of statistics, presumptively present for all, and at a time when all knew that contraception was accepted by and available to the middle class, doctors' efforts perpetuated the bifurcated system and made certain that it extended into the birth control forum.

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[1]Sanger, New Motherhood, pp. 145-47, 151.

CHAPTER VIII

MIDWIVES, TRAINED PHYSICIANS, AND MEDICAL RESPONSIBILITY

> My experience is unique, as is every woman's. Still I think one might safely extrapolate some generalizations from my own rather lurid particulars. One is that, more or less, it [labor] does hurt. (My first baby hurt more; my second, less.) Another . . . is that, given an unaggressive, authority-accepting woman, most doctors will effectively wrest control away from her, manipulate the experience to suit their necessities, and turn childbirth into a melodrama in which the laboring woman plays only a minor role. Childbirth is a drama in which, properly and literally speaking, doctors ought to play a supporting role. If they are permitted to do the casting, however, what you're likely to get is a production in which Sleeping Beauty waits obliviously for her Doctor Prince Charming Deliverer. Give most doctors an inch, in other words, and they'll take the rest with forceps and saddle blocks.
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> --Barbara Grizzuti Harrison, 1973

Woman's oppression appears at many levels, but none is more basic than her unnecessary loss of life in childbirth. Early twentieth-century observers of maternal mortality in childbirth invariably attached such words as "preventable" and "avoidable" to their descriptions. In 1914, for instance, J. Whitridge Williams declared that "the obstetrical care which is available for the great

majority of women in this country . . . is inexcusably poor."[1] In 1919, the maternal mortality per 1,000 live births was 2.3 in Uruguay, 4.4 in England and Wales, and 7.4 in the birth registration area of the United States (which incorporated the most developed and the wealthiest regions of the country).[2] In 1921, Michael Davis, a leading medical administrator in Boston, noted "how little the general American public realizes that maternity care is a problem."[3] Since childbirth and the midwife are linked inextricably in the early part of the century, the question of accountability inevitably arises. Was the midwife or the physician to blame for this death rate? By 1930, midwifery was practically eliminated in the United States while in Europe, it became an integral part of the obstetrical process. Does the end of midwifery in America bear upon the quality of care women received? Is it significant that in New York City, maternal mortality increased from 4.4 per thousand live births in 1917 to 5.3 in 1921, as women turned steadily to hospitals for childbirth?

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[1]J. Whitridge Williams, "The Limitations and Possibilities of Prenatal Care Based Upon the Study of 705 Foetal Deaths Occurring in 10,000 Consecutive Admissions to the Obstetrical Department of The Johns Hopkins Hospital," American Association for the Study and Prevention of Infant Mortality. Transactions of the Fifth Annual Meeting, November 12-14, 1914, Boston, p. 32.

[2]Elizabeth Hunt, Public Maternity and Infant Care in Berlin and Stockholm (New York: American Scandinavian Foundation, 1922), p. 6.

[3]Michael Davis, Immigrant Health and the Community

What was the validity of the following statement?

> What have those fifteen other nations with lower maternal death rates than ours in common that we lack. . . . They have each and all one thing which we are missing altogether, and that is skilled midwifery, trained in the obstetrical centers and supervised by the state for each peasant mother in Highlands and Alps.[1]

Organized medicine in the United States historically balked at the incorporation of the midwife as medical technician. In Europe, after the discovery of the forceps and its designation as a surgical tool (the Church, then governments, forbid women to practice surgery), the midwife's status reached a low ebb. However, whether because female lay-healing had an entrenched tradition in Europe or because midwives effectively resisted their submergence, they were not eliminated and regained rank in the twentieth century.[2] Nonetheless, through the nineteenth century, the upper classes in Europe and America turned to the

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(New York: Harper and Brothers, 1921, reprint ed., Montclair, N. J.: Paterson Smith Publishing Co., 1971), pp. 243-44.

[1]Mary Breckinridge, "The Nurse-Midwife--A Pioneer," American Journal of Public Health 17 (November 1927): 1149.

[2]Elisabeth Nihell, A Treatise on the Art of Midwifery. Setting Forth Various Abuses therein, Especially as to the Practice with Instruments (London: A Morley, 1760) is the classic attack on the pretenses of the "man-midwives" and defense of the female practitioner. See also Barbara Ehrenreich and Deirdre English, Witches, Midwives and Nurses. A History of Women Healers (Westbury, N. Y.: Glass Mountain Pamphlets, 1973) for a history of women lay healers and their threat to the male ruling class.

physician--the fashionable choice--as birth attendant.[1]

In the United States, while male obstetrical predominance came later, it was more encompassing. By the 1870s, male physicians began to feel snug. A physician spoke for women in 1870:

> Women actually prefer a male accoucheur to a female. They feel safer in his hands. They rely not only upon his superior knowledge, but upon his courage. They feel he would not flinch before duty. . . . I know of many cases where the female accoucheur, getting frightened, deserted her patient at the moment she was most needed.[2]

In 1876, William Goodell, Clinical Professor of the Diseases of Women and Children at the University of Pennsylvania, recited the educational advantages of the male practitioner over the midwife. He concluded: "What is more natural than that intelligent women should prefer the teacher to the inept pupil; should place their lives in skilled hands, than those that were unlettered."[3] Obstetricians' comfort soon ended, as the wave of immigration at the turn of the century, which brought with it

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[1]Maternity Center Association, Twenty Years of Nurse-Midwifery, 1933-1953 (New York: Maternity Center Assoc., 1955), p. 79.

[2]T. S. Verdi, Maternity: A Popular Treatise for Young Wives and Mothers (New York: J. B. Ford and Co., 1870), p. 131.

[3]William Goodell, "When and Why were Male Physicians Employed as Accoucheurs?" The American Journal of Obstetrics and Diseases of Women and Children 9 (August 1876):382.

an unexpected resurgence of the midwife, jolted the profession.

Obstetrics had often been used as an entering wedge. A calculating physician would take on childbirth, in the hopes of winning confidence and hence the more lucrative family practice. In 1916 the field could still be characterized as

> . . . a pot boiler of the profession, the chief resource of the young and inexperienced and least trained physician, to be abandoned as soon as possible for a less arduous and rest-disturbing and more remunerative field.[1]

The reemergence of midwifery in the United States around 1900 presented a threat to this segment of the profession and precipitated immediate conflict.

The upsurge of midwifery, particularly in American urban centers, resulted from strong preferences among immigrant women. Wherever immigrants settled, the midwife flourished.[2] Italian women, reinforced by Italian men's strong propensity for midwives, held to the

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[1]Inez C. Philbrich, "A Municipally Salaried Obstetrical Staff," Woman's Medical Journal 26 (August 1916):191.

[2]See P. R. Eastman, A Comparison of the Birth Rates of Native and Foreign-Born White Women in the State of New York During 1916 (Albany: Department of Health, 1916), p. 4: Native white women: total births, 64,888; by midwife, 2,504, or 3.9 percent. Foreign-born: total births, 37,194; by midwife, 14,165, or 37.3 percent.

custom of female birth attendants.[1] Immigrants shunned the hospital, not only because of their instinctive resistance to its remoteness from most foreign residential enclaves and its impersonality, exacerbated by the alien language, but also because birth often afforded the occasion for festive celebration (the Jewish custom of circumcision, for example) which proscribed the woman's and child's absence from the home.[2] The midwife, almost always foreign born and living in the newcomers' community, lay in the buffer which immigrant groups maintained against an already overwhelming cultural shock.[3]

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[1]Davis, Immigrant Health and the Community, pp. 198-99; Social workers noted the prevalence of the midwife among Italians. As late as the 1920s, in the East Harlem district, 85 percent of all Italian deliveries were at home by midwife; among blacks in West Harlem, 52 percent of all mothers were delivered in hospitals by the 1920s. See East Harlem Nursing and Health Demonstration, The Maternity Service Report of the East Harlem Nursing and Health Demonstration (New York: The East Harlem Nursing and Health Demonstration, 1928), p. 15. In 1905, midwives attended 43,834 mothers in New York City, representing 42 percent of the children born. Among Italians, midwives delivered 93 percent of the births. See J. Milton Nabbott, "The Regulation of Midwives in New York," The American Journal of Obstetrics and Diseases of Women and Children 55 (April 1907):516. After Italians, then Russians, Austro-Hungarians, Poles and Germans most readily used the midwife. See Eastman, A Comparison of Birth Rates, p. 12.

[2]Davis, Immigrant Health and the Community, p. 193.

[3]See Grace Abbot, "The Midwife in Chicago," The American Journal of Sociology 20 (March 1915):684.

But in America, where the only alternative to midwife delivery was the hospital (for the rich or charity patient) or the private physician (usually a general practitioner with no particular obstetric expertise), the midwife became an economic necessity. She charged less, and she did more. As part of the social network of relationships in immigrant ghettos, she played the role of woman's confidant. The midwife was the source of magical home remedies as well as abortions. She stood by the woman through labor and returned to the home for postpartum care, for anywhere from five to ten days after birth. In the home, the midwife performed household services, cooking, cleaning, and child supervision.[1] For these efforts, she charged between $7.00 and $10.00. (Baker calculated the average midwife's fee in New York City at $8.00.) Simple delivery care of a physician, with no postpartum observation, cost between $20.00 and $25.00.[2] Custom and

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[1]U.S., Department of Labor, Children's Bureau, Standards of Child Welfare. A Report of the Children's Bureau Conferences of May and June, 1919, Section III, "The Control of Midwifery," by Henry D. Chapin; see also S. Josephine Baker, "Schools for Midwives," The American Journal of Obstetrics and Diseases of Women and Children 65 (February 1912):257. In 1906, Elisabeth Crowell's study of five hundred midwives in New York City found that they generally returned to the home for nine days after a child's birth (longer when necessary), visiting twice daily on the first two to three days. "The Midwives of New York," Charities and the Commons, 17 (1907):672.

[2]Baker, "Schools for Midwives," p. 257; Children's Bureau, Chapin, "The Control of Midwifery," p. 158; Davis, Immigrant Health and the Community, pp. 201, 220.

economics aside, the immigrant had a strong rational foundation, based upon midwives' capabilities in Europe, for her preference. There, where states licensed and supervised all midwives, training ranged from a six-month program in government health clinics in Germany to a year's instruction in Norway, Sweden, Denmark and Britain, and two years in Holland, France, and Belgium.[1]

The laissez-faire attitude in the United States toward the regulation of midwifery was more than a "contempt for alien customs,"[2] as Lillian Wald phrased it. At minimum it represented a disdain for or ingrained indifference to women's welfare. Until at least 1920, in urban centers with large foreign populations, midwives delivered between 25 and 40 percent of births.[3] Notwithstanding this reality,

> . . . there seems to be a general determination on the part of physicians and departments of health to ignore her existence and leave her

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[1]Davis, Immigrant Health and the Community, pp. 199-200; Abbott, "The Midwife in Chicago," p. 685.

[2]Lillian D. Wald, The House on Henry Street (New York: Henry Holt and Co., 1915), pp. 57-58.

[3]Phillip Van Ingen, "The History of Child Welfare Work in the United States," in Mazyck P. Ravenel, ed., A Half Century of Public Health, Jubilee Historical Volume of the American Public Health Association in Commemoratory of the Fiftieth Anniversary Celebration of Its Foundation, New York City, November 14-18, 1921 (New York: American Public Health Association, 1921, reprint ed., New York: Arno Press, 1970), p. 311.

> free to practice without preparation, despite the fact that her services are extensively used in humble homes.[1]

In Europe, midwives could not legally practice without training; governments tested competency periodically.[2] Midwives conducted 75 percent of all deliveries in England at the close of the first quarter of the century, and the country's maternal mortality rate was lower than in the United States. In 1902, when Parliament passed the Midwives Act and created a Central Midwives Board, the English midwife gained official status.[3] The act established April 1, 1910 as the date beyond which women could not call themselves midwives or practice the specialty unless they earned certificates of proficiency from approved training programs. The act also required that the midwife call a doctor in cases of complicated delivery. To ensure the physicians' presence, another

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[1]Wald, House on Henry Street, pp. 57-58. See also Thomas Darlington, "The Present Status of the Midwife," The American Journal of Obstetrics and Diseases of Women and Children 58 (May 1911):871.

[2]See U.S., Department of Labor, Children's Bureau, Infant-Welfare Work in Europe. An Account of Recent Experiences in Great Britain, Austria, Belgium, France, Germany, and Italy, by Nettie McGill, Publication No. 76 (Washington, D.C.: Government Printing Office, 1921) for descriptions of requirements for midwives in various foreign countries.

[3]Children's Bureau, Standards of Child Welfare, Discussion, Arthur Newsholme in reponse to Chapin, p. 164.

Midwives Act of 1918 mandated that local authorities pay the doctor's fee when necessary. The Crown prosecuted women practicing illegally, and disqualified midwives guilty of malpractice.[1]

In the United States, only New York City sought to duplicate the ubiquitous European regulatory scheme. Efforts to supervise the midwife and to ensure quality care resulted from a 1906 study in the city conducted by the Public Health Committee of the Association of Neighborhood Workers. Elisabeth Crowell, a nurse, led the investigation. In 1905, 43,834 (or 42 percent) of women delivered in the city gave birth with midwives. In Manhattan alone, between nine hundred and one thousand midwives practiced. After examining ten thousand birth certificates issued in April and May of 1906, Crowell selected five hundred New

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[1]In 1926, Parliament passed the Midwives and Maternity Home Act, making "it . . . illegal to practice as a midwife without having obtained the certificate of the Central Midwives Board, which is issued only to candidates who have passed the examination held by the Board. Candidates for admission must be no less than twenty-one years old and must have completed a prescribed course of training at an approved center." G. F. McCleary, The Maternity and Child Welfare Movement (London: P. S. King and Son, Ltd., 1935), p. 88. See also pp. 135, 153, 155-56; Children's Bureau, Standards of Child Welfare, discussion, Newsholme, p. 164. When Great Britain established the National Health Service in 1946, women became entitled to doctors and midwives during the pregnancy, labor, and postpartum period, whether confined in hospital or at home. See Maternity Center Association, Twenty Years of Nurse-Midwifery, p. 92.

York City midwives to investigate.[1]

Crowell concluded her report with recommendations for public supervision and licensing of the midwife. Respect for immigrant tradition or recognition of the valuable potential of the midwife did not enter into Crowell's consideration. Rather, it was the observation that of five hundred midwives, only 10 percent could be called capable.[2] Crowell charged midwives with an aggressive overconfidence, based on the testimony of three-fifths of the investigated group who admitted that they would not call for medical aid in abnormal deliveries. She discovered filth and rusty instruments in midwives' bags, coupled with attitudes of scorn toward legal requirements for sterilization.[3] Finally, she found only 40 percent properly trained, that is, having earned foreign diplomas. Many of the others claimed they had received degrees from schools in America, schools which tailored themselves around proprietary diploma-mill medical schools, distributing degrees in exchange for tuition. Still others maintained that practicing physicians had certified them, the result, Crowell speculated cynically, of deals that the

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[1]Crowell, "The Midwife in New York," p. 668.

[2]Ibid., p. 673.

[3]Ibid., pp. 671-72.

midwife would call upon the doctor in difficult cases.[1]

Assuming that the male specialist was almost faultless, Crowell pleaded dramatically for the training of midwives:

> No child is "well born" who starts life handicapped with a crippled limb, an accident of birth, or who must live out his day in blindness. . . . No mother had received proper attention who must endure months, frequently years of suffering, caused by the sequelae of childbirth. Doubtless the ideal condition would be to have the entire obstetrical practice . . . in the hands of physicians.[2]

At the moment this latter ideal was impractical, and Crowell urged a licensing procedure for midwives. Regulation, following upon the heels of this study, had to be somewhat expedient. Public health leaders urged that until the midwife's ultimate demise, she must be regulated. While attempts to elevate the midwives' standards were well meaning, health administrators never saw the midwife as more than a necessary evil.

By an act of June 6, 1907, the New York Legislature defined the legal status of the midwife in the state as one assisting in normal childbirth and receiving compensation for it. The statute forbid the use of forceps or any mechanical device by the midwife, as well as

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[1]Ibid., p. 670.

[2]Ibid., p. 675.

any drug but a disinfectant, and restricted the midwife strictly to simple delivery situations. The law gave special authority to the New York City Health Department to establish its own rules and regulations governing midwives in the city.[1]

In 1908, the City Department of Health promulgated criteria governing midwives' practice. The regulations foreclosed the profession to anyone without a permit, valid for a year only, from the Board of Health. The Board granted permits only to applicants twenty-one years or older who demonstrated literacy, moral character, and personal cleanliness. Before licensing, the midwife worked under a physician, with clinical observation of at least twenty cases of labor and at least twenty ten-day follow-ups of mothers and infants.

The rules narrowed midwives' attendance to cases of normal vertex (head) presentation. During pregnancy, the regulations required midwives to summon a doctor if the patient showed indications of pelvic deformity, if she vomited excessively, or if any edema were apparent; serious bleeding, persistent headaches or convulsions also necessitated the doctor's intervention. Any abnormal presentation in labor mandated the physician's presence,

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[1]An Act Regulating and Restraining the Practice of Midwifery in the City of New York L. 1907, Ch. 432.

as did situations when symptoms indicated version and instrumentation or manifested toxic or eclampsic signs. The regulations legitimized Credé's method for the removal of the afterbirth; if it was not expelled an hour after labor, the rules told the midwife to call a doctor.

The midwives' code required sterilization. They were to carry a one-percent solution of silver nitrate, and administer drops to the newborn's eyes to prevent infant blindness from gonorrheal infection. For five days following birth, according to the regulations, the midwife was to return to the home and report any women with fever above 101. Finally, the rules required the midwife to file a birth report with the Department of Health within ten days.[1] (By 1919, the filing period was within five days of birth.)[2]

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[1]Rules and Regulations Governing the Practice of Midwifery in the City of New York, Adopted by the Board of Health (New York: Department of Health, 1908), pp. 3-6, 9-13. Dr. S. Josephine Baker recalled the reaction to New York City's implementation of midwifery regulation: "The medical profession, particularly the obstetricians, made a great deal of trouble for us at this point. Their idea was that the best thing would be to stamp out midwifery altogether instead of compromising with it. The doctors were never able to understand the sort of people we had to deal with. If deprived of midwives these women would rather have amateur assistance from the janitor's wife or the woman across the hall than submit to this outlandish American custom of having in a male doctor for confinement." In S. Josephine Baker, Fighting for Life (New York: The Macmillan Co., 1939), p. 113.

[2]John A. Foote, "Legislative Measures Against Maternal and Infant Mortality: The Midwife Practise Laws

In 1911, Bellevue Hospital opened the first public school of midwifery. Henceforth, New York City required that midwife applicants graduate from Bellevue or a comparable European school. The Superintendent of Nurses at the Bellevue Nursing School directed the Bellevue School of Midwives. The school boasted nineteen maternity beds and an outpatient department, and provided free training for six months, during which students lived in the school. The school accepted applicants between twenty-one and thirty-five years, and required cleanliness and moral rectitude. Training included practical care of mothers, observation and assistance in labor and postpartum care, and actual responsibility for delivery under the direction of an obstetrical resident. Teaching emphasized recognition of abnormalities, along with the instruction of delivery techniques. The school granted diplomas only after the student had assisted in a minimum of eighty deliveries and had delivered twenty cases herself. Successful completion of the course required students' satisfactory evaluations in oral and practical examinations.[1]

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in the States and Territories of the United States," The American Journal of Obstetrics and Diseases of Women and Children 80 (November 1919):543-44, 546-48, 500.

[1]Davis, Immigrant Health and the Community, p. 204; J. Clifton Edgar, "The Education, Licensing and Supervision of the Midwife," The American Journal of Obstetrics and Diseases of Women and Children 78 (March 1916):391-92; Baker, "Schools for Midwives," p. 263; Van Ingen, "The History of Child Welfare Work in the U.S.," p. 311.

As the Bureau of Child Hygiene made special efforts to survey midwives practicing in the city periodically, eliminating those without licenses and working with certified midwives so that their clientele would later use the baby health clinics,[1] New York State set more definitive standards for midwifery practice. The Public Health Law of 1913 created the Public Health Council to regulate midwives. As of January 1915, the state withheld permits to midwives under twenty-one and to those who could not read or write or who were not "moral" or "clean." A practicing midwife would have to graduate from a recognized school, or receive a written statement from a physician certifying that she had attended fifteen cases of labor. She was required to carry silver nitrate, which the State Department of Health furnished free.[2]

Even if New York City's supervision of the midwife emanated from a respect for immigrant tastes--

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[1]S. Josephine Baker and J. L. Blumenthal, "Spending a Million Dollars for Care of Women and Children in New York City," The Medical Woman's Journal 31 (March 1924):60; Jacob Sobel, Instruction and Supervision of Expectant Mothers in New York City (New York: Department of Health, Monograph Series No. 21, 1919), pp. 11-12.

[2]Linsly R. Williams, "The Position of the New York State Department of Health Relative to the Control of Midwives," New York State Journal of Medicine 15 (August 1915):296-98. Linsly Williams was New York State Deputy Commissioner of Health.

> . . . that in a city like New York, harboring so large an alien population which for hundreds of years has been bound to the midwife because of tradition, custom, and economic condition, if you will, the proper kind of a midwife is a social necessity[1]

--this regulation reduced the number of active midwives and fed into obstetricians' unrelenting desire to exclude their perceived competition from the obstetrical scene. In 1909, 3,131 midwives practiced in New York City; in 1923, only 1,341 were engaged in childbirth. The group shrank yearly.[2] Notwithstanding the effort to produce scrupulous, clean, and responsible female birth attendants, public health authorities in the city never took up the battle for the midwife as a contributing entity. Health officials wanted to make her a safe attendant, but only to fill in gaps which would eventually be turned over to medical personnel. Indeed, prenatal workers, with some trepidation lest they alienate immigrant women, tried wherever possible to urge medical confinement.[3] Powerless and inarticulate, immigrant women could not save the midwife. She faded gradually from the scene, with a minimum of mourning by the medical profession.

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[1]Sobel, Instruction and Supervision of Expectant Mothers, pp. 16-17.

[2]Baker and Blumenthal, "Spending a Million Dollars for the Care of Women and Children," p. 60.

[3]See, for example, the Annual Reports of the New York Milk Committee.

Physicians divided on the midwife question, particularly the short-range solution. One group of doctors, while admitting that "theoretically the midwife should not exist,"[1] recognized that her immediate abolition was unrealistic and premature. Dr. Linsly Williams noted that in New York State outside of New York City, midwives reported a fourth of all births; the legal elimination of the midwife without substitutes would mean "either that the midwives would continue to practice without a license, or that the patients would not be able to receive any assistance whatsoever during the period of childbirth."[2] This group suggested an education program for the existing midwife population, with a simultaneous increase in free maternity facilities.[3] Regulation would simply be for safety protection, not an "attempt to perpetuate [the midwife] as a separate profession."[4] New indoor and outdoor services would act to draw poor women from the midwife's domain.

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[1]J. M. Baldy, "Is the Midwife a Necessity?" The American Journal of Obstetrics and Diseases of Women and Children 73 (March 1916):406.

[2]Williams, "The Position of the N. Y. State Dept. of Health Relative to the Control of Midwives," p. 298.

[3]Baldy, "Is the Midwife a Necessity?," pp. 400, 406; Edgar, "The Education, Licensing and Supervision of the Midwife," pp. 386-88, 395-96, 398.

[4]Edgar, "The Education, Licensing and Supervision of the Midwife," p. 398.

A more adamant group of obstetricians charged that any supervision of midwives would legitimatize them--a classic example of the subordination of women's health to doctors' professional goals. Writing in 1898, Garrigues urged the maintenance of the status quo in New York State, with no attempts at midwifery regulation.[1] For Garrigues, "the institution of midwives is a remnant of barbaric times, a bolt on our civilization, which ought to be wiped out as soon as possible."[2] The preeminence of the physician represented, to him, a logical progression of the new order over the old. His remedy called for the legal banishment of the midwife and "a law by which midwifery . . . is exclusively placed in the hands of the medical profession, where it belongs."[3] He described the midwife as hopelessly incapable and uneducable, somehow steeped forever in unalterable ignorance exacerbated by ingrained obstinacy.

Garrigues had no hope of achieving surgical antisepsis with the midwife.[4] Glibly, he shunted aside the

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[1]Garrigues applauded the death of a bill, introduced in the New York State Legislature in 1884, which would have chartered a college for midwives. See Garrigues, "Midwives," Medical News (February 19, 1898):1.

[2]Ibid., p. 11.

[3]Ibid., pp. 4-5.

[4]Ibid., pp. 6-8.

European situation as inopposite to the American scene. The midwife prevailed in Europe, he said, only because there were not enough physicians. In the United States, he estimated, there were three times as many doctors than in Great Britain and yet more when compared to the continent.[1] Garrigues originally presented his statements to the Section of Obstetrics and Gynecology of the New York Academy of Medicine. On January 27, 1898, the group resolved in favor of a bill outlawing midwifery and limiting the practice to licensed physicians.[2]

Obstetricians' battles against the midwife were in large measure a struggle for their own independent recognition in a medical world in which they enjoyed marginal status. Their fight for identity was doubly complicated, since for decades the general practitioner had rather casually assumed childbirth responsibility amidst a busy family practice. The midwife's threatened invasion of the physician's territory posed a direct

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[1]Ibid., pp. 9-10: "In the State of New York the total population [1890] was 5,997,853 . . . [and] 3,020,960 were females. Taking the proportion for the United States, this leaves 1,555,190 women of child-bearing age. Now, there are 11,139 physicians and surgeons, or one physician for every 139 women of child-bearing age." In New York City (before the 1898 integration with Brooklyn), he found the proportion even higher, with 395,556 females of child-bearing age and 3,351 doctors and surgeons. This meant there was one doctor for every 118 women, "an average of but 15 confinements yearly for each physician practicing in the City of New York."

[2]Ibid., p. 13.

affront to doctors defending the necessity for special obstetrical training. Stark reality showed that "some 30,000 women have taken enough practice away from the physician to obtain livelihood."[1] Obstetricians could not afford this profit sharing. In rallying the profession, another physician cited the situation in New York City, where a "body of 1,448 midwives deliver approximately 53,000 babies per year, [and] all that the lying-in hospitals in New York City can care for is 11,000."[2]

To combat these twin threats, obstetricians urged their own indispensability. In justification of their existence, they stressed the pathological risks of pregnancy and labor: "Childbearing, while a normal function, is capable of such variation that only the physician should be permitted to delivery the patient."[3] Even stronger was the statement of Dr. Edward Reynolds:

> I have seen infinitely more damage to women from the absence of forceps, from unduly long labor, from that pernicious doctrine that nature is safe

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[1]Arthur B. Emmons and James L. Huntington, "The Midwife, Her Future in the United States," The American Journal of Obstetrics and Diseases of Women and Children 65 (March 1912):394.

[2]John Van Doren Young, "The Midwife Problem in the State of New York," New York State Journal of Medicine 15 (August 1915):291.

[3]Ibid., p. 295.

> and not dangerous in obstetrics, than from all causes combined.[1]

It should not be surprising that the first quarter of the twentieth century was the heyday of obstetrical operative interference (viz., interference with natural labor through forceps, version, or cesarean section) and that analysis of maternal mortality in the late twenties would single out the frequently unnecessary use of forceps and cesarean section as major causes of that mortality. In essence, though, physicians insisted that the midwife would hold no value "until she becomes a practising physician."[2]

Obstetricians claimed that their unique attributes could not be transferred to others. They saw midwives as an obstreperous lot who would never bow to supervision.[3]

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[1]Discussion, Dr. Edward Reynolds, in Edward P. Davis, "The Need of Hospitals for Maternity Surgical Cases," American Association for the Study and Prevention of Infant Mortality. Transactions of the Fifth Annual Meeting, November 12-14, 1914, p. 205.

[2]Joseph B. DeLee, "Progress Toward Ideal Obstetrics," The American Journal of Obstetrics and Diseases of Women and Children 73 (March 1916):414.

[3]Emmons, and Huntington, "The Midwife, Her Future in the United States," p. 393; Darlington, "The Present Status of the Midwife," p. 873: "The midwives in New York City are still [1911] ignorant and incompetent women as a class, and no amount of supervision will make them otherwise." This opinion was hardly unique. See E. R. Hardin, "The Midwife Problem," Southern Medical Journal 18 (May 1925):349: "No training under the sun could make her a competent obstetrical attendant."

Then, they asserted that the midwife would always remain incapable of recognizing the frequent abnormalities in labor, as she could never be trusted to make an antiseptic environment.[1] Proper prenatal care, with blood pressure readings and urinalysis, lay beyond the midwife's scope, as did adequate medical inspection of the newborn. And what was good obstetrical care without the forceps and chloroform?[2] Physicians blamed midwives for the massive amount of gynecological surgery resulting from unmended childbirth lacerations, and for the prevalence of blindness from ophthalmia neonatorum.[3] Finally, doctors depicted midwives as willing abortionists. One physician made midwives accountable for one-third of the abortions in New York City.[4] Interestingly, he did not question the source of the remaining two-thirds.

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[1]Ralph W. Lobenstine, "The Influence of the Midwife upon Infant and Maternal Morbidity and Mortality," The American Journal of Obstetrics and Diseases of Women and Children 58 (October 1911):878; Henry J. Garrigues, A Text-Book of the Science and Art of Obstetrics (Philadelphia: J. B. Lippincott Co., 1902), p. 213.

[2]J. Milton Mabbott, "The Regulation of Midwives in New York," The American Journal of Obstetrics and Diseases of Women and Children, 55 (April 1907):526-27; Young, "The Midwife Problem in the State of New York," p. 294.

[3]Hardin, "The Midwife Problem," p. 347.

[4]Lobenstine, "The Influence of the Midwife," p. 878; see also Garrigues, A Text-Book, p. 214; Young, "The Midwife Problem in the State of New York," p. 294.

Like the institution of monarchy, physicians portrayed the midwife as "an old continental custom" which alien people sought to foist--"to engraft"--on a modern nation. "We do not want midwives. The mothers of our children ought not to have midwives."[1] Another doctor denied any valid distinction between midwives of the New York tenements and her sisters who were educated in Europe: "They are equally dirty."[2]

More than all the purported hazards which the midwife posed to her patients, doctors feared that by giving the midwife a distinct standing or place, the physicians' rank would sink correspondingly. Supervision of the midwife would create two obstetrical standards, an intolerable situation. Obstetricians had stood too long in an ambivalent position, and they saw the midwife's sudden flourishing as a drag on the forward movement of the profession. "As long as the medical profession tolerates that brand of infamy, the midwife," one very certain physician remarked, "the public will not be brought to realize that there is a high art in obstetrics and that it must

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[1]Discussion, Dr. George W. Goler (Health Officer of the City of Rochester), in Williams, "The Position of the New York State Department of Health Relative to the Control of Midwives," p. 300.

[2]Discussion, Dr. Edward Reynolds, in Davis, "The Need of Hospitals for Maternity Surgical Cases," p. 205.

pay as well for it as for surgery."[1] Without a single obstetrical standard, "the modern tendency . . . to lift obstetrics to the level of medicine and surgery" seemed impossible.[2]

Even when statistics demonstrated that midwives were more than adequate birth attendants vis-a-vis contemporary medical performance, their opponents did not relent. They retorted simply that the answer lay not in regulation and training of midwives, but in the production of better trained obstetricians. "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."[3]

Later obstetricians scoffed, as did Garrigues, at European training of the midwife. While conceding that a midwife's six-month intensive training course in Germany was "far superior to that which the great majority of

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[1]DeLee, "Progress Toward Ideal Obstetrics," p. 410; see also Hardin, "The Midwife Problem," p. 347; Emmons and Huntington, "The Midwife, Her Future in the U.S.," p. 398.

[2]J. J. Huntington, "The Midwife in Mass.: Her Anomalous Position," Boston Medical and Surgical Journal 168 (March 20, 1913):419.

[3]Emmons and Huntington, "The Midwife, Her Future in the United States," p. 397; see also DeLee, "Progress Toward Ideal Obstetrics," p. 411.

physicians receive in this country before graduation,"[1] and that the German midwife's oral and written examination "is one that the average graduate of an American medical school would have difficulty in passing with distinction,"[2] American doctors called these systems expensive and insisted that they would foster resentment among licensed physicians.

Medical arguments against the midwife centered upon the ominous side of pregnancy and labor. The juxtaposition of the midwife and the doctor presented the physician as virtually infallible. Midwives were dense; no matter how often midwives heard antiseptic principles, they would invariably wander out of the sterile field.[3]

Specialists recommended the education of the public to the recognition of "such a thing as the 'science and art of obstetrics,'" rather than the education of the midwife. They wished to make the public realize the nature of the obstetrician's skill, "so time and strength-consuming, and so exacting," that they will be willing "to duly compensate to him for the work." Doctors urged municipalities to do anything, to provide more free

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[1]Hardin, "The Midwife Problem," p. 347.

[2]Emmons and Huntington, "The Midwife, Her Future in the United States," p. 396.

[3]Ibid., p. 397.

services, hospital rooms at moderate prices, or government subsidies to doctors, but not to yield to the midwife. The recognition of the midwife, they warned, would demoralize the profession. How could the medical student be convinced to "specialize [in obstetrics] when midwives and practitioners deliver babies without training"?[1]

With minimal exceptions (e.g., such areas as New York City and State, Newark and Philadelphia), the American midwife never reached such basic levels as regulation and education.[2] Instead, the midwife remained a declassed person. Second generation immigrant women abandoned the custom of their mothers and turned to the physician. A new generation of women learned to distrust the midwife and doubt the naturalness of childbirth.

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[1]Charles E. Ziegler, "How We can Best Solve the Midwifery Problem," American Journal of Public Health 12 (May 1922):409, 407; see also Mabbott, "The Regulation of Midwives in New York," pp. 526-27; Hardin, "The Midwife Problem," p. 348; Young, "The Midwife Problem in the State of New York," p. 294.

[2]In 1921, Michael Davis detailed the official status of the midwife in the states of the nation: "Only twenty-one of our forty-eight states have laws regulating midwifery, but in many of these, the laws are almost valueless because no provision for enforcement is made. In Massachusetts and Nebraska, the midwife cannot practice legally. In thirteen states there are no laws applying at all, and the midwife may practice for weal or woe. They are Arizona, Arkansas, Florida, Georgia, Idaho, Kentucky, Maine, Mississippi, New Mexico, South Carolina, Tennessee, Vermont, West Virginia. In twelve states the midwife is legally recognized, but there are no general laws regulating her training or practice." Immigrant Health and the Community, p. 205.

Midwives could not long survive such an atmosphere. In New York City in 1900, they delivered 48.51 percent of the births; midwives handled 39.2 percent of births in the city in 1915, while they attended the births of 40 percent of the population in the entire United States, 75 percent in St. Louis, 50 percent in Wisconsin, and 50 percent in Chicago.[1] In New York City in 1909, the Health Department listed 3,191 midwives as registered, reporting attendance at 49,616 births, or 40 percent of the total; in 1920, the city roster carried only 1,517 practicing midwives who delivered 36,369 women in childbirth, or 26 percent of the total. This decline took place notwithstanding an increasing population, as births in New York City increased from 103,881 in 1905 to 141,564 in 1917.[2] The downward trend accelerated; in 1923, midwives in the city delivered 21 percent of the births and in 1933 midwife delivery amounted to a mere 8.5 percent of the total

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[1]John Duffy, A History of Public Health in New York City: 1866-1966 (New York: Russell Sage Foundation, 1974), p. 461; Darlington, "The Present Status of the Midwife," p. 870; B. Abbott, "The Midwife in Chicago," p. 684; J. Clifton Edgar, "The Education, Licensing and Supervision of the Midwife," The American Journal of Obstetrics and Diseases of Women and Children 73 (March 1916):388.

[2]Lewinski Corwin, The Hospital Situation in Greater New York, p. 64; J. Clifton Edgar, "Why the Midwife?" The American Journal of Obstetrics and Diseases of Women and Children 78 (August 1918):243.

annual births.[1] Was medical hegemony worthwhile? Was there a commensurate decline in maternal mortality, matching the midwife's demise? Was it possible to have elevated the midwife's status to the level of a paraprofessional? In a wildly misallocated medical system, was there still no place for her?

When health officials educated the midwife, evidence demonstrated that she offered safe, if not safer, care. Where city health departments regulated the midwife, physicians' hostile charges of midwife stubbornness and individualism proved mythical, clear fabrications without substance. These cooperative efforts seemed to engender midwives' professional pride, and effective mutuality between health officials and the foreign birth attendant often followed. The midwife reciprocated when the system legitimized her distinct role. Upon collaborating with the city's midwives and emphasizing the importance of care during the prenatal period, the staff of the Division of Midwives and Foundlings of the New York City Bureau of Child Hygiene found 65 percent of those receiving prenatal city care enrolled in the program by virtue

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[1]New York Academy of Medicine, Manuscript Collection, Box 8, New York Obstetrical Society, Folder: Correspondence Regarding the Study of Maternal Mortality, 1930-1934. Report of the Committee of the New York Obstetrical Society, to Review the Maternal Mortality Report of the Public Health Relations Committee of the New York Academy of Medicine.

of midwives' referrals. Midwives responded generously, with scrupulous care. Among the prenatal patients in city clinics, midwives delivered their 65 percent. "Of this number," Baker reported in 1914, "we have had no deaths, no cases of ophthalmia neonatorum or eclampsia."[1]

Many observers realized that where midwives were supervised, they posed no danger. In Providence, Rhode Island, where midwives worked with city officials, their infant mortality rate fell to 77, against a mortality rate of 117 for the rest of the city.[2] In Buffalo, health workers reported that midwives' patients underwent significantly less operative interference, yet midwives properly called for medical aid for abnormalities when required.[3] In 1913, Newark's Division of Child Hygiene

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[1]Discussion, S. Josephine Baker, in Mrs. Max West, "The Development of Prenatal Care in the United States," American Association for the Study and Prevention of Infant Mortality, Transactions of the Fifth Annual Meeting, Boston, Mass., November 12-14, 1914, p. 113. Grace Abbott studied 182 midwives in Chicago. Fifty-two had been trained in Europe, and the quality of their childbirth attendance reflected that training. Their persons, bags, and homes were clean; they performed a minimum of vaginal examinations during labor; and the women whom they attended suffered few lacerations. Of the remaining 125, 50 had no education beyond the fourth grade, and 91 none beyond the eighth grade. No surprisingly, this group exhibited little surgical cleanliness. See Abbott, "The Midwife in Chicago," pp. 684-99.

[2]Davis, Immigrant Health and the Community, p. 213.

[3]Williams, "The Position of the N. Y. State Dept. of Health Relative to the Control of Midwives," p. 300.

began working with the midwife. Capitalizing on midwives' influence (they delivered 50 percent of the city's babies), district nurses relied on the midwife for their prenatal clientele. Julius Levy, director of the division, felt more than satisfied. The city's maternal mortality dropped steadily, to compare favorably to other large cities. In 1914, it stood at 5.3 per 1,000 births; by 1915, the rate fell to 3.6 and in 1916 it was 2.2. In 1916 in Boston (where the midwife was illegal), the maternal mortality rate lay at 6.5.[1] Infant deaths in the first month of life remained considerably lower among babies whom midwives had delivered. In this group, 25 of each 1,000 births died before reaching one month, compared to 38 per 1,000 for the infants delivered by physicians at home and 57.3 per 1,000 births for babies born in hospitals.[2]

Was there statistical validity for the midwife's exclusion from the medical system? In the case of ophthalmia neonatorum (blindness from gonorrheal bacteria,

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[1]Julius Levy, "The Maternal and Infant Mortality in Midwifery Practice in Newark, New Jersey." The American Journal of Obstetrics and Diseases of Women and Children 77 (January 1918):41-42; see also Davis, Immigrant Health and the Community, p. 205.

[2]Levy, "The Maternal and Infant Mortality in Midwifery Practice in Newark, New Jersey," p. 44; Infant mortality in 1916: Neward 89.6; New York, 93.1; Boston, 104; Detroit, 112.8; Buffalo, 113.9.

which the infant contracts in passage through the birth canal), studies failed to corroborate physicians' allegations. The prophylactic application of two drops of one percent solution of silver nitrate in each of the infant's eyes immediately upon birth easily prevented the infection, which caused seven thousand cases of blindness in the United States in 1910.[1] In 1909, the Massachusetts Eye and Ear Infirmary investigated 116 cases of ophthalmia neonatorum. In only two cases did midwives deliver the victims, while 114 were under doctors' care.[2] This was not an isolated example. Nurses of the New York City Health Department visited homes of twenty-seven cases of the infection and found that in twenty-two, physicians attended to the birth. The New York School of Philanthropy made a similar survey of a sample of thirty-three cases of infant blindness and discovered physicians responsible for the deliveries of twenty-two and midwives for eleven.[3] Research by the Boston School for Social

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[1]Van Blarcom, "A Possible Solution to the Midwife Problem," Proceedings of the National Conference of Charities and Correction at the 37th Annual Session, St. Louis, Mo., May 19-26, 1919, p. 350. Van Blarcom was Executive Secretary of the Committee on the Prevention of Blindness of the New York Association for the Blind.

[2]Ibid., p. 356; see also Davis, Immigrant Health and the Community, p. 214; "Conservation of Eyesight," Survey 25 (February 7, 1911):522.

[3]"Conservation of Eyesight," p. 522; Van Blarcom, "A Possible Solution to the Midwife Problem," p. 356.

Workers in five Massachusetts cities uncovered doctors using lemon juice in place of silver nitrate; of the ninety-five doctors interviewed, only 17 percent routinely applied the prophylactic.[1] "It is common knowledge," wrote Sobel of the New York City Bureau of Child Hygiene, "that prophylactic instillation into the eyes of the new-born of various silver preparations is more commonly practised by the midwives of this city than by physicians." Doctors balked at centralized supervision, while midwives obeyed. New York City law required both groups to report cases of sore eyes in newborns (a symptom of infection); the Bureau found physicians negligently indifferent to this requirement and the midwives responsive.[2]

In New York City in 1916, with about 40 percent of births in midwives' hands, only 21 percent of the deaths from puerperal sepsis could be traced to their deliveries. Physicians, who reported approximately 60 percent of the city's births, bore responsibility for 69 percent of the female deaths from puerperal septicemia.[3] Again, infants in their first week of life did better when delivered by

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[1]"Infant Blindness in Massachusetts," Survey 25 (October 1, 1910):9.

[2]Sobel, Instruction and Supervision of Expectant Mothers, p. 18.

[3]Ibid., p. 17. The rate of puerperal sepsis per 10,000 births, according to attendant: Midwives, 1915, 8.6; 1916, 10.7. Doctors: 1915, 24.0; 1916, 20.7.

by midwife. In a study of 581 first-week deaths, 35.1 percent were midwife babies, compared to the 64.9 percent which physicians had delivered.[1] Was the midwife indeed obdurant, uneducable? New York City health officials thought not. After working with the midwife, Sobel, speaking in his official position at the Bureau of Child Hygiene, found the midwife amenable:

> . . . to the limitations of her calling. She has been taught just how far she may go and when she must call for medical assistance. If we are to be honest with ourselves, can we say the same of a large number of the medical profession, many of whom are engaged in the practice of obstetrics because they must, rather than because they want to, and who in their impatience or because of activities in other lines, resort to unnecessary, untimely, or unwarranted interference?[2]

The early twentieth century is a particularly poignant period in the history of maternity care. Slaying the midwife robbed women of a potent paramedical assistant. The maternity manpower shortage[3] offers just one

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[1]Ibid., p. 18.

[2]Ibid.

[3]The elimination of the midwife and the parallel decision to leave existing practitioners uneducated had its most devastating effect in rural America, where medical personnel and facilities were sparse or nonexistent. Were the midwives' detractors consciously callous in advocating a policy of noninterference when they were unwilling to practice in rural areas themselves? Mary Breckinridge, who established a midwife service for Kentucky in the 1920s, asked: "What value is it to her [the rural mother, where the nearest doctor is often a day's ride away on horseback] that we, erect costly buildings in the cities,

illustration of the conflicting interests of public health and the medical monopoly.

Medicine as an elite, specialized corps is relatively recent. Unlike the present, where the medical establishment often seems to link a paucity of doctors

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and perfect the obstetrical genius of a few men--to reach with superperfect care a fraction only of our motherhood?" See Mary Breckinridge, "The Nurse-Midwife--A Pioneer," American Journal of Public Health 12 (November 1927):1148. The Kentucky service provided care for a two hundred square mile area. Four centers sent midwives, who provided prenatal assistance, delivery and ten-day postpartum care, for $5.00. See "The Nurse-Midwife," p. 1148. The alternative for rural mothers was the kind of midwives who Dorothy K. Brown found in Georgia. Brown decried some of their superstitions: "One says she can cure any kind of trouble with wild plants. Another told of stopping convulsions with garlic. One whole garlic cut and steeped on one-half cup of boiling water. Eat it with a spoon." Another custom which she described as follows: "to bring the after-birth, they put chicken feathers in a large pot, pour boiling water over it, and have the women sit over the steam. . . . To put turpentine in cold water and sprinkle it over the abdomen will also bring the after-birth." See Manuscript Collection, Schlesinger Library, Dorothy K. Brown Papers, Box 2, Folder 36a, 1926-1929. In 1931, the Maternity Center Association began a training program for nurse-midwives. The Lobenstine Midwifery Clinic opened on West 113th Street in Manhattan. Its purpose was to accommodate women who still desired home delivery and who gave signs of normal birth. It allowed for more leisurely prenatal visits, and provided the emotional ambiance of home birth for women who desired it. By 1936, 1081 mothers had been delivered by the nurse-midwives' service. Yet in 20 years, the program graduated only 231 nurse-midwives. In 1953, the clinic moved to the Maternity Center Association building at 48 East 92nd Street. The same year, the Maternity Center Association called for a new look at the psychological benefits of domiciliary confinement. See Maternity Center Association, Twenty Years of Nurse-Midwifery, 1933-1953, pp. 7, 11, 18, 28, 79, 86, 115. See also Log, 1915-1963 of the Maternity Center Association, p. 9.

to high professional standards (some argue incomes), last century's training flooded the American market with an abundance of physicians. Medical education through 1870 involved a two-year didactic course of study, with classes meeting for only four or five months each year. Dispensaries provided the chief source of clinical experience. As such, they received more use from aspiring graudates than students in training. As ill-equipped as most graduates were, medical schools did not become totally responsible until bacteriology turned pathology from a speculative to an empirical science.[1]

In the latter part of the century, an astronomical increase in medical schools[2] coincided with significant advancements in medical knowledge. The colliding trends meant that if all schools did not uniformly incorporate the equipment and personnel for dissemination of the new knowledge, physicians of widely differing abilities would graduate. That happened. Entrepreneurs often established schools on proprietary, commercial bases. While enrolling

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[1]See William G. Rothstein, American Physicians in the Nineteenth Century. From Sects to Science (Baltimore: The Johns Hopkins University Press, 1972), pp. 89, 92. Martin Kaufman, American Medical Education. The Formative Years, 1765-1910 (Westport, Connecticut: Greenwood Press, 1976), p. 40.

[2]Rothstein, American Physicians, p. 286. After the Civil War, the medical schools increased 16 percent between 1860 and 1870, 23 percent between 1870 and 1880, and 34 percent between 1880 and 1890.

students from the middle and lower economic strata, they operated chiefly as profit-making diploma mills, unwilling to incur the expense which installation of laboratories and employment of full-time faculties required.

Prior to 1900, even states which had licensing laws ignored them, and the medical degree itself became a license to practice. This state of affairs meant several things. First, it offered no means by which doctors' qualifications could be tested. Moreover, it swelled the ranks of practitioners while it attenuated the financial status of the profession.[1] The transformation of medical training began among older institutions, traditionally drawing students from the wealthy. These schools were most receptive to scientific and pedagogic change; they could also afford it. Better training became an emblem for the social elite. Medical reform was unable to shed an aura of social snobbism.

Harvard, in 1871, was the first school to extend the medical program into a three-year course. Johns Hopkins, formally established in 1893, was the first to require a B.A. for admission, as well as to install laboratories, hire a full time staff, and annex a teaching

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[1]See John Duffy, The Healers: The Rise of the Medical Establishment (New York: McGraw-Hill, 1976), p. 266.

hospital to the school.[1] Yet even among the established institutions, change came at a desultory pace. In 1938, Dr. Lewis Conner recalled his medical education at the Columbia College of Physicians and Surgeons in 1887:

> I suppose there may have been worse medical schools in the country at that time than P. & S., but it is really very hard to believe it. All that was done for us as students was to give us the privilege, after paying our fees, of attending didactic lectures all day long for three years and then getting our diploma. During the last two years we had a few clinical lectures in the Vanderbilt clinic, but we never came within a mile of touching a patient.[2]

In November 1908, the Carnegie Foundation engaged Abraham Flexner to survey and evaluate American medical education. His findings of widespread commercialism, lax requirements, and inadequate school facilities and clinical preparation of students stunned the profession. Flexner's primary message urged that medical schools keep pace with the new demands of knowledge.[3] Many schols did not even require a high school diploma for admission

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[1]Rothstein, American Physicians, pp. 285, 290-91. In 1893, Hopkins, Pennsylvania, Harvard, Michigan and Chicago medical schools required a four-year course of study for the medical degree.

[2]Quoted in J. A. Harrar, The Story of the Lying-In Hospital of the City of New York (New York: The Society of the Lying-In Hospital, 1938), p. 75.

[3]Abraham Flexner, Medical Education in the United States and Canada. A Report to the Carnegie Foundation for the Advancement of Teaching, Bulletin No. 4 (New York: Carnegie Foundation, 1910), p. viii.

and there appeared to be no way in which the public could confidently pick a doctor. (Of the 150 American and Canadian schools Flexner investigated, only Harvard, in addition to the Hopkins, required a baccaulaureate degree and reading knowledge of French and German for admission.)[1]

Flexner deplored the blatant commercialism of medical education, in which many deans "know more about modern advertising than about modern medical teaching." With a certain elitism, Flexner condemned the profit orientation of many schools: "A medical school may . . . eschew clinics and laboratories, cling to the didactic type of instruction and arrange its dates so as not to conflict with seedtime or harvest." In the same paragraph, he continued that a school may choose to adopt the modern advances, "but it cannot . . . open the latter type of school to the former type of student . . . crude and untrained."[2]

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[1]Ibid., p. 19, 28. Requirements for admission varied from two years of college downward through four years of high school or the "equivalent," to nothing. Only sixteen schools demanded two years of college, another six one year. See Ibid., pp. 268-72, for the requirements of New York City schools: P & S, high school; Cornell, three years of college; University and Bellevue Hospital and Medical College, high school; Fordham, high school; New York Medical College and Hospital for Women, four years of high school; New York Homeopathic Medical College and Flower Hospital, high school.

[2]Ibid., p. 22.

The report sprouted the notion that elimination of the overproduction of doctors was a major goal of medical reform. Although Flexner discussed only the surplus of poorly trained practitioners, he could not see how maintaining the existing number of schools could draw consistently competent students. Only a cutback would eliminate the "cheaply made doctors."[1] In his opinion, Flexner rejected the possibility that expensively-trained students would shun small towns or rural communities. He could not conceive that doctors might be guided by income, not by professional motives.[2]

In his evaluation of medical curricula, Flexner emphasized the lack of clinical instruction--the failure of most schools to connect themselves with hospitals or dispensaries. He found obstetrics the weakest area in the entire medical curriculum:

> The very worst showing is made in the matter of obstetrics. Didactic lectures are utterly worthless. The manikin is of value only to a limited degree. . . . The safety and comfort of both patients--mother and child--depend on the trained care and dexterity of the physician. The practice is a fine art which cannot be picked up in the

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[1]Ibid., p. 14. See also pp. xi, 49. With about one doctor to every 568 persons (in large cities, approximately one to every 400), the United States had four or five times the number of doctors in proportion to its population as did Germany.

[2]Ibid., p. 44.

> exigencies of out-patient work. . . . Principles, methods, technique, can be learned and skill acquired only in an adequately equipped maternity hospital.[1]

Others echoed Flexner's judgment on the place of obstetrics. In addition to their lack of clinical preparation, obstetricians generally lacked knowledge of gynecology, and gynecologists knew nothing of childbirth. The separation of gynecology from obstetrics in American medical schools was unique to this continent. Commonly,

> . . . professed experts in obstetrics [were] incompetent to deal surgically with some of the most urgent and important complications of their patients, directly connected with the act of childbearing.[2]

Maternity health campaigners began to see that women's peculiar maladies were connected to obstetrics. Perhaps neurasthenia was not psychologically rooted, but had a real physiological basis. Women, left scarred, some made invalids from childbirth, became depressed simply because they were not well. If they were lucky, some sought gynecological aid and remedy. Dr. Ralph W.

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[1]Ibid., p. 117; see also p. 76.

[2]Barton C. Hirst, "Fifteen Years' Experience with the Intermediate Repair of the Injuries of Childbirth," The American Journal of Obstetrics and Diseases of Women and Children 75 (May 1917):755-76; see also W. W. Chipman, "Teaching Obstetrics: Necessary Equipment," American Association of the Study and Prevention of Infant Mortality. Transactions of the Fifth Annual Meeting, Boston, Mass., November 12-14, 1914, pp. 181-82, 184; Mary Sherwood, "Statement to the Section on Obstetrics," Ibid., p. 176.

Lobenstine, an obstetrical expert and founder of the Maternity Center Association, estimated that approximately 50 percent of all gynecological surgery was performed to heal childbirth injury.[1] If the obstetrician was not versed in gynecology, he could not treat the immediate minor problems which often developed into more serious ailments. For example, local lesions left unmended frequently became infected, a major source of women's postpartum irritability, one physician contended. "Everywhere else in the world obstetrics and gynecology are regarded as one subject, and are so taught to students, and to a great extent are practiced by the same men."[2]

J. Whitridge Williams, who set out in 1911 to assay the competency of the midwife, ended with a dissertation on the incompetence of the physician practicing obstetrics.[3] In attempting to balance the physician's

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[1]Children's Bureau, Standards of Child Welfare, p. 179. See also Hirst, "Fifteen Years' Experience with the Intermediate Repair of the Injuries of Childbirth," p. 757.

[2]Edward Reynolds, "The Relation of Gynecological Surgery to Bad Obstetrics," American Association for the Study and Prevention of Infant Mortality, Transactions of the Fifth Annual Meeting, Boston, Mass., November 12-14, 1914, pp. 187-89, 195.

[3]J. Whitridge Williams, "Medical Education and the Midwife Problem in the United States," Journal of the American Medical Association 58 (January 6, 1912). The American Association for the Study and Prevention of Infant Mortality requested that he conduct the study.

qualifications against the midwife's, he sent questionnaires to professors of obstetrics around the country. Williams recognized sadly that "the average practitioner, through his lack of preparation for the practice of obstetrics, may do his patients as much harm as the much-maligned midwife."[1]

The forty-three responding professors came from educational backgrounds without clinical obstetric experience. Many continued to teach in schools unaffiliated with hospitals or dispensaries, and more than a third replied that they were not experts in the area. "As several of them admit that they are not competent to perform major operations, it is apparent that they cannot be ideal teachers."[2] One professor had assumed his teaching position without ever witnessing a childbirth.[3]

The most glaring difficulty was that medical schools did not devote enough curriculum attention to the teaching of obstetrics. Williams himself acknowledged that:

> After eighteen years' experience in teaching what is probably the best body of medical students ever collected in this country--the student

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[1]Ibid., p. 1.

[2]Ibid., pp. 1-2.

[3]Ibid., p. 2.

> body at Johns Hopkins medical school for the year 1911-1912 [sic]--I would unhesitatingly state that my own students are unfit on graduation to practice obstetrics in its broad sense, and are scarcely prepared to handle normal cases.[1]

Although internships had come into vogue by the 1930s, still in 1934 the majority of states and schools in the country did not require a year's internship before a doctor assumed the role of obstetrician.[2]

The exposure of deep-seated deficiencies in obstetrical and medical education stimulated progress. Medical reformers spoke uniformly in their prescriptions for change: the number of schools must be reduced, and requirements for admission must be stiffened. Demands followed for laboratory equipment, hospital facilities, and trained faculty. Advocates constantly reiterated the need to shrink the base of education.[3] The reduction meant that the wealthy schools would survive. And with

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[1]Ibid., p. 5.

[2]New York Academy of Medicine, Manuscript Collection, Papers of Dr. George W. Kosmak, Scrapbook of newspaper clippings on birth control, child-birth deaths, etc., Vol. 2, 1917-1941, Editorial, "Reduction of Maternal Mortality," Medical World (April 1934):160.

[3]Williams, "Medical Education and the Midwife Problem," p. 7; Sherwood, "Statement," p. 174. Between 1904 and 1914, medical schools declined by 35 percent; there were eleven thousand fewer students in 1914 than there were in 1904, and two thousand fewer graduates. See also William T. Howard, Jr., "The Real Risk-Rate of Death to Mothers from Causes Connected with Childbirth," The American Journal of Hygiene 1 (March 1921):229.

the new expenses of equipment, the only way for schools to maintain solvency was through an affluent student body.

New licensing laws, beginning in 1900, and more stringent medical college entrance requirements (first the completion of high school, then one or two years of college, and finally four) effectively excluded lower economic groups from medical careers.[1] In 1924, when Flexner reviewed the transformation of medical training, he pointed to the demise of almost half the medical colleges, largely in the West and South. Since schools in these areas catered primarily to students from low income brackets, including women and blacks, medical reform became synonymous with the economic, ethnic and gender homogenization of the medical profession.[2]

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[1]Duffy, The Healers, pp. 266, 299: "In the twentieth century, the developments largely responsible for increasing the income of physicians were the successful drives to improve the quality of medical education and to limit entrance into the profession. Physicians were fortunate that, in the fight to upgrade the quality of medical training, virtue and self-interest went hand-in-hand. . . . While more rigid educational and licensing requirements clearly benefited the patient, the physicians who fought for them were not unaware of the value of limiting competition." (In 1915, 85 percent of the medical colleges demanded one year of college for admissions. See Kaufman, American Medical Education, p. 117.)

[2]See Kaufman, American Medical Education, p. 178; Duffy, The Healers, pp. 266-67, 277-78: "Between 1904 and 1909 both the number of women medical students and those graduating showed a steady decline. Whereas a total of 254 women received medical degrees in 1904, only

Unlike specialists in the first third of the twentieth century, early nineteenth-century obstetricians were humbled by childbirth. For whatever reason, perhaps in a day before science understood the theory and principles of infection and antiseptics and because practitioners vaguely linked obstetrical interference to medical mishap, early accoucheurs bid their students patience in childbirth attendance. In seeming awe at nature's power and plan, doctors urged conservative caution before interfering with spontaneous labor. The physician should await in calm respect, for "it is astounding how much pain some women can suffer without maternal injury; and the manner in which the child's head is moulded by the form of the passage is often surprising."[1] The doctor's catchword was restraint, especially if he contemplated instrumentation. Labor was marvelously, almost miraculously divided into four parts--the dilation of the cervix, the passage of the child through the pelvis, the delivery of the child, and the expulsion of the placenta--and the

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162 were granted them in 1909." Mary Roth Walsh, Doctors Wanted. No Women Need Apply. Sexual Barriers in the Medical Profession, 1835-1975 (New Haven: Yale University Press, 1977), p. xvii: "At the beginning of the twentieth century there were 95 female physicians in France (chiefly in Paris), 258 in England, and more than 7,000 in the United States, at least a third of whom had medical degrees."

[1]Alexander Hamilton, A Treatise on the Management of Female Complaints, and of Children in Early Infancy (New York: Samuel Campbell, 1792), p. 191.

attendant rarely diverted it from its natural course. An American physician, Samuel Bard, reported that his "principal [professional] objects have been, to check the too frequent interposition of art, and to restore nature to her just authority."[1] Even before Credé and Semmelweis, he warned against the physician's rash introduction of hands in the delivery of the afterbirth; instead he would give nature a full hour, for "the introduction of the hands into the womb, is always attended with some hazard."[2]

For most of the nineteenth century cesarean section was not even discussed, since the operation meant certain death to the mother. Thus, when physicians advocated a "conservative midwifery," they meant the forceps. For the early nineteenth-century doctor, clear, defined symptoms indicated the application of instrumentation. Thomas Cock, a physician to the New York Lying-In Asylum and Bellevue Hospital, approved their use only in emergencies, when uterine contractions ceased or if

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[1]Samuel Bard, A Compendium of the Theory and Practice of Midwifery, containing Practical Instruction for the Management of Women During Pregnancy, in Labour, and in Child-Bed; Calculated to Correct the Errors, and to Improve the Practice, of Midwives; as well as to serve as an Introduction to the Study of this Art, for Students and Young Practitioners (New York: Collins and Perkins, 1807), pp. 212. See also pp. 105, 125, 140.

[2]Ibid., p. 169.

labor's length threatened the mother's life. He maintained that forceps should never be used until the cervix had dilated fully and the attendant was confident that natural birth was impossible. For sure, they were not to be used "to save ourselves trouble."[1] Yet after mid-century, physicians, perhaps in attempts to distinguish themselves from the empty-handed midwife, indulged in more frequent interference. Gunning Bedford, Professor of Obstetrics and the Diseases of Women and Children at New York University Medical College, wrote: "On the subject of instruments, I have spoken without reserve, and have not failed to raise my voice . . . in rebuke of what I believe to be oftentimes their unnecessary and reckless employ."[2] He decried the overuse of the forceps and sought "to inculcate upon the accoucheur a due reverence for the resources of nature."[3] Had parturition suddenly become unnatural? How had children for centuries been brought to life?[4]

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[1]Thomas F. Cock, Manual of Obstetrics (New York: Samuel S. and William Wood, 1853), pp. 227-28.

[2]Gunning S. Bedford, The Principles and Practice of Obstetrics (New York: Samuel S. and William Wood, 1861), p. v.

[3]Ibid., p. vi.

[4]Ibid., p. 569.

The forceps certainly had valid uses. Yet the warnings against their misapplication were based not upon sentimental reverance for older traditions but on rational awareness of the dangers to mother and child. Contemporary practitioners knew that instruments could tear and lacerate the mother's soft parts and perineum or rupture her uterus, and that they might "congest" the brain of a child (today referred to as intracranial hemorrhage) or cause cranial fractures.[1]

This early awareness foresaw a major problem of twentieth-century medicine. It tells of a discrepancy between knowledge and application. There is hint of an undisciplined profession; the sense of a heterogeneous group of life-savers with varying degrees of knowledge, abilities, and ethics. There is an obvious parallel to a central contradiction in twentieth-century obstetrical history: that despite the technological progress, and the advances in controlling the abnormalities of pregnancies and deliveries, death rates did not decline. Public application did not match academic progress.[2]

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[1]Ibid., p. 576.

[2]By 1923, it was evident that scientific knowledge was not the problem which still made infection the cause of death in half of maternal fatalities. "It is not my idea," wrote Dr. Emma J. Neal, "to tell any of you how to conduct a delivery. All of you know what is causing all the difficulty. It is that in too many cases neither the

Despite pilot demonstrations of lower maternal mortality, greater use of hospitals for confinement, the decline of the midwife's influence, the wherewith to create an aseptic field, and the understanding of the elements of a full prenatal care program, maternal mortality did not decline between 1915 and 1930. Rates, in fact, may have increased slightly. A comparison of the same eleven states in the birth registration area in 1915 and 1929 shows rates of sixty-one per ten thousand for 1915 against sixty-five per ten thousand in 1929.[1] Today, it is almost incomprehensible that infection accounted for almost half of parturient deaths in the 1920s. The observation of an obstetrician in 1886 that "antiseptic delivery is not yet practiced so universally as it should be in hospitals, and still less is it employed in private practice,"[2] can be attributed

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physician nor the patient is applying all that is known." Emma J. Neal, "Sane Obstetrics," The Medical Woman's Journal 30 (October 1923):292.

[1]The eleven states were Connecticut, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, New York, Pennsylvania, Rhode Island, Vermont, and the District of Columbia. See E. D. Plass, "The Relation of Forceps and Cesarean Section to Maternal and Infant Morbidity and Mortality," American Journal of Obstetrics and Gynecology 22 (August 1931):176.

[2]Henry D. Frey, "The Value of the Antiseptic System in Private Obstetric Practice; Conclusion Based on a Study of the Puerperal Temperature," The American Journal of Obstetrics and Diseases of Women and Children 19 (April 1886):337.

apologetically to relatively recent antiseptic discoveries. Harsh judgment might still be withheld in 1895, when the same obstetrician noted progress in hospital maternity antiseptics while private physicians still lagged.[1] But what rationalization can be mustered to explain the necessity of the Children's Bureau's strenuous recommendation in 1933 that physicians come to appreciate the requirements of aseptic technique, including the use of rubber gloves and masks?[2] In a study of 7,380 puerperal deaths in fifteen states, puerperal septicemia caused 40 percent:

> Women who have been weakened by hemorrhage, by eclampsia, or by the exhaustion of a long and difficult labor are an easy prey to infection; and infection is the chief cause of death of women for whom an operative delivery is necessary and who survive the shock of the operation itself. It is also the chief cause of death following abortion from any cause.[3]

The decentralized heterogeneity of American medicine diminished its potential. There could be no uniformity without federal and state controls. Yet, there could be no such controls as long as medicine

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[1]Henry D. Frey, "The Universal Application of the Principles of Asepsis to Private Obstetric Practice," The American Journal of Obstetrics and Diseases of Women and Children 32 (July 1895):19.

[2]U.S., Department of Labor, Children's Bureau, Maternal Deaths, A Brief Report of a Study Made in Fifteen States, Publication No. 221 (Washington, D.C.: Government Printing Office, 1933), p. 58.

[3]Ibid., p. 37.

continued as a free enterprise business and the rights of unrestrained licensed physicians subjugated the notion of public health. Therefore, medical schools continued to graduate students of uneven development (as early as 1908, Great Britain required medical school graduates to take national examinations, which an average of 30 percent failed).[1] American graduates then entered hospitals with minimal supervision, primarily because no public agency forced facilities to scrutinize their staffs.[2]

The irrationality of federalism as it was applied to medicine is particularly clear in maternity care. This imbalance added a callousness to the statistics, deriding the value of human life. In Massachusetts, midwifery was illegal, yet midwives practiced. Thirty-seven states required midwives to register, yet only eighteen required licenses. Then, only ten of these eighteen set up educational requirements as well, and

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[1] A. D. Beven, "Medical Education in the United States; the Need for a Uniform Standard," Journal of the American Medical Association 51 (August 15, 1908):568. In 1940 in the United States, only about a fourth of medical graduates took qualifying examinations in medical specialties, and the notion of national medical examinations was new. See Duffy, The Healers, p. 297.

[2] "Reduction of Maternal Mortality," Medical World, p. 161. In 1924, there were 6,762 public and private hospitals in the United States. See U.S., Department of Labor, Children's Bureau, Maternal Mortality. The Risk of Death in Childbirth and from all Diseases Caused by Pregnancy and Confinement, by Robert M. Woodbury, Publication No. 158 (Washington, D.C.: Government Printing Office, 1926), p. 82.

these qualifications varied from state to state. Again, while basic medical knowledge recognized that venereal diseases complicated pregnancy seriously and caused fetal death, by 1925 only eight states required "passage" of a venereal disease test before issuing a marriage license.[1]

The marked rise of operative interference between 1915 and 1930 was the most striking result of medical free enterprise manifested in maternity care. Through proliferation of forceps and cesarean section deliveries (operative interference), physicians expressed their sense that they answered to no higher authority than themselves. Obstetricians, as children with new toys, became intoxicated with new obstetrical techniques. Medical advances apparently stripped uncertainty from the procedures, and unlike their predecessors who cautioned against overuse and favored natural birth, contemporary obstetricians smugly scorned nature. As technicians, they assumed an air of omnipotence. Physicians hurried; business was increasing, and one woman's delivery could not be allowed to interfere with busy practices.

The annual reports of the Nursery and Child's Hospital provide vivid demonstration of the operative fever. In 1914-1915, the staff used forceps in the birth

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[1]Children's Bureau, Woodbury, Maternal Mortality, pp. 76-77.

of 56 children of the 598 women delivered in the hospital. In 1915-1916, although the report does not reveal the total number of women delivered, forceps deliveries increased to sixty-five and the number of cesarean sections jumped to fourteen from five for the previous year. In the next year, among 784 women confined in the hospital, forceps were applied 173 times. No one knows with historical certainty whether this use of forceps was validly indicated. Yet comparison with similar applications of instrumentation in home deliveries supplies some clues. Among the 887 women who the Nursery staff delivered at home, attendants used forceps only four times. What role then did hospitalization play? It is true that women using the hospital for confinement often did so because of complications in pregnancy or previous births, but do abnormalities explain such numerical discrepancies? Do the figures alter in the twenties, when hospital confinement in New York City became more popular and did not necessarily indicate likely delivery problems? Did the hospital itself engender these kinds of methods? Or did it give the doctor freedom and a sanctuary for experimentation?

In the fiscal year 1917-1918, the difference between operative interference in the indoor and outdoor departments did not change. The hospital delivered 728

women and doctors used forceps 196 times (27 percent). The outdoor department delivered 784 women, with 15 forceps deliveries (less than 2 percent). The next three years (1919-1921) saw a stability in forceps use for home patients (13 of 569, or 2.3 percent; 12 of 633, or 1.9 percent, and 16 of 620 patients delivered, or 2.6 percent), while forceps deliveries increased steadily in the hospital from 279 of 1,370 women attended (20.4 percent) to 387 of 1,771 (21.9 percent) and 409 of 1,679 (24.4 percent). The figures in the following three years are even more demonstrative. In 1922, the staff performed 14 forceps deliveries for the 635 women confined at home (2.2 percent); the next year they did only 8 among the 702 home deliveries (1.1 percent) and in 1924, they used forceps only once in 444 deliveries (little more than two-tenths of 1 percent). In the same years in the hospital, forceps delivered 425 babies in 1,760 cases (24.1 percent), with an additional 49 cesarean section births, followed the next year with 547 forceps deliveries of 2,307 births (23.7 percent), and the next year with 501 forceps births among 1,833 (27.3 percent).[1]

Clearly, hospital confinement was basic to this spiral. In part, the explanation may lie in the campaign

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[1]See Annual Reports of the Nursery and Child's Hospital, 1915-1924.

to save lives. Obstetricians, arguing for their unique services, exaggerated the risks of pregnancy and delivery, perhaps unwittingly. The myth emerged that while parturition carried attributes of a normal physiological process, "the morbid conditions of our modern life have conspired to make of it almost a pathological calamity."[1] Reeducation of women stirred their fears and insecurity regarding this bodily function, engendering a sense of helplessness and dependency. The relatively recent popular interest in pregnancy, especially the idea that labor might be painless, and the debate over the merits of various anesthetic methods made it a general-interest topic in popular magazines. An editorial in Medical World warned women against trusting themselves to the advice of popular articles dealing with twilight sleep, version, cesarean section, and forceps. The net effects of these

> . . . sensational articles highly magnify the supposed horrors of childbirth not conducted in accordance with the writer's pet scheme to a degree that often leads to unreasonable fear and a tendency to unnecessary and meddling interference with the normal process of labor.[2]

Hospitals' almost universal use of anesthesia by the twenties affected women and doctors alike. Pain

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[1]Chipman, "Teaching Obstetrics: Necessary Equipment," p. 181.

[2]"Reduction of Maternal Mortality," Medical World, p. 160.

is hardly pleasant, and the desire for its withdrawal is natural, especially if the negative consequences of relief are unknown. Women came to believe that only medical specialists could extricate the life from within them. The more involved the delivery, they believed, the more service they had received. Comfort and speed became values in childbirth for which the public was willing to pay. To doctors, anesthesia provided a false sense of security, a heightened sense of their omnipotence. Medicine extended the indications for forceps to include the convenience of those involved: the doctor, patient, and even the husband. Technology proved far superior to nature, or so it seemed.[1]

In 1925, the Nursery delivered 1,840 patients in the hospital, with 425 forceps deliveries (23.1 percent) and 45 cesarean sections. The next year cesarean sections totaled 73 with 518 forceps deliveries (26.9 percent) in the hospital. In 1927, forceps deliveries jumped to 827 of 2,613 indoor deliveries (31.6 percent), with 65 cesarean sections. For 2,332 patients confined in the hospital in 1928, attendants used forceps 838 times (35.9 percent), with 63 cesarean sections. In the next year, with a slight decline, doctors performed 665 forceps

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[1]Plass, "The Relation of Forceps and Cesarean Section to Maternal and Infant Morbidity and Mortality," p. 178.

deliveries (31.5 percent) and 62 cesarean sections among the 2,113 hospital births.[1]

This escalation of obstetrical interference did not go unnoticed. Contemporary obstetricians branched into two groups, the so-called radicals and conservatives, with the latter's members highly critical of what they perceived as unnecessary and too frequent interference. The argument between the groups centered on what constituted valid indications for operative procedures. The conservatives measured the bottom line by maternal stability, while radicals extended indications to include fetal condition. Invasion of spontaneous delivery, conservatives maintained, should only be undertaken with the mother unable to deliver herself or when the presence of cardiac disease, toxemia, or tuberculosis mandated speedy delivery for the woman's sake. Delay in the second stage of labor was not sufficient reason, nor were fetal heart tones or even fetal distress, as radicals contended.

Conservatives did not demean the value of the infant's life, but they refused to sacrifice the mother for the sake of the child. In practice, this meant that the mother did not suffer the trauma of surgery in the

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[1]Annual Reports of the Nursery and Child's Hospital, 1925-1929.

throes of eclampsia or hemorrhage. Vague medical jargon had created a new indicative category which radicals used to cover themselves, or so the conservatives claimed. "Prophylactic forceps" was an indulgence; it allowed the obstetrician, surreptitiously, to yield to his own convenience. Upon investigation, most forceps deliveries metaphysically labeled "prophylactic" show "no good evidence that they prevent anything but loss of time on the part of the operator."[1]

Conservatives ventured explanations for this seemingly obsessive need on the part of so many obstetricians "to do something." Was it, as one female doctor contended, that obstetrics would fare better in the hands of female physicians or midwives? "Men," she asserted,

> . . . have an instinctive distaste and incapacity for the detail and drudgery that an obstetric practice demands. Surgeons are fortunate in relegating to nurses all the drudgery of preparation and cleaning up--otherwise there would be no surgeons.[2]

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[1]See Plass, "The Relation of Forceps and Cesarean Section to Maternal and Infant Morbidity and Mortality," p. 180; for another example of conservative obstetrical sentiment, see Rudolph Holmes, "The Fads and Fancies of Obstetrics. A Comment on the Pseudoscientific Trend of Modern Obstetrics," The American Journal of Obstetrics and Gynecology 2 (Sept. 1922):234, 236.

[2]Inez C. Philbrick, "Municipally Salaried Obstetrical Staff," p. 193. The United States has continued to exclude women from the professional medical process. In

For other detractors, obstetrics had lately been permeated with a basic misconception:

> That pregnancy and labor are pathologic entities, that childbearing is a disease, a surgical malady which must be terminated by some spectacular procedure. There is too insistent preachment by those who are defending a reign of terror, of promiscuous operative furor, by the argument that women have so degenerated that childbearing is a phase of pathological anatomy.[1]

Another physician speculated about the temptation of obstetric fees, which doubled for version or forceps.[2]

This upsurge in operative intervention was peculiar to America, posing special problems because of the wide diversity of medical capacities in the United States. Although forceps, especially low forceps, are rarely fatal in capable hands, the intoxication with interference was not restricted to the well-educated practitioner operating in well-equipped aseptic institutions.[3] Other, less qualified attendants tinkered with the new gadgetry, often with disastrous results.

1973, women physicians consisted of 7 percent of the total. In England, 24 percent of the doctors were women, and in the Soviet Union, women made up 75 percent of physicians. See Ehrenreich and English, Witches, Midwives and Nurses, p. 19.

[1]Holmes, "The Fads and Fancies," p. 233.

[2]Plass, "The Relation of Forceps and Cesarean Section to Maternal and Infant Morbidity and Mortality," p. 197.

[3]Ibid., p. 196.

While radicals defended their procedures as necessary to protect infant life, they ignored the striking rise in the infant death rate from injuries at birth, an increase of 5 percent per year between 1918 and 1925. In 1925, injuries incurred at birth caused nearly 15 percent of deaths in the first day of life and almost 17 percent of deaths in the first week after the first day.[1] Conservatives reminded radicals that forceps blades, especially in unskilled hands, placed enormous pressure on the infant's head. Since physicians found birth injuries relatively difficult to gauge, statistics were probably low. Forceps could cause facial paralysis, intracranial lesions, and hemorrhage, which might cause future morbidity and retardation, rather than death.[2] One conservative obstetrician concluded "that many conditions, today somewhat indiscriminately termed congenital, simply because they existed since birth, really represent birth injuries."[3] Aggravating the

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[1]Frankel, "The Present Status of Maternal and Infant Hygiene in the U.S.," p. 1212. In 1918, the death rate from birth injuries was 360 per 10,000 live births; in 1924, it stood at 552.

[2]P. Brooke Bland, "Injuries of the Infant During Delivery," American Journal of Obstetrics and Gynecology 11 (April 1926):483; Plass, "The Relation of Forceps," p. 186.

[3]Hugo Ehrenfest, "Better Obstetrics and the Problem of the Birth Injuries to the Newborn Infant," American Journal of Obstetrics and Gynecology 4 (July 1922):64.

problem further, competition in the twenties between pediatricians and obstetricians precluded the presence of the pediatrician in obstetrical wards. The obstetrician clung to his traditional role in the aftercare of the newborn, postponing expert detection and treatment of birth injuries.[1]

Meddlesome midwifery once meant manual or forcible dilitation of the cervix, or pulling the cord for the afterbirth. The marked rise in forceps deliveries was dangerous, most likely unnecessary, but did not cause large numbers of fatalities. Cesarean sections, however, which rose precipitiously during the period, were another matter. An inflated sense of the value of infant life often prevailed, at the mother's expense. Physicians used fetal distress as the chief indication to justify cesareans, notwithstanding the risk of maternal mortality following surgery.

Ironically, with the perfection of surgical technique in the twenties, elective cesarean section, forecast and planned, posed minimal risk. The majority of deaths, however, followed spontaneous sections. These emergency operations often followed superficial prenatal

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[1]Ibid., p. 66; see also Brooke M. Anspach, "The Trend of Modern Obstetrics. What is the Danger? How Can It Be Changed?" American Journal of Obstetrics and Gynecology 6 (November 1923):574.

care, when danger signs went undetected. Far too many confused doctors then chose fast delivery, in spite of textbook practice which first urged the relief of any trauma in emergencies. The Children's Bureau study of maternal mortality in fifteen states found that doctors ignored warning bleeding from placenta previa[1] during pregnancy, failing to order blood transfusions, only to attempt delivery with the patient in shock or hemorrhaging.[2]

The Children's Bureau found aseptic technique faulty in major operative procedures. In 1888, Garrigues urged physicians performing cesarean sections to act quickly, without exhausting the patient by other means of delivery, to avoid vaginal examinations, and to observe scrupulous antisepsis.[3] Yet, in the same study of maternal deaths in fifteen states, the Children's Bureau reported sixty-two cases of cesarean section following attempts at vaginal delivery. Physicians were not qualified to

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[1]The premature separation of the placenta from the uterus, cutting off nutrients to the fetus and causing severe hemorrhage in the mother.

[2]Children's Bureau, Maternal Mortality in Fifteen States, pp. 163-65. The proper treatment of placenta previa called for control of bleeding, shock, and anemia; immediate delivery was contraindicated.

[3]Henry J. Garrigues, The Improved Cesarean Section, reprinted from American Journal of the Medical Sciences, May 1888, p. 15.

operate, or they were callous. Doctors simply practiced bad obstetrics, performing operations when symptoms indicated induction of labor to produce spontaneous delivery.[1] They missed opportunities to employ transfusions, and performed operations after membranes had ruptured, after numerous vaginal examinations, and after patients had been allowed to endure long, exhaustive labors. It is small wonder that the Children's Bureau discovered sepsis as the cause of death in 47 percent of all cases of mortality.[2]

Valid indications for cesarean section include contracted pelves, abnormal fetal position (making normal travel through the pelvis impossible), or failure of the mother's cervix to relax and dilate. Yet once attitudes shifted and women and doctors alike saw pregnancy as something more than a simple physiological phenomenon, the public failed to understand that "a spontaneous delivery calls for more knowledge, skill, and judgment than those of operative intervention."[3] An emotional component entered when obstetricians campaigned for infant's well-being. Roman Catholics, who would only baptize living

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[1]Children's Bureau, Maternal Mortality in Fifteen States, p. 88.

[2]Ibid., pp. 98, 101.

[3]Plass, "The Relation of Forceps," p. 196.

infants, looked upon abdominal surgery with favor "whenever there is the least doubt concerning the welfare of the unborn child."[1] But "that a mother with one or more small children at home should die from cesarean section done for eclampsia" to save the baby "does not seem logical."[2]

In 1933, the New York Academy of Medicine published a report by the Subcommittee on Maternal Mortality of its Committee on Public Health Relations. The study analyzed and interpreted all maternal deaths in New York City from January 1, 1930 to January 1, 1933. Each week in the three-year period, the Department of Health furnished copies of all death certificates in all cases implicating puerperal causes, "whether primary or contributory." The Committee then studied each death to determine its preventability and personal responsibility. Investigators sought and questioned the doctor or midwife who had signed each certificate, and check hospital records and conditions if the patient spent any time in a hospital. Staff members then classified each case as preventable or nonpreventable; if avoidable, they assigned culpability to midwife, doctor, or patient. The Committee evaluated

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[1]Frederick C. Irving, Safe Deliverance (Boston: Houghton Mifflin, 1942), p. 261.

[2]Children's Bureau, Maternal Mortality in Fifteen States, p. 99.

the quality of prenatal care, determining whether it included pelvic measurements and whether physicians discerned the presence of syphilis or tuberculosis. The researchers questioned the conduct of hospital delivery, the routines of asepsis, the availability of delivery rooms (distinct and separate from operating rooms), and the stated indications for major surgery such as version, extraction, and cesarean section.[1]

The report shook the medical world and public alike. The Committee concluded that among the 2,041 deaths, 1,343 (65.8 percent) were preventable. Among these preventable deaths, the study found physicians responsible for 61.1 percent; that is, these deaths resulted from "some incapacity . . . lack of judgment, lack of skill or carelessness" on their part.[2] Researchers discovered doctors misusing anesthesia, failing to transfuse blood when indicated, and lax in aseptic technique. Attendants routinely anesthetized patients and exposed them unnecessarily to infection. Although more than a third (36.7 percent) of the preventable deaths were laid to patients' ignorance or inertia, the report blamed women only indirectly:

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[1]New York Academy of Medicine, Committee on Public Health Relations, Maternal Mortality in New York City, A Study of all Puerperal Deaths, 1930-1932 (New York: Oxford University Press, 1933), pp. 3, 11-12, 16, 19-20.

[2]Ibid., pp. 32, 49.

> She is . . . helpless by reason of circumstances which are not of her making and are outside of her control. She may be, and very often is, the victim of poverty or ignorance and, in such eventualities, it is manifestly the failure of society to provide proper and effective education, assistance, and care, which have forced her, unwittingly, and surely unwillingly, to become the deciding factor in her own death.[1]

In only 2.2 percent of the preventable cases did midwives appear responsible.

The report lashed out at the stupidity and indifference of the medical profession's attitude toward the midwife. Ignore her and keep her ignorant while she is still responsible for between 10 and 12 percent of the country's births? New York City, paraded as the model of midwifery control, had 863 licensed midwives in 1933. Yet no authority bothered to supervise their work. The investigators encountered fifty-nine midwives, judging nineteen competent, twenty moderately so, and another twenty as completely incompetent. Twenty-two midwives, although licensed and trained twenty years earlier, had received no further instruction since. Seventeen trained at Bellevue and another seventeen in European schools; private physicians had purportedly apprenticed ten more, and "one had been trained 40 years ago by a sister who

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[1]Ibid., p. 31.

was a midwife in Italy."[1] The Committee found midwives willing to cooperate with physicians, only to receive the cold shoulder; doctors persistently rejected patients sent by midwives for prenatal care and often failed to respond to midwives' calls in delivery emergencies. Even prenatal clinics engaged in propaganda against the midwife, trying to dissuade the prospective mother from using her. The report insisted that especially in view of physicians' showing, the midwife should be made an adjunct in the maternity care scheme.[2]

The Academy's evaluation of prenatal care proved that it was faulty when used at all. In spite of the educational campaign of the preceding years, women failed to seek medical coverage during pregnancy; if they did, it was often in the later months. As prenatal supervisor, the physician did little worthwhile work. They rarely gave Wassermann tests, or took pelvic measurements. Delivery prognoses were thus necessarily inaccurate.[3] Physicians confined prenatal attention largely to upper-income strata, who could afford the costs of multifaceted pregnancy care.[4] The public health movement had failed to

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[1]Ibid., p. 195; see also pp. 190, 192.

[2]Ibid., pp. 193-94, 209, 212.

[3]Ibid., p. 214.

[4]Ibid., p. 160.

eradicate the class bias of American medicine.

In New York City, which led in the infant and maternal welfare crusade and was among the first to shake public lethargy and disgorge tax funds for health, where death rates were among the lowest, with highly sophisticated medical personnel and facilities, many hospitals continued to deliver babies in general operating rooms and allowed residents to perform major obstetrical surgery.[1] What were conditions like in other cities and towns if this prevailed in New York? A commensurate reduction in puerperal death rates did not accompany the rise in hospitalization for parturition. New York City listed 348,310 live births in 1930, 1931, and 1932. Of these, only 102,105 or 29.3 percent, were delivered at home. The home delivery death rate for women stood at 1.9 per 1,000 live births, against a hospital rate of 4.5.[2] Abnormalities did not explain the higher hospital rate; instead, investigators saw the cause as the high rate of operative interference. The Committee estimated the rate as between 10 and 20 percent, while the maximum rate should have been 5 percent.[3] In the study alone, deaths following cesarean section made up almost 20

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[1]Ibid., p. 216.

[2]Ibid., pp. 139-40.

[3]Ibid., p. 113.

percent of total deaths (excluding deaths caused by abortions, which constituted 17.5 percent of the total). Decidedly, physicians had discounted the home as proper territory for operative procedures. Yet they gave blanket approval to the hospital as a suitable environment for any procedure, without analysis of the merits and deficiencies of individual hospitals.

Perhaps the hospital became the doctors' haven because its administrators asked so little of the physician. Here the doctor could experiment. The Committee discovered anesthesia adopted almost universally in hospitals and linked this routine to the greater necessity for instrumentation, as drugs numbed the muscular expulsive walls of the uterus and made them flaccid and useless in delivery. Operations began long after women had been exposed to the hazards of infection; doctors performed cesarean sections once membranes had broken and they had attempted delivery by other means.[1]

Almost entirely, the Committee classified deaths following version and forceps extraction or cesarean section as preventable, with the physician responsible. "These deaths are almost always due to the anesthesia, to hemorrhage from severe laceration of the cervix or rupture of the uterus, or to the shock attendant upon

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[1]Ibid., pp. 113, 134, 207-08, 215.

prolonged and maladroit operative procedures."[1]

The message was clear. If physicians could try whenever possible to employ natural delivery, they would be capable of avoiding hemorrhage, shock, and infection. Yet despite the conservative caveats of the 1920s, the word did not penetrate.

The poor bore the brunt of bad obstetrics. Native maternal death rates were 3.69 per 1,000 live births, compared to a foreign rate of 6.26. The Committee recognized that while racial characteristics determined physical peculiarities and social status weaved attitudinal responsiveness to medical care, a woman's "economic position with its effect on her diet and living conditions will not only alter, to some extent, the operation of the previous factors, but will fix the type of care to which she will have access."[2] The poor (in New York City, blacks and immigrants), who required the strongest medical buffers, received the least. Obstetrics had become a science, but men failed to apply the knowledge.

The Committee published the report. The Council of the Academy of Medicine unanimously approved it, notwithstanding spirited criticism and debate among the Fellows of the Academy and the New York Obstetrical

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[1]Ibid., p. 27.

[2]Ibid., pp. 143, 165, 169.

Society. Members of the Subcommittee on Maternal Mortality met in response to their colleagues' claims that the report would malign the profession. The Subcommittee retorted that it certainly did not distort the truth, "being compelled to present its findings in a straightforward manner."[1] Where did obstetricians' interest lie, in remedy or cover-up? The editorial staff of the Journal of Obstetrics and Gynecology conceded that while the report may "not be pleasant reading," and that it might "arouse resentment, perhaps indignation," the facts were indisputable and demanded active redress.[2]

The New York Obstetrical Society had a final word of protest, which however vigorous could not diminish the effect of the Academy's report--the turning point in the favorable reversal of national maternal mortality. In March 1934, the Society appointed a committee to review the report on maternal mortality and "to clarify certain points at issue." The committee's report was presented to the Society on April 10, 1934, and received immediate endorsement.[3] Basically, the counter statement sought

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[1]Manuscript Collection of the New York Academy of Medicine, Committee on Maternal Mortality, Public Health Relations Committee, 1934.

[2]"Another Study of Puerperal Mortality," American Journal of Obstetrics and Gynecology 27 (January 1934):125.

[3]Report of the Committee of the New York Obstetrical Society, to Review the Maternal Mortality Report of the

point-by-point refutation of the original report. The Society maintained that the original had created "false impressions concerning childbirth and maternal mortality in this city," both among the laity and the medical profession.[1] The committee questioned the ability in the first place to assign preventability. It suggested, instead, that deaths be categorized into controllable and uncontrollable groups.[2] The committee criticized the report for fostering fear of cesarean section and anesthesia. It denied that anesthesia encouraged operative intervention, but urged on the contrary that it engendered patience for natural labor. "Furthermore, this Society is convinced that anesthesia and analgesia, in the hands of well-trained doctors, do not add to the maternal or fetal death rate."[3]

The Society's report called for upgrading training for obstetrical practice, with a mandatory internship of no less than a year and with the provision of more hospital facilities for maternity patients. It bowed to the

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Public Health Relations Committee of the New York Academy of Medicine, Manuscript Collection of the New York Academy of Medicine, Box 8, New York Obstetrical Society, Folder, Correspondence Regarding the Study of Maternal Mortality, 1930-1934.

[1]Ibid., p. 5.

[2]Ibid., p. 3.

[3]Ibid., pp. 6-7.

supervision and training of existing midwives, but categorically rejected the notion that more should be trained as obstetrical assistants. This, the report maintained, would mean the ultimate debasement of obstetrics as science. In the discussion which followed presentation of the report, Dr. Harvey B. Matthews condemned the Academy's report as crediting the midwife. He admitted that because there were few doctors in the rural south and southwest, midwives should continue to practice, but he exclaimed, "I don't see any excuse for her existence in the City of New York or any other city. There are plenty of doctors--too many."[1] Other members of the society feared the report would result in malpractice suits, while Dr. Onslow A. Gorden, in petty competition, wondered what might be revealed by a similar investigation into medical and surgical deaths in the city. He felt "sure that the figures would arouse even more adverse comment in the public press concerning the doctor that has the Maternal Mortality Report."[2]

George W. Kosmak, a member of the Academy's Committee on Maternal Mortality and one of the city's most

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[1]Ibid., pp. 3-4.

[2]Ibid.

scholarly and respected obstetricians,[1] sought to assuage, soothe and finally smother the criticisms of the New York Obstetrical Society. Speaking before the Society, he reassured its members that the report was not addressed to "the 70 obstetrical specialists who are members of this Society," but to the 4,000 practicing physicians in the city. He implied that the debate was moot, since the report's actual target and the obstetrician's real threat were identical: the general practitioner who still monopolized childbirth attendance in the city. Kosmak urged the Society to withhold the publication of its criticisms lest "the general practitioner can get hold of them to use as an argument."[2]

Kosmak's professional career suggests the difficulty of assigning descriptive appellations of conservative or progressive. A Catholic and staunch opponent of birth control, he also crusaded persistently against deplorable methods of obstetrical practice and was an

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[1]Kosmak, who died at the age of 81 on July 10, 1954, had been editor of The American Journal of Obstetrics and Diseases of Women and Children from 1909 until its discontinuance in 1919. In 1920, he founded the American Journal of Obstetrics and Gynecology and edited it until 1952. He also edited The New York State Journal of Medicine from 1945 until 1952 and The Bulletin of the Lying-In Hospital from 1904 to 1932. See Manuscript Collection, New York Academy of Medicine, Box 8 New York Obstetrical Society, Folder, "In Memoriams," 1924-1954.

[2]Manuscript Collection, New York Academy of Medicine, Box 8, Correspondence, Kosmak, 1934.

early advocate of natural childbirth and home delivery. From his editorial position at The American Journal of Obstetrics and Diseases of Women and Children, he demanded that the medical profession respond affirmatively and immediately to the statistics of maternal death rates. Fatalities from major contagious diseases, he noted, had dropped significantly between 1890 and 1913, while maternal mortality rose from 15.3 in 1891 to 15.8 in 1913.[1] In strong language he decried medical apathy to the preventability of maternal deaths:

> Why had not the medical profession manifested a more intense desire to correct this unfortunate state of affairs, if it can be corrected? Shall we wait for the laity to take the initiative? This would be a sorry fact for the medical profession to admit.[2]

While some saw solution in better obstetrical education, and others in more prenatal and maternity facilities, Kosmak believed that the first step must be a study to uncover just where and why the deaths were occurring, a recommendation which went ignored until the Academy's study in 1930. Foremost, he wanted to open public interest

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[1]Between 1890 and 1913, typhoid fever deaths diminished from a rate of 46.3 per 100,000 population to 17.9; diphtheria from 97.8 to 18.8; tuberculosis from 252 to 147.6; and pneumonia from 186.9 to 132.4. See George W. Kosmak, "Maternal Mortality," reprinted from The American Journal of Obstetrics and Diseases of Women and Children 76 (New York: William Wood and Co., 1917), p. 1.

[2]Ibid., p. 2.

on the subject of maternity and to remove from it the aura of medical mystery.[1]

As early as 1923, just when women had practically conquered their antipathy to hospital confinement, Kosmak hoped that the hospital would not be viewed as the end-all, that childbirth would not be stripped of its human and emotional components, and that the hospital would be used only for primiparae (first births) or abnormal cases.[2] But in the 1930s his position became even lonelier. Medical propaganda practically hypnotized the public into believing in hospital birth, so that women failed to discriminate between the quality of various hospitals. With no sustained supervision of voluntary and proprietary institutions, the public thought mistakenly that ipso facto, a hospital delivery meant competence.

Physicians' unrestrained reign practically nullified improved sanitation in hospitals. Kosmak did not hesitate to identify doctors' irresponsibility and recklessness, their impatience taking precedence over

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[1]Ibid., p. 3 "Maternity and the proper recognition of the peculiar functions of women in this world," wrote Kosmak, "must receive adequate acknowledgement and recognition before we can hope to reduce the element of danger which accompanies it."

[2]George W. Kosmak, "Prenatal Care and Maternity Welfare from the Standpoint of the Maternity Center without Hospital Connection," reprinted from New York State Journal of Medicine, August 1923, p. 5.

professionalism, causing the appreciation in unnecessary operative interference.[1]

In caustic refutation of all of the glorified obstetrical advances of the preceding decades, Kosmak attributed the low maternal mortality of Italian and Russian-born women to the fact that they never set foot in hospitals for delivery.[2] Childbirth had become a technique, cold and impersonal, poorly run at that. Kosmak did not like it:

> Where can you get in this day and age a doctor who will sit through long hours of labor? Very few doctors will even consider a home confinement --they have no time for it. The majority of women go to hospitals on the advice of their doctors, whether their cases are normal or not. Modern physicians do not wish to spend hours at a bedside giving sympathy and assistance. The woman is usually advised of the proper time to go to the hospital, and there the nurses do not call the doctor until the last moment.[3]

He blamed hospitals for countenancing the routine use of anesthesia, allowing women to give up the experience of childbirth and surrender to their insecurities. Yet it

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[1]George W. Kosmak, "Reduction of Maternal Mortality," Medical World, April 1934, Manuscript Collection of the New York Academy of Medicine, Kosmak Scrapbook, vol. 2, newspaper clippings on birth control, childbirth deaths, etc.; "Control of Midwives now Held Necessary," New York World Telegram, April 18, 1931, from Kosmak Scrapbook, vol. 2.

[2]"Correspondent Urges Child-Bearing at Patient's Home," New York Evening Sun, May 9, 1933, from Kosmak Scrapbook, vol. 2.

[3]Ibid.

was not the American woman who lacked "nerve," but the doctor, in a hurry to return to his office, who automatically hushed the cries of childbirth.[1] Kosmak protested the exaggeration of the "pains and perils of childbirth." The experience had lost its proportion and "some expectant mothers are so frightened at the prospect of labor that they beg physicians to perform the dangerous Cesarean operation in preference to undergoing a natural delivery."[2]

The first period of American obstetrical history, when physicians grasped the ability to end the childbirth death toll while public interest first focused on the subject, ended in mixed fashion. In spite of science, women died at practically the same rate as two decades earlier. The Standards of the American College of Surgeons for Hospitals Taking Obstetric Patients (e.g., prescribing segregation of obstetric patients from others, the isolation of obstetric patients with fever or infection, and the selection of an obstetrical nursing staff which did not work on other wards) essentially repeated the same dicta which Garrigues advocated at the end of

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[1]Ibid.

[2]"Rise in Caesarean Operations Ascribed to Baseless Dread," New York World-Telegram, April 7, 1931, from Kosmak scrapbook, vol. 2.

the nineteenth century.[1] Doctors who had learned an expertise misused it widely, with 23 percent of maternal deaths in childbirth resulting from hemorrhage, trauma, or shock, and 41 percent following infection, in 1940.[2] Yet the era exposed and acknowledged the extravagance and recklessness. After the publication of the New York Academy of Medicine report in 1933, physicians no longer enjoyed the freedom they once possessed in hospitals. Hospital maternal deaths did not become simple statistics, recorded and forgotten. Instead, investigators made inquiries, with a view to locating the responsibility. Rates began to decline, at first slowly, but steadily. In 1929, the rate of maternal death stood at 69.5 per 10,000 live births; by 1936, it dropped to 56.8.[3]

The United States had much to do. In 1936, American maternal mortality seemed no more enviable among the developed nations than twenty years before. For example, Norway had a maternal mortality in 1936 of 28 per

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[1]Children's Bureau, Maternal Mortality in Fifteen States, p. 182.

[2]U.S., Department of Labor, Children's Bureau, Births, Infant Mortality, Maternal Mortality, 1940, Publication No. 288 (Washington: D.C.: Government Printing Office, 1943), p. 258.

[3]Sam Shapiro, Edward R. Schlesinger, and Robert E. L. Nesbilt, Infant, Perinatal, Maternal and Childhood Mortality in the United States (Cambridge, Mass.: Harvard University Press, 1968), pp. 145-46.

10,000 live births; Italy and the Netherlands' rate was 30, with Sweden's at 33.[1]

Interpretation of this disastrous and tragic waste of life is difficult. To blame women's deaths on a misogynous American medical system is tempting, yet perhaps facile. To read the minds of men who practiced medicine fifty years ago is impossible; to surmise from their works perhaps more reliable; to judge from their actions, the surest. Physicians' writings, and especially their behavior--vividly demonstrated in organized medical opposition to social insurance and even the relatively unthreatening Sheppard-Towner Act[2]--manifest desires for unrestrained power and status. Doctors seriously wished no government interference in the development of medicine; they demanded a profession with no centralized supervision. Their victory would doom the midwife. She would die because her existence necessarily required oversight, not because doctors hated women. The approval of any outside review meant that control would one day fall upon the doctor himself.

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[1]Baker, Fighting for Life, p. 258.

[2]See Chaps. X and XI.

CHAPTER IX

THE PROFESSIONALIZATION OF MOTHERS: MOTHERHOOD BECOMES SISTERHOOD

> She was a beautiful baby. She blew shining bubbles of sound. She loved motion, loved light, loved color and music and textures. She would lie on the floor in her blue overalls patting the surface so hard in ecstasy her hands and feet would blur. She was a miracle to me, but when she was eight months old I had to leave her daytimes with the woman downstairs to whom she was no miracle at all, for I worked or looked for work.
>
> --Tillie Olsen
> I Stand Here Ironing

> The ideal motherhood cannot be restricted to care of one's own children. The mother spirit must go out to every child who needs us and who we can serve. The joy of motherhood must find expression in the desire to help those mothers to whom maternity means only suffering and sorrow.
>
> --Elizabeth S. Chesser, 1913

> Yea, verily, women's place is in the home! Women must be sheltered, protected! Womanhood is sacred! Motherhood is divine. Woman's hands must be kept unsullied, her shoulders free from burdens!
>
> It was ten o'clock on the down-town streets. The scrubwomen were going to work--and they went laughing.[1]

The Public health movement coincided with the professional coalescence of social workers. As health workers in major cities discovered, improved health depended largely upon environmental modification and attitudinal adjustments

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[1] Mary K. Reely, "Women," Survey 31 (November 15, 1913):184.

among the urban poor. The reality of life linked physical well-being inexorably to its political and social ramifications. Hence the social worker became an integral part of the public health movement; he worked as a necessary adjunct to health agencies as liaison between the patient's health and home; he furnished statistical weaponry for political arsenals, campaigning for the benefit of poor humanity huddled in urban tenements. Social workers served as spokesmen for the foreign heap clustered in urban ghettos, and empathized with and understood them. Since the public health movement in the early part of the century concentrated so heavily upon the health of women and children, social workers' vivid descriptions of the poor helped shatter the Victorian myth of motherhood. Social workers transformed dry data into human portrayals of the daily life of the poor.

In the late nineteenth century, the abstraction of motherhood allowed the continuance of illusion; social theory made the working mother invisible while it maintained the phantom of autonomous households in which mothers possessed unlimited powers to shape the environment and to mold those who came within it. As long as the myth of motherhood persisted, it would shelter the government from any demands for intervention to make the various facets of mothering reconcilable.

Motherhood is a major projection of the female. The exaltation of the myth of motherhood accompanied a lack of material rewards (perhaps reflecting the general status of women). In the early twentieth century, various advances offered the possibility of realizing the interdependence and dialectic unity of the key elements of a woman's life: safe maternity, healthy infancy, and fulfilling motherhood.[1] Social workers became catalysts in this process of transformation. They were the sensitizing agents who broke through the rhetoric of motherhood into the reality of the lives of the urban poor, particularly with immigrant families.[2] A vivid new dimension of motherhood and childhood exploded.

The interjection of the social worker into the lives of the city poor, as case worker and social reporter, was not devoid of conflict--although the tension derived from the collision of cultural habits and expectations, and not from mocking derision or animosity. In fact, the social workers' new intimacy with the immigrant provoked a genuine respect for the unflagging courage of the immigrant family,

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[1] See Chapters X and XI.

[2] In 1910, 40.4 percent of New York City's population of almost 5,000,000 was foreign-born. See Edward B. Phelps, "Certain Phases and Fallacies of American Infant Mortality Statistics," reprinted from American Journal of Public Health (November 1913):1204.

especially the mother, thrown upon foreign, often unfriendly, shores. Survey magazine, the bible for social workers for the first three decades of the twentieth century,[1] well illustrates social workers' attitudes and ambitions for the immigrant family.

Collectively, the articles voiced anger at the social and political realities which gave validity to the fatalistic writings of Theodore Dreiser and Thomas Hardy. The immigrant could not successfully combat the demands of an industrial network which provided him meager income while it shattered his health. He would never realize the American dream without major social reformation. Social workers articulated the workers' unspoken bitterness:

> Breed us more men, ye Daughters of Toil;
> Ye alien mothers in far-off lands,
> Sire them strongly, clean brawn and bone,
> For we sift from the chaff the wheat alone,
> When they come to die at our hands.

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[1]The Survey originated as Charities, the house organ of the New York Charity Organization Society, with Edward T. Devine as its editor. In 1905, it merged with Graham Taylor's The Commons; in 1906, it absorbed Jewish Charity and the title changed to Charities and the Commons. Paul Kellogg assumed the editorship in 1912, and the magazine terminated its connection with the Charity Organization Society and was retitled the Survey. Kellogg's editorship continued until 1952 (with the journal briefly called the Survey Graphic in the 1920s), when publication ceased. "The Survey's role for the developing professions of social service cannot be gainsaid--it served a synthesizing function in an age of specialization. For two generations of social workers the Survey was their 'bible' (as many of them put it)." Clarke A. Chambers, Paul U. Kellogg and the Survey. Voices for Social Welfare and Social Justice (Minneapolis: University of Minnesota Press, 1971), p. 245.

Think on our greed in your travail-throes,
    Think of us when ye bare your breast.
Mine and smelter shall claim their Toll,
Roads shall be broken and reach their goal,
Though ye smell their blood from the West.

We build us strong on your woman's woe
    Pier of granite and iron span,
Glare of the furnace and caisson's gloom,
Crane, and derrick, shall rear the Tomb
Of him whom ye gave us--a man.

Seas shall not bar your sons from harm;
    Steppe or forest or alpine slope,
Our arms are long to grasp what we need,
The New World springs from your trampled seed
Ye drain the dregs of our draught of Hope.[1]

Still, the tone of most writers reflected the belief that all would eventually be rectified, as this poetic romanticization of immigrant motherhood recites:

Down yonder she sits in the half-open door,
    Tis plain she has never had time to before;
Her first little child sleeping there on her breast,
Poor soul, how she feasts on this banquet of rest.
    But all is so strange to her, people don't care,
    They just pass her by with a questioning stare. . . .

Too soon she must leave the wee son of her youth
    To toil in the shops with the bold and uncouth,
To roll fat cigars or to tie willow plumes
Or stand the day long by the thundering looms,
    Where no one is strange and the bosses don't care,
    But just pass her by with a growl or a glare.

Yet courage to you, little Mother of Men,
    Some day the whole land will protect you, and then
Your pure young blood will strengthen our race
Renewing our life, setting hope in our face,
    And you'll find it strange, how all of us care,
    Who once passed you by with contempt in our stare.[2]

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[1]Gordon Thayer, "Immigrant Motherhood," Survey 31 (December 6, 1913):244.

[2]Madeline S. Miller, "Immigrant Motherhood," Survey 31 (December 6, 1913):244.

At their best, social workers hoped for a cultural reciprocity in which immigrant characteristics would not totally be submerged. In the area of health care, they pressed for solutions which would preserve humanism against technology. They urged and reminded the powerful that successful administration and distribution of health services depended upon consideration of the kinds of people serviced.[1]

Yet in practical daily contact with the immigrant, social workers also saw the immigrant as a victim of his own folly. His mistakes, although perhaps not of his own making, nonetheless impeded him and should be eliminated. Compassion notwithstanding, the immigrant's roots lay in an older, less advanced order, with survival dependent largely upon adaptability to the urban industrial setting. This required that his habits change. At the same time, the family also needed modernization for its members to fare well in the new world. The family remained the basic component of society, and social workers sought to reach individuals through the family unit.

Thus, the confrontation between two cultures did not produce uncritical praise from the social worker. More than

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[1]Lillian D. Wald, "Address," Transactions of the Third International Congress of Nurses, Pan-American Exposition, Buffalo, September 18, 19, 20, 21, 1901. In Files of the Visiting Nurses Service. See also Michael M. Davis, Immigrant Health and the Community (New York: Harper and Brothers, 1921), p. 3.

that, social workers' practical advice often contradicted their romantic idealization of the immigrant. As much as social workers battled for legislative reformation of living and industrial conditions, they persisted in their belief that immigrant life would improve significantly with the adoption of scientific management of home life. The concept of "domestic science," allegedly the culmination of "the researches of physiologists, chemists, economists, and architects,"[1] carried with it a concomitant acquiescence. The immigrant mother, commonly acknowledged as head of the family, if instructed in the proper methods of ventilation, order, cleanliness, garbage disposal, and fire protection, would achieve a satisfactory living environment notwithstanding, "given conditions typical of those in the neighborhoods in which they live."[2] The social worker found the apparent irregularity and disorderliness in immigrant homes most appalling. At the same time, case workers supposedly understood the heavy burdens of women who worked and managed homes. Dietary habits also worried social service agents; e.g., the "amazing ignorance on the part of many mothers of the first principles of proper feeding and cooking."[3] Diet

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[1]Sophonisba P. Breckinridge, New Homes for Old (New York: Harper and Row, 1921; reprint ed., Montclair, N.J.: Paterson Smith, 1971), p. 15.

[2]Welle Reeder, "Educating Tenement Dwellers," Survey 32 (April 11, 1914):55.

[3]New York Diet Kitchen, Forty-third Annual Report, October 31, 1915, p. 10.

revision for nutritional value became a "habit forming process, successful only with constant repetitions."[1]

The notion that immigrant women could calmly and scientifically run their homes in the midst of their poverty and work demands, so graphically depicted by social workers, seems farcical in retrospect. Yet social workers manifested little awareness of this conundrum.

The public health movement's emphasis on preventive medicine let the apostle of health enter the most personal aspects of his client's behavior. This necessarily caused resentment by the recipient; the total estrangement between American and foreign customs probably strengthened the tension.

Social workers saw the immigrant mother as rigid and most insulated from modern American values, the least amenable to change. Indeed, she was. Rarely did foreign-born women wander beyond the scope of their enclaves. They remained the standard-bearers of tradition, the least "American" of the immigrant family. Since women were so localized, social workers pinned their hopes on immigrant children as conduits of cultural transmission. As "the

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[1]Lucy H. Gillett, Adapting Nutrition Work to a Community, Publication No. 134 (New York: AICP, 1924), pp. 28-29. Health and social workers found Italian dietary habits the worst.

child is plastic to new ideas,"[1] he must be freed from alien subservience to his parents.

Ignoring the economic realities of urban tenement life, social and health workers deplored the use of children as economic assets. The immigrant mother must be made to appreciate the necessity for free development of her child's personality; she must surrender her anachronistic belief in family economic collaboration. Childhood should be a time of "wholesome play." But "the foreign-born mother," wrote Sophonisba Breckinridge, "from a rural district in Europe, where children were put to work helping the parents as soon as they could be in any way useful, frequently does not recognize this need and hence does not even do those things within her power to secure it."[2] Social service dicta seemed often so idealistic as to induce guilt. Mothers' absence from the home further deprived immigrant children. Workers saw women's work as a Hobson's choice: abstention, dooming families to poverty, or engagement, ordaining children's social maladjustment.[3]

Since initial contacts between social worker and immigrant emanated from the health protectionist movement

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[1]"The Relation of the Settlement to Women and Children," Charities 1 (May 1898):5.

[2]Breckinridge, New Homes for Old, p. 157; see also p. 151.

[3]Ibid., pp. 4, 46.

for infants, American health prosyletizers dissected the most intimate customs of nationalities. Antithetical to social workers' desires to make motherhood scientific were the immigrant mothering customs of demand feeding, swaddling the newborn, and the use of the pacifier.[1] Whether these immigrant practices stemmed from the perceived recognition that infants need security and warmth more than discipline and routine, or from a desire to quiet the baby's cries quickly in an already harried existence, social workers inveighed uncompromisingly against the customs.

Along with the irregularity of infants' diets, social workers assailed the prevalent practice of feeding infants farinaceous foods and young children coffee and tea. The Children's Bureau's investigators into infant mortality found the most widespread problem among immigrant rearing patterns to be the early introduction of solid foods (defined in infancy as any dietary substance other than breast or modified milk and water). So common was the practice that a mother--a Bohemian--who had actually been in this country for fourteen years "reported that her fourth child had been born on Saturday at 3 p.m. During the night

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[1]See U.S., Department of Labor, Children's Bureau, Infant Mortality. Results of a Field Study in Akron, Ohio, Based on Births in One Year, by Theresa S. Haley, Publication No. 72 (Washington, D.C.: Government Printing Office, 1920), p. 19. Ironically, demand feeding is presently in vogue, many American hospitals now wrap newborn infants, and today the pacifier is acceptable to pediatricians.

he began to cry, and, as her milk had not come, the mother got up at midnight, and made some tea, and gave it to the child."[1] Some health workers understood that parents' inability to afford what they had formerly supplied their infants in the old country marred immigrant habit transplantation. European nationals customarily deviated from breast milk diets with solids, but could provide wholesome foods such as fresh soups or buttermilk. Since these foods lay beyond the immigrant's budget in this country, he often replaced them with beer or coffee.[2]

Other infant beliefs conflicted with health advocates' drives for personal cleanliness and proper ventilation. Infants should not be bathed, went the theory, and open windows caused disease.[3] In scanning her career, Baker ruminated on this subject:

> When we started educating slum mothers in the necessity of ventilation, for instance, we ran into the inconquerable European prejudice on the subject of drafts and night air. An Italian or Rumanian mother knew, as certainly as she knew the sun was going to rise next morning, that to expose a room to outside air after dark was tantamount to suicide and she was pretty apprehensive about an open window between September and June in any case. Neither persuasion nor scolding succeeded; the open window was unattainable. So we had to think

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[1]Children's Bureau, Infant Mortality, Akron, p. 32.

[2]Davis, Immigrant Health and the Community, p. 250.

[3]N.Y. AICP, Fresh Air Work (New York: AICP, 1904), p. 17.

> of some way of getting ventilation with closed windows. The answer proved to be a plain wooden board, its length the width of the window. [An immigrant mother] would consent to open her window if she could immediately fill the gap at the bottom with an . . . impermeable board, and its appearance reconciled her to the fact that a certain amount of air was coming in between the seams.[1]

To those seriously promoting public health, the most frustrating of immigrant attitudes was apathy and acceptance of illness. This fatalism was especially acute among Italians. Malnutrition and rickets had higher incidence among Italian children, as did mortality and morbidity rates among New York City's Italian population.[2]

Health workers found superstition and reliance on providence or divine intervention as real stumbling blocks, requiring strategic maneuvering for health safeguards to be accepted. For instance, a social worker, confronted with little cooperation in his efforts to placate and isolate contagious disease, wrote: "An Italian woman once explained to me why she had exposed her large family of children to diphtheria. 'All sickness comes from God,' she said. 'Would He send sickness to my baby because I helped Rosina nurse hers when it had diphtheria? No, He would rather send

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[1] S. Josephine Baker, Fighting for Life (New York: The Macmillan Co., 1939), p. 117.

[2] Davis, Immigrant Health and the Community, p. 36. Health workers claimed their greatest successes among Jews, who of all immigrant groups most readily accepted vaccination and substitute modified milk. See Maurice Fishberg, "Health Problems of the Jewish Poor," Jewish Charities 7 (November 1916):141-42.

it in punishment if I had not been kind.'"[1] The Italian belief in theological therapy confounded health workers. When Italians invoked a saint, they eliminated all medication, often for three days or more. Unsatisfactory results did not deter the believers; they simply selected another saint. Italians were also the last stronghold of bleeding by leech.[2]

Health workers had to accommodate to these ingrained fears and prejudices to accomplish progress. Baker, as chief of New York City's Bureau of Child Hygiene, knew full well that the Schick test (for diphtheria immunity) should be part of an infancy health program. She began the program among school children, aware that immigrant mothers would never consent to such testing on their babies. So the Bureau "parted company with sense and science" (the period of greatest susceptibility to diphtheria fell between the ages of six months and two years), testing older children in order to make these mothers comfortable with the idea.[3]

The immigrant fear of hospitalization, not only for themselves but also for their infants,[4] combined with their

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[1]Alice Hamilton, "The Social Settlement and Public Health," Charities and the Commons 17 (1907):1037.

[2]New York Infirmary for Women and Children, Fifty-third Annual Report, 1906, pp. 16-17.

[3]Baker, Fighting for Life, pp. 152-53.

[4]The East Harlem Nursing and Health Demonstration, The Infant Service Report of the East Harlem Nursing and

blind faith in the healing powers of medication. Baby health station workers observed immigrant mothers disappointed when leaving clinics, reluctant to return, with merely a doctor's prescription of proper food, bathing, clothing, and fresh air. Luckily, by the early 1920s medicine recognized cod liver oil as a preventive and cure for rickets; it gave health workers a "considerable hold on the mothers, by giving a very small bottle of cod liver oil and making them come back often to the [babies'] class for a fresh supply."[1]

Immigrant use of the medical quack whose advertisements in the immigrant press promised cures for man's most dreaded diseases, as well as the newcomer's indulgence in patent medicines, baffled the public health interventionist. Quacks' promises of easy and encompassing cures played directly into immigrants' fears of surgery and death. The local drugstore was a central institution in the ethnic community. Immigrants regarded the pharmacist, who usually spoke the foreign tongue, as a learned man; they trusted him and often consulted him before a doctor. Because health had always been a private matter in the old country, and since

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Health Demonstration, Final Report, Section III (New York: East Harlem Nursing and Health Demonstration, 1928); see p. 32 for case histories of babies who died because mothers rejected health workers' advice to use a hospital.

[1]The Society of the Lying-In Hospital of the City of New York, Annual Report for the 124th and 125th Years, from January 1st, 1922 to December 31, 1923, p. 88.

the transition from agricultural to urban culture brought new health hazards, the foreign-born population in America tended to look suspiciously upon medical intrusion which did not produce a fast cure.[1] As a result, foreign patients looked upon doctors dubiously, changing them constantly and thereby deterring accurate diagnosis and treatment of disease.[2]

Immigrant women's attitudes toward childbirth constantly irritated health workers and often barred effective communication. Aside from the newcomer's preference for the midwife, immigrants displayed a casualness to childbirth which confused Americans dedicated to saving mothers and babies. Immigrant mothers were up and out of bed within six days after birth.[3] The Children's Bureau report on infant mortality in Akron, Ohio, recited the not so atypical story of a thirty-two-year-old Magyar mother, literate and residing in the country thirteen years, who delivered her sixth child:

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[1]Davis, Immigrant Health and the Community, pp. 113, 127, 131, 145, 148, 156, 161.

[2]New York Infirmary for Women and Children, Annual Report, 1906.

[3]Davis, Immigrant Health and the Community, p. 189. He cites a New York AICP study of 265 maternity cases. Of the women studied, 60 percent stayed in bed six days or less after childbirth. Davis also reported that Serbo-Croatians were likely to dispense with any childbirth attendant whatsoever; p. 190.

> She called in a midwife . . . but the midwife did not come, so the mother with the "help" of her five-year old daughter, delivered the baby herself. One-half hour after the birth the mother went to bed and stayed there until the following morning. Then she got up, prepared breakfast, attended to the needs of her three children, and went back to bed. Later in the day a doctor was called in; he examined the mother and child and pronounced everything satisfactory. For the first two days the mother did all the housework that had to be done, resting all she could. On the third day she finished washing which had been in progress when the baby was born.[1]

Workers for the New York Milk Committee found that in New York City "among all races of the laboring class there is a general tendency to place too little importance on the child-bearing state."[2] Prenatal workers blanched at the drinking habits of pregnant immigrant women. "The Italian and French mother has used and still uses her light wine; the German and the Irish mother uses beer and ale to a moderate degree, despite all instructions to the contrary, and will continue to do so unless we can present convincing data that such use is harmful and dangerous."[3]

The superstitions of the foreign-born thwarted maternity health workers' efforts at hygiene. Southern

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[1]Children's Bureau, Infant Mortality, Akron, p. 32.

[2]New York Milk Committee, Seventh Annual Report for the Year Ending December 31, 1913, p. 40.

[3]Jacob Sobel, Instruction and Supervision of Expectant Mothers in New York City (New York: Department of Health, Monograph Series, No. 21, 1919), 21; see also Milk Committee, Seventh Annual Report, 1913, p. 40.

Italian women, perhaps because they bathed in Italy in outdoor lakes or the sea and associated such bathing with miscarriage, refused to bathe while pregnant. Jewish lore required that a pan of water be put under the confinement bed at delivery to fight poisons and bed sores.[1] Blacks refused to remove the dirt in the confinement room; instead they swept it into a corner in the belief it would bring good luck.[2] And Turks heralded the arrival of the newborn with a decorated bower hung over the delivery bed.[3] In all cultures, childbirth was a family ritual. Unintentionally perhaps, the maternal life-saving movement stripped the event of many of these warm traditional associations. Birth would acquire a uniformity, disassociating the birth process from women's emotional thrust; birth became a medical phenomenon.

Significantly, while black women and children did not stir health and social workers' emotional responses to the same degree as did immigrants, blacks were medically more responsive. When there was contact between black populations and health workers, the authorities maintained a

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[1]Davis, Immigrant Health and the Community, p. 192.

[2]Irene Kuhn, "Babies 24 Hours a Day. Nurses Must Contend with Superstitions on Their Job," New York World-Telegram, August 28, 1935, from the files of the Visiting Nurse Service, New York City.

[3]New York Milk Committee, Seventh Annual Report, 1913, p. 40.

segregationist attitude. The New York Nursery and Child's Hospital, whose outdoor department district ran from 24th Street to 104th Street west of Fifth Avenue, included the "black belt." The hospital's location forced it to hire "a colored nurse and assistants."[1] The Bureau of Child Hygiene, reacting to black mortality statistics twice as high as whites', placed special prenatal nurses in the Columbus Hill district and upper Harlem.

But only the New York Association for Improving the Condition of the Poor established a specific maternity program for blacks. To their surprise, these workers found social barriers with blacks more penetrable than with other racial groups. The people "appear to be unusually willing to avail themselves of the excellent medical services provided by the hospitals and dispensaries of the area. Of this no better evidence can be offered than the fact that many of the mothers take up temporary residence in the district as lodgers solely to be eligible for delivery by doctors of the two maternity hospitals" (Sloane Hospital for Women and the New York Nursery and Child's Hospital).[2] Yet black citizens remained peripheral to the concerns

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[1]New York Nursery and Child's Hospital, Annual Report for the Year Ending September 30, 1917, p. 14.

[2]New York Association for Improving the Condition of the Poor, Health Work for Mothers and Children in a Colored Community, Publication #131 (New York: AICP, 1924), p. 5.

of the leaders of the early twentieth-century public health movement.

The contact between social worker and immigrant may have been a mixed blessing for the latter. Yet for the middle class, the composite of life which social workers depicted added a new dimension to public awareness. Social workers' undisputed contributions were their descriptions of the lives of women who mothered and worked and raised children in poverty. Perhaps this provided "consciousness raising" of a sort which eventually mobilized middle-class women into political action. Perhaps never denying the centrality of motherhood to women's lives, middle-class women began to coalesce on issues of structural reorganization to make the reality of motherhood conform more closely to its rhetoric.

A picture of poor motherhood emerges from the Survey's descriptions of women who worked. Mothers left children, often quieted by drugs, with older siblings or equally harassed neighbors. Worse, mothers often locked children in apartments with some food until their return. In the best circumstance, children might go to a day nursery, from which their weary mothers would take them home each evening to dinner, then the washing, and whatever cleaning for which the mothers had any reserve energy. Some women who stayed at home all day caring for their children went off to work every night. Social workers imagined their exhaustion,

their irritability. "If we valued home life as we hypocritically say that we do, there would not be one of these . . . girls away from the family home in the dead of night serving the public [in a telephone exchange], not because they served it better than men would do, but because they are cheaper."[1] In 1919, one discussant at the Children's Bureau's Child Welfare Conference suggested that industry, not the socialists, would most probably destroy the home life which conservatives were so interested in preserving.[2]

With the aid of studies of working women and synopses in the Survey, social workers discredited the notion of women working only for pin money. The theory gave employers excuses to underpay women. Analysts debunked the assertion that women did not require living wages because they lived with parents or spouse. Canvasses of working women in New York City, Chicago, and St. Louis showed that 84 percent of women working in stores and 88 percent of those toiling in factories gave their entire earnings to their families.[3]

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[1]Florence Kelley, "The Family and the Woman's Wage," Proceedings of the National Conference of Charities and Correction at the 36th Annual Session held in the City of Buffalo, June 9-16, 1909, p. 119.

[2]U.S., Department of Labor, Children's Bureau, Standards of Child Welfare, A Report of the Children's Bureau Conference May and June 1919, Publication No. 60 (Washington, D. C.: Government Printing Office, 1919), p. 233.

[3]"Why Girls Work in Department Stores," Survey 29 (October 19, 1912):63; Edith M. Hadley, "The Housing Problem

"It would never occur to some of the daughters of foreign parents to withhold even part of their wages."[1] The Bureau of Social Research of the New York School of Philanthropy conducted a study of working women in New York City's West Side, populated primarily with Italians and Germans, and confirmed the economic necessity of their work.[2] The reporter posited working women's insoluble dilemma: "They had been driven into work outside the home by conditions of poverty. They had also become wage-earners in obedience to the most primitive of maternal instincts. Their children would have suffered seriously had they failed them."[3]

The least skilled, most precarious, employment went to wage-earning mothers. Since dire economic circumstances often determined the decision to leave the home, carfare

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as It Affects Girls," Survey 30 (April 19, 1913):93; Paul H. Douglas, The Worker in Modern Economic Society (Chicago: University of Chicago Press, 1923), pp. 228-29.

[1]U.S., Congress, Senate, Report on the Condition of Women and Child Wage-Earners in the United States, S. Doc. 645, 61st Cong., 2d sess., 1910, Wage-Earning Women in Stores and Factories, 5: 148.

[2]Katharine Anthony, "Mothers Who Must Earn. A Study of New York's West Side," Survey 32 (April 4, 1914):17-20, 42. Among 370 women studied, 33.8 percent (or 125) were widows, 10.8 percent (40) had been deserted, 2.4 percent (9) were separated from their husbands, 5.7 percent (21) had incapacitated husbands, 3.2 percent (12) worked because their husbands were idle, and 44.1 percent (163) worked while their husbands did as well.

[3]Ibid., pp. 42-43.

represented a real factor in picking a job. Also, since women lacked men's freedom to leave for work without making arrangements for their children, working mothers were reluctant to traverse neighborhood boundaries.

The New York State Factory Investigating Commission's dissection of the facets of women's work underscored the mythology of the pin money thesis. Ester Packard, assistant secretary of New York City's Consumer's League, accumulated comprehensive information regarding the expenditures of three hundred working girls, from all areas of New York State, who earned less than $10.00 a week. The women, chosen arbitrarily, worked in factories and department stores. Their central uniformity was the sense of fatalism that work was mere survival and not a source of future comfort. Researchers also saw their penny-pinching budgetary calculations, which made a lunch of seven cents an extravagance.[1] Packard discovered the common strain of "incessant economy, of minute plannings over unexpected bills, and of nerves already worn, stretched taut. . . . Pleasure was obtained only after laborious plannings."[2]

Between the winters of 1918 and 1920, Children's Bureau staff members analyzed intensively the effects of

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[1]Ester Packard, "Just Getting Along," Survey 33 (February 6, 1915):514.

[2]Ibid., p. 515.

work on 843 mothers with 2,066 children under the age of 14. The women, all from Chicago, came from low-income families. The Bureau justified its selection on the basis that most working mothers stood in marginal income brackets, and also because "the social problems" resulting from mothers' extra-domestic employment became most "acute in this class."[1] Final results for the 843 women showed that the absence or insufficiency of fathers' earnings caused mothers' employment.[2]

During the period, many authorities insisted that children suffered from their mothers' absence. The Children's Bureau's study made a separate point, however--that when poverty caused women's withdrawal from child-rearing, the children could not be compensated, even with a hygienic and nourishing physical environment. The school performance of children of working mothers compared unfavorably to records of children of non-working mothers in the same school districts. Where women worked, home environments

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[1] U.S., Department of Labor, Children's Bureau, Helen R. Wright, Children of Wage-Earning Mothers. A Study of a Selected Group in Chicago, Publication No. 102 (Washington, D.C.: Government Printing Office, 1922), p. 1.

[2] Ibid., pp. 9, 13: Of the 843 women, only 164 came from families where the father's support was regular; 255 women were widows; 226 had been deserted, separated, or divorced; 10 had husbands in prison, 25 in institutions, and 6 in the army; and 53 had incapacitated husbands.

[3] Ibid., pp. 66, 68, 76.

usually stayed tense and disorderly. Worn mothers, who could not escape domestic duties with their outside employment, usually delegated chores to children too young to perform them successfully.

The research staff's object was not the reiteration of what was already familiar in the social service world, that healthy child development depended upon adequate family living. The report made a more subtle point, emphasizing the mutual necessities and interdependence of mother and child. Social interventionists had persisted in outlining the interests of mother and child distinctly when, in fact, they were inseparable. The report demanded that the prevention of the over-fatigued mother be a goal of child-welfare reform.[1] Researchers understood that women who worked for survival lacked the endurance for nourishing motherhood. With their lives painfully divided, neither their mothering nor their work brought reward. For instance:

> A Polish mother who finished coats at 15 cents a coat began work at 7:30 in the morning, after she had cleared away breakfast dishes. She sewed all day and often until late in the evening to earn $8.00 a week. When the investigator called at 8 o'clock in the evening she was still sewing. She washed, ironed, scrubbed, and made beds after she had finished work at night. It is not surprising that the house and the children were very dirty, and the mother too tired to be patient with the three small children.[2]

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[1] Ibid., pp. 49, 76-77, 86.

[2] Ibid., p. 33.

The analysts called for a general upgrading of men's wages, the enforcement of desertion laws so that mothers would not lose their legitimate support, and the establishment of day nurseries, equipped medically and educationally.[1]

In the twentieth century, domestic service no longer attracted the interest of female workers as it had in the nineteenth.[2] By 1910, although household employers anxious to hold onto their servants, had raised wages by an average $1.50 a month, twentieth-century women, both native and immigrant, had no use for the social isolation of service.[3] Unmarried working women preferred the factory or department store, offering freedom at the end of the day. The decision or necessity to work was not as clear-cut for married women, since they had to reconcile employment with mothering responsibilities. If mothers were not to leave their children entirely, they could become midwives, take in boarders, bring home factory work, or toil at night in factories or as office cleaners.

In the first decade of the twentieth century, female retail store employment increased more than any other

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[1] Ibid., p. 77.

[2] The 1890 census showed 1.2 million working women employed in domestic service, with the majorty young and single, with the married mainly black. See Robert W. Smuts, Women and Work in America (New York: Columbia University Press, 1959), p. 17.

[3] "The Trend of Things," Survey 24 (May 28, 1910):351.

women's occupation. Although department store employment, in sales, shipping, or packing, held more prestige than factory work, it tested women's health and strength severely. Pauline Goldmark of the Bureau of Social Research in New York City conducted one phase of the New York Factory Investigating Commission's work. During November and December 1912, she led a study of female employees at department and 5 & 10 cent stores. The researchers found that while work in such an environment avoided many of the physical hazards and noise harassment of factory work, the jobs were far from easy. The average work week extended almost 60 hours, with the women almost never off their feet. The long hours of standing in poorly ventilated rooms left women with swollen feet, broken arches, and varicose veins. Standing had worse effects on women's spines and reproductive organs; uterine displacement commonly resulted.[1] Wages hardly compensated for the effort and strain. Among 49 5 & 10 cent stores employing 1,038 women, wages did not exceed $6.00 per week in 67.6 percent of the cases. In almost 92 percent of the sample, weekly earnings were no greater than $8.00 a week. The pay scale at department

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[1]State of New York, Senate, Second Report of the Factory Investigating Commission, 1913, Volume II, Appendix IX, "Preliminary Report on the Employment of Women and Children in Mercantile Establishments," by Pauline Goldmark and George Hall, pp. 1197, 1214-16, 1220.

stores was slighly better; still, 51 percent of the women earned $7.00 or less.[1]

If conditions and wages were bad for the woman who left home for factory or shop, they were worse for married women whose dual responsibilities forced them into the least desirable and most exploitative labor. Night work in factories and as scrubwomen in public and private office buildings offered one way for married women to reconcile survival and motherhood. Women who worked at night usually averaged four and a half hours of sleep; they prepared three meals a day, did the washing, cared for their children, and then left for the night shift which ran from 7:00 in the evening until 5:30 the next morning. Factories paid women by the piece; on the average, they earned a dollar a day.[2] Analysis of one hundred night workers showed the majority widowed or married. The Factory Investigating Commission described one typical night worker: "[A] woman spinner had children ages 7, 4, 3. Her husband works here [a hemp and twine factory] in the day time. She says she cannot work during the day because she must look after her children and

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[1]Ibid., pp. 1239, 1259-60, 1263.

[2]Second Report of the Factory Investigating Commission, Volume II, Chapter II, "Night Work of Women," pp. 440B, 453.

house. She snatches a few hours sleep in the morning while a neighbor looks after the children."[1]

Although by 1912 most European countries had abolished night work for women as inimicable to health,[2] night work continued in the United States under the most horrid conditions. Employers did not permit scrub women, for instance, to use long-handled mops. Upon inquiry, they justified this method not by its cheapness but on its greater cleaning effectiveness.[3]

In New York City, home work provided immigrant women with supplementary incomes, without requiring them to leave their children. Home work, or the finishing of manufactured goods in the house, was most prevalent among Italian women.

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[1]Ibid., p. 440C.

[2]Great Britain, Austria, Holland, Belgium, France, Germany, Italy, Luxemberg, Portugal, Sweden, Switzerland, and the Netherlands had all abolished night work. In the United States, only Massachusetts, Indiana, and Nebraska banned such work. Ibid. The prohibitions of night work for women evokes the topic of special protective legislation and equal rights for women. Ideally, night work should be illegal for both men and women as antithetical to humanistic life. But in the progressive battle to make government serve human needs, it is important that the public take as much as it can get from a not-overly-generous government. Equality implies respect for differences. In reality, home life is not the equal responsibility of husband and wife. Expectations leave the care of the children and the home with the wife, whether or not she is employed. Moreover, men do not get pregnant, are not subject to the health hazards of pregnancy, and do not die in childbirth.

[3]Anthony, "Mothers Who Must Earn," pp. 18-19.

This occupational pattern correlated with the sporadic and seasonal work among Italian men, who formed the bulwark of the construction industry, characterized by long periods of unemployment.[1] Home work included such tasks as finishing clothing; hand embroidery and crocheting; making various types of embellishments for luxury items such as fringes, ornamentation, and lacing; making dolls and dolls' clothing; threading novelty beading for bags and jewelry; and making artificial flowers and feathers. The predominant home occupations in New York City were making artificial flowers and the needle trades, especially embroidery.[2] In 1902, the New York City Bureau of Labor Statistics estimated home workers in the city at somewhere between 25,000 and 30,000. But when the New York Factory Investigating Commission surveyed the tenement manufacturing situation in 1912, it conservatively gauged outworkers in the embroidery trade alone at 51,500.[3]

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[1] Second Report of the Factory Investigating Commission, Volume III, Appendix IV, "Report on Manufacturing in Tenements in New York State," by Elizabeth C. Watson, pp. 684, 698.

[2] Ibid., pp. 678-79; see also Elizabeth C. Watson, "Home Work in the Tenements," Survey 25 (February 4, 1911): 774.

[3] Watson, "Report on Manufacturing in Tenements," p. 677. She based her figures on 18 factories which contracted embroidery home work; the factories reported an average of 103 home workers each.

The tenement house law of 1892[1] was the only statute in New York State which applied to home work, and it required that a landlord be licensed by the State Department of Labor if any manufacturing were to be conducted on his premises. A license would be granted only when the tenement house passed sanitary inspection and the landlord complied with the law's enumeration of items permitted for home manufacturing. When the Factory Commission investigated, it found the law marginally enforced. The dearth of inspectors was not the only problem, since even biannual inspection could not ensure sanitary and contagious disease control in tenement life existence where conditions changed daily. Manufacturing in the homes extended beyond the forty-one-item legal listing; the flats themselves were filthy and the workers indifferent to the presence of contagious diseases.[2]

Elizabeth Watson of the National Child Labor Committee led the Factory Commission's investigation. She reported the presence of diphtheria, scarlet fever, and tuberculosis in the manufacturing tenements.

> In . . . [one] house, a young woman, whose father had been sent away to a tuberculosis hospital, was working on dolls' clothes in the same room where her sick father

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[1]Article VII, Sections 100-105 of the Labor Law.

[2]Watson, "Report on Manufacturing in Tenements," pp. 726, 730.

> lay. The Charity Organization had refused this young woman further assistance unless she would go to a tuberculosis hospital. She refused to do this, and is working day and night on the dolls' clothes with tuberculosis going towards its final stages.[1]

Home work enveloped the entire family. It chained the children to the tedium of indoor work away from play and school, and also converted whatever home ambiance a New York City tenement flat offered into a miniature factory. With steam heat a rare luxury in tenements, home workers often gathered around a coal stove in the kitchen to do their work. If the kitchen was avoided, then the workers huddled in a bedroom with their trade materials. The Factory Commission report displays a picture of an Armenian woman and her three children crocheting in a bedroom, with the mattresses piled high to allow work space.[2] How could the adoption of "domestic science" be reconciled with a picture and a life such as this? Did social workers recognize the capriciousness of immigrant life?

In the chaotic world in which immigrant women found themselves, home work satisfied their need to be with their children. At the same time, however, it tempted employers to greater exploitation as they avoided child labor and

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[1]Ibid., p. 732.

[2]Ibid., p. 674, see also p. 693.

compulsory education laws; women's cheap labor at home also allowed businesses to shrink the indoor factory labor force.

Children as young as three years became premature adults, with work demands which even adults should have been spared. If the home work involved flowers or feathers, parents put young children to work. Since children were incapable of knitting or embroidering, adults used them as messengers, carrying work to and from the factories. Parents also expected them to handle the household washing and take care of babies.[1] Homes stayed dirty, with meals served haphazardly, for every moment spent away from work was money lost. The money itself was of value only when matched against the husband's earnings. The Factory Commission visited a woman making passimenterie frogs, working more than ten hours a day. She received 30 cents a frog, which took her six hours to make; she averaged 63 cents a day.[2] If instead of going to the factory herself or sending her children, she depended upon a contractor or goods distributor, the third party's disproportionate commission swallowed her wages.[3]

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[1]Ibid., pp. 690-91; see also Watson, "Home Work in the Tenements," p. 776.

[2]Watson, "Report on Manufacturing in Tenements," p. 674.

[3]Ibid., p. 680: "The amount taken by the contractor varies, according to the work and the ignorance of the worker from 10 to 50 percent or even 75 percent of the wages earned."

The reality of poor motherhood emerged. Elizabeth Watson reported:

> Last March, on a bitter cold day . . . while visiting a tenement in which finishing was done, a little shivering group of children was found whimpering and huddling in the second floor hallway. The baby, a tiny scrap of 14 months, was crying with cold, while the little mother (of seven) cuddled him in her arms, trying to forget her own discomfort in caring for him. A third child, a little girl of five, said they were locked out because the mother had taken the work to the boss. On returning, the mother was much distressed at finding her little family crying with cold. . . . She asked: "What, I must do? I maka the coats, my man he no gotta job. He walk this day for work. I lock a children in, they burn up. I lock a children out, they cry. What I must do?"[1]

Propagation of the notion that there was another kind of motherhood, that there were working mothers who had less leisure than their hard-pressed husbands, was one of social workers' most significant contributions in the early twentieth century. Working men at least had some semblance of relaxation after work. Women, on the other hand, returned from work only to prepare dinner, get the children to bed, and tidy the home. When the Children's Bureau questioned Chicago working mothers about their routines of employment and home chores, 125 of 361 respondants said they did all the house work after work, 118 received help from their children, 38 from their husbands, and 64 from relatives or lodgers. "This burden that wage-earning mothers accept without comment comes out clearly from the simple

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[1]Watson, "Home Work in the Tenements," p. 776.

matter-of-fact statement of an Italian mother. The father and mother both worked in a tailoring shop. The mother did all the housework aside from the washing, which was sent out, except that her husband dried the dishes for her 'when he was not too tired.'"[1]

Medical and social welfare workers made the connection between poverty and illness in the late nineteenth century. In the early twentieth, they began to recognize the double burden of housekeeping and work on women's health. All immigrant working groups suffered ill health because they attempted to live on the same diets which sustained them in the old country, where labor was generally conducted under vastly different conditions.[2] But women bore a greater burden. Manufacturing tobacco products in factories or tenements damaged the health of men and women alike, but if a woman were pregnant, poisons would invade the amniotic sac, often causing miscarriage or stillbirth. Sedentary work left women constipated with abdominal obstruction; pelvic inflammation often ensued, with the "tendency to perpetual invalidism." The use of sewing machines (prohibited to pregnant women in middle-class

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[1]Children's Bureau, Children of Wage-Earning Mothers, pp. 38, 43; see also Anthony, "Mothers Who Must Earn," p. 21.

[2]Robert Hunter, Poverty (New York: Grosset and Dunlap, 1904), pp. 33, 49-50, 143.

maternity advice literature) destroyed women's reproductive organs.[1] The capacity for and function of childbirth thrust unique risks upon women. Reformers finally recognized that if general health were the aim, women needed special protections and guaranties.

Social workers realized that poor families could not buy adequate or even minimal health care on workers' incomes. In 1910, the Buffalo Charity Organization Society prepared a budget based on prevalent earnings of $1.50 a day. The annual income on such a daily wage, presupposing work every day but Sundays and holidays, was $450.00. The Society noted that "this allows for no interruptions through bad weather, slack work, or sickness. The usual income of steady workers is seldom over $400."[2] The Charity Organization Society estimated that for a family of five (husband, wife, and three children under sixteen years) "the lowest tolerable budget without charity . . . is figured at $560."[3] An income of $630.00 would have been more realistic, the Society contended, and even that necessarily foreclosed extravagance and savings.

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[1]Abraham Jacobi, "The Physical Cost of Women's Work," reprinted from The Charities and the Commons, February 2, 1907 (New York: Charity Organization Society, 1907), pp. 5-7.

[2]Frederic Almy, "Decencies which a Laborer's Wage Denies," Survey 24 (June 4, 1910):370.

[3]Ibid.

The budget planners in Buffalo worked from conservative estimates. They calculated the rental of three small rooms with a sink (but without bath or toilet) at $7.00 per month, or $84.00 annually. If food expenses were kept to $5.00 a week, food consumption would account for $260.00 a year. With clothing costs based on shoes alone (a dollar pair of shoes, the Society maintained, would last a boy but six weeks), each child required $9.00 a year. Fuel and lighting (coal and kerosene) would take $30.00 per annum. The planners incorporated another $10.00 for home furnishings, such as sheets or blankets. This was all the average family could afford. An income of $460.00 could not allow for emergencies.[1]

This modest budget excluded any health expense, which if estimated at $5.00 per person would add another $25.00 to the yearly cost of living. It excluded carfare, which was $30.00 a year (ten cents a day) merely for the husband to travel to and from work each day. Adding $20.00 for burial insurance (which the poor frequently carried to prevent a pauper's funeral), $12.00 for recreation (five cents a week for each member of the family), and $3.00 for sundries (e.g., newspapers), expenses immediately soared to $550.00 a year.[2] In New York City in 1913, supporting a wife and three children required weekly earnings of between

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[1]Ibid. [2]Ibid.

$15.00 and $20.00. Studies demonstrated that in Manhattan, a family of five with three children under fourteen could not live on less that $900.00 a year. Families needed the same income in Boston, Buffalo, and Chicago. More was required in Pittsburgh; a little less in Philadelphia and Baltimore.[1] Social workers discovered "that the immigrant labor supply furnishes the fundamental common labor base which is at the root of our present industrial system . . . and that the wages paid are those which represent a minimum of subsistence."[2]

The other dynamic at play in the new century was the evolution of middle-class motherhood from isolation through social convergence to political action. Beginning in the late nineteenth century and moving into the twentieth, middle-class women (in no sense politicized or feminist) coalesced, initially on traditional and individualistic grounds (e.g., how to be better mothers), eventually becoming highly political. Groups such as the National Congress of Mothers became strong lobbyists for federal institutional intervention and change, to help alleviate the individualistic burden of motherhood. Activists gained a concomitant

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[1]Edith M. Hadley, "The Housing Problem as It Affects Girls," Survey 30 (April 19, 1913):92-93.

[2]H. Parker Willis, "The Findings of the Immigration Commission," Survey 25 (January 7, 1911):576.

awareness that women alone could not successfully raise a family.

The myth of motherhood shrouded middle-class women's lives. The exaltation of woman's role in the home, and her indispensability as child-rearer, was in practice the psychology of individualism. It made women's place in the home as unthreatening as possible to the free functioning of industrial capitalism. It locked women into an isolation from the productive spheres of life (only two occupations, mothering and housekeeping, offered no financial remuneration). Yet "the ambition of the mother cannot rise to a greater height than it attains in the fulfillment of all that is comprised in the phrase--maternal function. This includes the performance of the object for which she was created."[1] Motherhood presented the only "natural life for a woman"; it was the source of her "real value."[2] The eulogists of motherhood attempted further to convince women of

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[1]H. Laing Gordon, The Modern Mother. A Guide to Girlhood, Motherhood, and Infancy (N.Y.: R. F. Fenno and Co., 1909), p. 264; Margaret E. Sangster, The Mother Book (Chicago: A. C. McClurg & Co., 1912), p. i.

[2]"The Value of a Woman," Florence Crittenton Magazine 7 (March 1906):465. In 1950, an obstetrician wrote: "Despite women's statements to the contrary and their efforts to conceal it from those about them, experienced clinicians, particularly those of the obstetric fraternity, believe that since the dawn of creation the dominant feminine instinct is that of reproduction." James R. Bloss, "Causes of Fear Among Obstetric Patients," Journal of the American Medical Association 144 (December 16, 1950):1359.

the rewards of unobtrusiveness. Women were valuable in direct ratio to their dignified repose. They were to be loved for their malleability, for their "affability, grace and tact," for their adaptability to the person with whom they were dealing so as to create "at once . . . harmonious relations."[1]

The ideology that mothering was woman's destiny and only fulfillment, and that it was inborn and instinctive, came as the culmination of social tendencies dating back to the advent of industrialism. The modern nuclear family, with private energies directed to the development of its offspring, is a relatively recent development. Not until approximately 1700 did the child become central to family life, and even then the centrality of childhood, requiring special nurturing and devotion, was not universal among all social classes. Industrialization first freed the upper and upper-middle classes so that children were no longer intrinsic to the economic survival of the home; childhood could be appreciated for its unique attributes and apprenticeship would cease. Lower-class life retained longer the loose extended form of family life. Poor people found income needs were too precious to extend childhood indefinitely or

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[1]Albert Mathews [Paul Siegvolk], Ruminations. The Ideal American Lady and Other Essays (New York: G. P. Putnam's Sons, 1893), pp. 7, 12.

allow motherhood to become a full-time occupation.[1] Instead, child-nurture and economic sufficiency remained the responsibility of the group, which responded to necessity with individuals assuming eclectic roles unconnected with gender. When industrialism destroyed the extended family among the poor, it added a double burden to women's existence. Since motherhood was woman's mandate and the government remained uninvolved, lower-class women were themselves forced to assume both the productive and reproductive functions which now became geographically divided in space.

The maturation of industrialization affected children and women alike. Its requirements for new skills postponed the graduation of the child from the home. The function of the home changed from production to the education of children in the new social demands; the care of the dependent child became woman's function. Since factory production limited the necessary pool of workers, women had to find useful employment in the home. Thorstein Veblen reduced women's corset to its economic setting and meaning, a distinct product of industrial surplus: "In economic theory, [the corset was] a mutilation undergone for the purpose of lowering the subject's vitality and rendering her

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[1]See Philippe Ariès, Centuries of Childhood. A Social History of the Family, trans. Robert Baldick (New York: Alfred A. Knopf, 1962); see also William L. O'Neill, Divorce in the Progressive Era (New Haven: Yale University Press, 1967), pp. 4-7.

permanently and obviously unfit for work."[1] Women might be incorporated into the industrial world at only the lowest and most menial levels.[2]

In pre-industrial society, gender role assignment was minimal. When industry made up part of home life, women's productive and reproductive functions were not disengaged. Domestic duties did not connote divorce from economic participation, and distinct functioning did not carry a gender stamp. Before industrialization, "the unit of production is the unit of kin relationships, and life is not divided into what one does to earn a living--called work--and what one does the rest of the time.[3]

Industrialization drew women inward into the privatism of family life. The home environment became spatially separated from the productive realm; gender roles predominated.[4] Productive opportunities narrowed; the myth of motherhood served as social justification of industrial

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[1]Thorstein Veblen, The Theory of the Leisure Class. An Economic Study of Institutions (New York: B. W. Heubach, 1899), p. 171.

[2]See Ann Oakley, Woman's Work. The Housewife, Past and Present (New York: Pantheon Books, 1974), pp. 31, 44-46, 53, 55-56.

[3]Ibid., p. 10.

[4]Ibid., p. 32: "For men . . . [industrialization] enlarged the world outside the home, chiefly by expanding the range of occupations available to them, for women it meant an involution of the world into the space of the house."

restriction. Women's reproductive roles overshadowed their productive functions: life for women who had to work became disrupted, for social expectations still held child-rearing to be women's primary responsibility.

Thus the exaltation of motherhood reached crescendo levels as the need to shut women out of productive fields increased. In 1908, President Theodore Roosevelt judged the supreme purpose of education to be the training of girls for the assumption of maternal duties. The mother had become a national asset in the international competition among states. "Unless the average woman is a good wife and good mother, unless she bears a sufficient number of children, so that the race shall increase, and not decrease, unless she brings up these children sound in soul and mind and body--unless this is true of the average woman, no brilliancy of genius, no material prosperity, no triumphs of science and industry, will avail to the race from ruin and death."[1]

Wealthy women directed their lives toward demonstrations of their husbands' earning capacities. Abstinence from work was a source of pride, an emblem to be displayed with ornaments and cumbersome clothing. It became a model for

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[1] First International Congress in America on the Welfare of the Child under the Auspices of the National Congress of Mothers, Washington, D.C., March 10 to 17, 1908 (Washington, D.C.: The National Congress of Mothers, 1908), pp. 14-15. Roosevelt rebuked the woman who "shirks her duty as wife and mother. . . . We despise her as we despise and condemn the soldier who flinches in battle." Ibid.

emulation among women of all social classes. A woman's "conspicuous waste and conspicuous leisure are reputable because they are evidence of pecuniary strength." For Veblen, women's economic dependence was her slavery; she existed and assumed importance only as a reflection of her husband's power or lack of it.[1]

As the chances for infant survival increased, middle-class advice literature devoted more space to women's socializing roles and less to the physical care of infants and young children. Once health were assured, women could devote their energies to the child's emotional welfare. The literature of child socialization, often cited by historians to delineate changing social ideals and aims,[2] can also be used to gain some grasp of women's psychology vis-à-vis the changing demands on her nurturing capacities. For instance, John Fiske's seminal work, "The Meaning of Infancy," influenced the rearing of many American children, yet had definite implications for women as well.

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[1]Veblen, The Theory of the Leisure Class, pp. 181-82.

[2]See Bernard Wishy, The Child and the Republic. The Dawn of Modern American Child Nurture (Philadelphia: University of Pennsylvania Press, 1968); Joseph M. Hawes, Children in Urban Society. Juvenile Delinquency in Nineteenth-Century America (New York: Oxford University Press, 1971); Geoffrey H. Steere, Changing Values in Child Socialization: A Study of United States Child-Rearing Literature, 1865-1929, Unpublished Ph.D. Dissertation, University of Pennsylvania, 1964.

Fiske's thesis was simply that an infant, born undeveloped, if properly nourished possessed unlimited possibilities for intellectual and moral growth. Thus, the reason that human infancy or dependency lasted so much longer than in other species was that man's potential for progress was so much greater. "It is babyhood that had made man what he is."[1] Fiske reflected optimism. A child's heredity was peripheral to his evolutionary upbringing. While his theory, with its emphasis on environmental molding, broke with past fatalism, it also presented an enormous responsibility for those who controlled that environment. Implicit in his thesis was that training could be "good" or "bad"; the child could "be unfolded and enhanced or checked and stifled."[2] With collective responsibility for raising children, the possibilities of individual guilt would be diminished. Yet with isolated women the primary rearers of children, women's psyches could easily become torn by ambivalence, self-doubt, and blame.

From the viewpoint of child-rearing, Fiske was correct. The child is not merely a miniature adult. He is plastic, and through love, education, and encouragement his potentials are infinite. The child's malleability did, in

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[1]John Fiske, "The Meaning of Infancy," in Excursions of an Evolutionist (Boston: Houghton Mifflin and Co., 1891), p. 307.

[2]Ibid., pp. 315-16; see also pp. 306, 311, 313, 319.

fact, become the motto of the twentieth-century child study movement.[1] But did parents have these same limitless opportunities in shaping the environment for the sake of the child? After all, children's infinite opportunities came with sufficient sleep, proper food, and freedom to learn. The Puritan concept of inherent human depravity may have been poor child psychology, but it provided a buffer for parents, especially mothers, if children swerved from the proper paths of righteousness.

If mothers remained segregated from each other, bringing up children in solitude, the expectations of the child study movement, based as it was on the soundest psychological tenets, could easily produce guilt and lack of spontaneity among women. The child study movement held that children, because of their unique peculiarities, required

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[1]For example, see the repetition of the idea in Le Grand Kerr, The Care and Training of Children (New York: Funk and Wagnalls Co., 1910), pp. 133, 137: "It is only by placing ourselves as nearly as possible at the child's viewpoint that we may hope to accomplish much with children"; Mary L. Read, The Mothercraft Manual (Boston: Little, Brown and Co., 1921), p. 44: "The child is not a small edition of an adult. His anatomical proportions, his physiological processes, his ways of thought and of thinking, his motives, his interests, likes, emotions, methods of expression are all different from the adult's; and they are all different at different stages of his development"; Aureitta R. Aldrich, Children, Their Models and Critics (New York: Harper Brothers, 1893), p. 5: "We believe that society is made, the next generation lies like plastic clay in our hands!" See also pp. 8, 14, 19, 66; Frank H. Richardson, A Doctor's Letters to Expectant Parents (New York: Children, The Parents' Magazine and W. W. Norton and Co., 1929), p. 80.

specialized study and care.[1] Child advocates valued neither child docility nor rote learning. They called play for children paramount; it was the experimental arena from which adult maturity and judgment would grow.[2] Writers encouraged children to test reality through experimentation; one child study proponent wanted the words "naughty" and "don't" obliterated.[3] American authors bowed in thanks, acknowledging Friedrich Froebel's principles of education. "A certain conversion comes over one upon reading Froebel which I wish each one of my mother friends might experience."[4]

Aligning themselves with Froebel and Maria Montessori, child-culture writers frowned upon corporal punishment. They called parental love essential, and declared that "wise love never 'spoiled' any child."[5] The concept of

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[1]See Hawes, Children in Urban Society, pp. 114, 126-27, 205, et al.; Wishy, The Child and the Republic, pp. 85, 107-08, 111, 112; Joseph F. Kett, "Adolescence and Youth in Nineteenth-Century America," in The Family in History. Interdisciplinary Essays, ed. by Theodore K. Rabb and Robert I. Rothberg (New York: Harper and Row, 1973), pp. 98-99.

[2]William Byron Forbush, Child Study and Child training (New York: Charles Scribner's Sons, 1915), pp. 1, 3, 11-12; William Byron Forbush, The Coming Generation (New York: D. Appleton and Co., 1912), p. 120.

[3]Aldrich, Children, Their Models and Critics, p. 78.

[4]Andrea H. Proudfoot, A Mother's Ideals. A Kindergarten Mother's Conception of Family Life (Chicago and New York: A. Flanagan Co., 1897), pp. 32-33; see also Aldrich, Children, Their Models and Critics, p. 130.

[5]J. H. Greer, Marriage, Maternity, Health and

children's rights came into vogue. Frank Richardson, chairman of the editorial board of Children, The Parents' Magazine, reminded adults that "though children bring parents much joy and profit, we must realize that they are not sent us primarily for any such purpose. They are separate individuals, whose lives we are permitted to help shape, and mold, and direct."[1] William B. Forbush, president of the American Institute of Child Life, enumerated the three indivisible and inalienable rights of children: "To be loved, to be understood, to be educated."[2] Parents should respect each child's individuality, as they recognized that children had "hopes, fears, ambitions, misgivings, aspirations, and other emotions."[3] Learning must not be foisted upon the child, but should emerge from the child's self-directed activity; progressive educators insisted that childhood imagination played a vital role in the learning process. The starting point of all education began with the child's

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Hygiene (Chicago: Charles H. Kerr and Co., 1899), pp. 31, 38; see also Proudfoot, A Mother's Ideals, p. 11; Kerr, The Care and Training of Children, pp. 162-63, 165, 167; Read, The Mothercraft Manual, p. 218; William Byron Forbush, The Government of Young Children (New York: Monographs of the American Institute of Child Life, 1913), pp. 10, 25.

[1]Richardson, A Doctor's Letters to Expectant Mothers, pp. 16-17.

[2]Forbush, Child Study and Child Training, p. 26.

[3]Kerr, The Care and Training of Children, p. 149.

own interest.[1] "To clip the wings of imagination in a child is to permit an almost unpardonable sin."[2]

According to the philosophy of the child study movement, mothers were to become educators of their children in the most crucial years. The impact of this new interest in child development heightened the seriousness of parenting. Yet at the same time that motherhood became a profession, women relied increasingly upon the trained expert. Therefore, while woman's reproductive realm enveloped her every activity, she was forbidden spontaneous trust in her own abilities. By the twentieth century, women would not reign supreme, even in their own sphere.

Experts agreed that the first four or five years of life were the most formative and impressionable. Nothing less than "the future life of the child is determined by the methods employed." Early mistakes left indelible stains upon growing children.[3] Hence women must give more concentration and reflection to their role as mothers. The child study movement itself was the first assault on the notion of inborn maternal propensities, for mothers had to be educated

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[1]Read, The Mothercraft Manual, pp. 196-97, 203.

[2]Sangster, The Mother Book, p. 81.

[3]Ellen Kay, The Woman Movement (G. P. Putnam's Sons, 1912), p. 201. See also Forbush, Child Study and Child Training, p. 13; Proudfoot, A Mother's Ideals, p. 120; N. E. Richardson, ed., "First Steps toward Character," The American Home Series, No. 8 (New York: The Abingdon Press, 1914), p. 2.

in order to care capably for their children. "There is nothing magical about motherhood per se," Forbush cautioned, "that enables a mother who is not intelligent to be an intellectual influence." Mothers now needed the necessary tools to raise a child properly.[1]

Advice urged mothers to create their own home kindergartens, which experts considered preferable even to available public classes.[2] Literature told mothers they were the constant source of every educational need; with an engaging curriculum for each stage of the child's development, mothers were to be unfailing, selfless suppliers: "Every woman who stands in any relation to children should feel herself to be able to answer the ever-recurring demand of restless childhood--'What shall I do,' or 'Tell me something to do.'"[3] Mothers should prepare daily lessons, and be ready with a stock of sensory stimuli and motor activities. Experts suggested that homes be furnished with clay, wooden balls, ribbons, and buttons to teach colors, and

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[1]Forbush, Child Study and Child Training, p. 24; also Forbush, The Coming Generation, pp. 66-67.

[2]At the end of 1916, less than one-eighth of the children in the country went to public school kindergartens. See Bessie Locke, "Kindergartens," Survey 37 (December 30, 1916):372.

[3]National Congress of Mothers, International Congress, p. 158.

colored papers for cutting and teaching shapes.[1] To foster memory training, mothers should not deviate from strict regularity in the routines of feeding, bathing, dressing, and sleep.[2]

In 1908, one Atlantic Monthly writer condemned children's amusements--specifically, the circus, vaudeville, and theater--as signs of mothers' laziness and expedience. For the author, the great sin of these diversions was that they "make the mother's . . . task easier." Instead, mothers should have time to spare to read classical literature to their children, and write plays for them to incorporate history and mythology into their early experiences. Parents raised a generation without a sense of purpose: "No wonder we see them blasé at eight, nervous wrecks at twelve, neurasthenia, insomnia, dipsomania, decadence ahead of them." Where did the blame lie? With none other than the "unwise mother."[3]

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[1]Edith S. Warner, "Our Kindergarten. The First Gift for Older Children," Mothers' Journal 7 (February 1898):143; Edith S. Warner, "Our Kindergarten," Mothers' Journal 8 (July 1898):121, 123.

[2]Read, Mothercraft Manual, p. 249: "Curriculum for Babyhood,"; see also N. E. Richardson, ed., American Home Series, No. 16, "The Home Kindergarten" (New York: The Abingdon Press, 1914), pp. 6-7; Mrs. Burton Chance, Self-Training for Mothers (Philadelphia: J. B. Lippincott Co., 1914), pp. 100-14. She wrote: "When the home provides the proper environment, kindergarten is unnecessary. It is often, indeed, inadvisable, for there is a possibility of overstrain."

[3]Anna A. Rogers, "Why American Mothers Fail," Atlantic Monthly 101 (March 1903):293-95. To blame mothers

The new and progressive child-rearing advice failed to assess or appreciate the social pressures influencing parental abilities and the collective, political responsibility for making good mothering possible. Moreover, it also shielded the father from paternal participation and accountability. The risks and burdens of raising children lay with women. The elevation of motherhood carried the concomitant diminution of fatherhood; while this philosophy was unfair to women in its unequal burden, it was ultimately more dehumanizing for men for it robbed them of their children and outlined a monodimensional life pattern.

Invariably, when the literature touched upon husbands and their house-bound roles, it reminded women of the burdensome cares of men outside the home. Predictably, authors relieved husbands of child-caretaking chores. Yet the dramatic accentuation of mothering gave no leeway to ignore the husband's rights. When father returned home, his wife was "to abstain as far as possible from relating the trifling ills of infanthood to a man who has undoubtedly troubles enough of his own."[1] Husbands should not be

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for adult deviance was typical. For example, another author maintained: "Why are the common avenues of life so crowded with unsuccess and so lacking in characterful men? Because mothers waste their children's plastic years in indulgence and emptiness." Proudfoot, A Mother's Ideals, p. 98.

[1]Ormsby A. Court, "A Young Mother's Mistake," Mothers' Journal 8 (September 1898):194.

shunted aside and "hushed" when they came in at night.[1] Care of the children could not supersede devotion to the man. One author considered the great glory of American men to be their desire, regardless of social station, to provide for their wives' every request.[2] Therefore, women must brush aside any inconveniences their husbands posed and sublimate the fatigue and irritability of a long day at home. "Whatever you do, don't nag or sulk. . . . Don't be inconsolable when your husband tarries late at the office and keeps the dinner waiting. Don't object to his bringing home guests, unannounced."[3]

Father's role began when his children grew older. Now his task was not merely to participate, but in reality, to usurp the mother's position. As the children matured, they would require an "adviser . . . friend, companion, and counselor."[4] Notwithstanding the reiteration of woman's paramount role in the raising of her children, the person with wider outside experience won ultimate respect with those he hardly raised.

The exaggerated contrasts between the two kinds of mothering experiences in urban America at the beginning of

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[1]Rogers, "Why American Mothers Fail," p. 292.

[2]Sangster, The Mother Book, pp. 58-59.

[3]Ibid., p. 184.

[4]Chance, Self-Training for Mothers, p. 192.

the century heightened the classist orientation of this advice. In individualistic fashion, the child study movement presupposed an ability for material provision for each nuclear unit. An author challenged her readers: "Have your children a playroom--a day nursery? If they have not, give yourself no rest until you have provided them with one of the most important elements of their proper development. Despoil your guest chamber, sleep in your parlor, eat in your kitchen--provide it in some way."[1]

By making the early years of childhood central to future maturity, and by placing the onus for crucial nurturing on parents regardless of the social odds they faced, the child study movement indirectly removed the responsibility from the social order, which did not intervene in the child's life until his fifth or sixth year. Isolated middle-class women would raise equally isolated middle-class children. Advisers warned women to guard their control, and not to view public education as their liberation. "Don't hail the schoolroom as your sign of emancipation. Think twice before you share your kingdom with another."[2]

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[1]Edith S. Warner, "Undressing the Baby," Mothers' Journal 8 (July 1898):108.

[2]Gabrielle E. Jackson, A Series of Don'ts for Mothers Who May or May Not Stand in Need of Them (Boston: Lee and Shepard, 1903), p. 57.

Counselors enjoined mothers not to nag, not to impede childhood development with don'ts. "Don't bring up your children upon a steady diet of 'don'ts'; miserable, prickly little word that it is, and sure to rub the wrong way."[1] Yet advice bombarded women themselves with don'ts both didactic and contradictory. Authors urged mothers to be educators, and to esteem themselves as a professional body. Manuals told them to be their children's first and most impressionable preceptors, yet condemned child precocity: "The apparent dull and stupid children are frequently those who in later years astonish the world by their brilliancy."[2] Writers reminded women never to punish in anger. "Absolute control of the tongue, of the temper, even of thought"[3] was required lest children "detect a flaw."[4] Books ordered mothers to love their children, educate them, and create a paradise of a home (or "some other mother will"[5]) but never to forget the underlying power struggle

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[1]Ibid., p. 34.

[2]Jessie A. Fowler, "Cherub Culture," Mothers' Journal 8 (July 1898):97.

[3]Elizabeth S. Tillinghast, "Which Will Be the Woman Who Has Power?" Mothers' Journal 8 (June 1898):52.

[4]Jackson, A Series of Don'ts, p. 25; see also Felix Adler, "The Punishment of Children," in E. H. Richardson, ed., American Home Series No. 15 (New York: The Abington Press, 1914), pp. 1, 9; Annie W. Allen, Maxims of Home Discipline (New York: American Institute of Child Life, 1907), pp. 3-4, 6.

[5]Jackson, A Series of Don'ts, P. 75.

between themselves and their offspring. Children must grow in freedom, but never be allowed to criticize their mothers.[1] In theory, the home upbringing cultivated children's instincts for investigation and curiosity at the same time it implemented respect for authority and emotional control.[2] Each mother stood as vigilante, on watch for deviant habits--a veritable "St. Peter at the Golden Gate, forever on guard."[3] Mother was her children's constant companion, their unflagging molder, yet she must never become cross.

The demands upon women were crucifying. The literature counseled that while the home and family were to remain women's "chief occupation," when the day's lessons, surveillance, and chores were done, women should reserved energy for themselves. They shirked responsibility if they did not find time "for the gratifications of [their] individual tastes and pleasures."[4] Another author asserted that motherhood should never cause the sublimation of women's personality or interests: "True motherhood is essentially unselfish, but the perfect mother is not self-abnegating."[5]

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[1] Ibid., p. 44.

[2] Read, Mothercraft Manual, p. 49.

[3] Edith S. Warner, "Our Kindergarten. The Third Gift." Mothers' Journal 8 (May 1898):33.

[4] Gordon, The Modern Mother, p. 130.

[5] Chance, Self-Training for Mothers, p. 22; see also pp. 19-21, 26-27.

Yet single definitions and standards stood in the way of women's abilities to express their personalities and mothering traits freely; the movement defined motherhood categorically. "If we are selfish in one single thought we are not true mothers. We must be unselfish absolutely, and sacrifice all self-comfort for our great purpose."[1] Pressure came from all directions for women to be nothing less than perfect.

If anything, the mythology of motherhood grew in intensity and scope beyond the Victorian period. In the twentieth century, the myth developed a scientific aura. To be a mother carried little weight; to be a "good mother" was the highest human honor. In unwitting testament to the unarticulated emptiness of women's lives, the theorists of scientific motherhood argued that women's problems stemmed from their failure to make a profession of their work, rather than from confinement to their homes with children. At a time when many middle-class women were moving beyond their constricted spheres, the concept of professionalizing motherhood gave formal purpose to the existence of women at home. It expressed the need for greater meaning in women's lives. An author provided gratuitous comment on the discontent of contemporary mothers:

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[1]Proudfoot, A Mother's Ideal, p. 92.

> A mother seldom regards her life as either a profession or a calling, and barely elevates it above a mere necessity. Only as she wins standing as a mover in society is she recognized, and this is often accomplished at the expense of her children. . . . Is it any wonder, then, that women are struggling to get into other lines of work, especially the professional?[1]

The author suggested that in lieu of leaving the home, mothers organize on professional lines, as did lawyers and doctors.

Initially, the rejection of inborn maternal instincts and the demand for mother training and knowledge immersed women more deeply into the realm of motherhood which, by contemporary definition, excluded outside occupation. In 1908, speaking before the National Congress of Mothers, Lucy Wheelock, principal of a kindergarten training school in Boston, propounded an educational curriculum for prospective mothers. The scheme included knowledge of hygiene and anatomy, so that mothers could properly direct their children in health and exercise; cultural exposure, important so that women could converse intelligently with their children; and the study of child psychology, to become an unquestionable part of women's backgrounds. Finally, women would be exposed to a series of courses in the fine arts, since "the home-maker should be able to make a 'Home Beautiful.'"[2]

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[1] Ibid., p. 215.

[2] Lucy Wheelock, in National Congress of Mothers, International Congress, pp. 153-54, 156-57.

This ideology, making motherhood a skill to be mastered as much as tennis or crocheting, came just as many women searched for tangible justifications of their existence. However intended, it renewed the identities of many women at home. But the philosophy, coming when a vocal fraction of womankind voiced dissatisfaction with its station, social and political, was likely a reaction. The newly-concrete attitude seemed a deliberate reaction to the "restless" woman; it made her claim to a more rounded existence appear bogus. The notion of a woman, alone in her home, mothering, reached new heights: Motherhood "is not more an instinct than is gardening or building. It is not merely being with children. Its requisite is vital working knowledge of the fundamental principles of biology, hygiene, economics, psychology, education, arts. It is mothering--that oldest . . . most satisfying vocation to women . . . made intelligent and efficient and joyous."[1] In addition to the manifold responsibilities of the modern mother, this author suggested that women keep score cards of their children's development, measuring motor, sensory, and psychological growth.[2]

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[1]Read, Mothercraft Manual, p. 1. See also introduction by Mrs. Frederic Schoff, president of the National Congress of Mothers and the Parent-Teachers Associations of America, in Elizabeth S. Chesser, Woman, Marriage and Motherhood (New York: Funk and Wagnalls Co., 1913); Edith S. Warner, "Nursing the Baby," Mothers' Journal 7 (January 1898): 101.

[2]Read, Mothercraft Manual, p. 224.

Standing alone, the philosophy of a scientific motherhood heightened the differences between the two classes of mothers. The concept worked myopically to focus women's attentions with even greater intensity on their own units. Nonetheless, it eventually became an expression of grievance among middle-class women. If women were to be educated, their isolation would be diminished. Women united on the basis of their motherhood. This convergence, while initially grounded on the traditional value system of separate spheres, became a statement of women's desire to end "tutelage, or vicarious life"; a collective wish to end exclusion "by the canons of good repute from all effectual work."[1] Veblen deciphered the malaise of contemporary women, especially the middle class, who were most estranged from a sense of workmanship. He predicted that rebellion would emanate from the ranks of middle-class women; poor people simply have no time to rebel. Besides, their lives, while suffused with drudgery, nonetheless carried purpose in the unrelenting daily routine. Hungry stomachs must be fed.[2] Thus among middle-class women, their coalescence around mothering functions represented a part of the transition from the old to the new.

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[1]Veblen, Theory of the Leisure Class, pp. 356-57.

[2]Ibid., pp. 353, 358-59.

In the last decades of the nineteenth century and the early part of the twentieth, middle-class women began to form mothers' clubs and child study organizations. In New York City, the child study groups combined to form the Child Study Association; nationally, the mothers' clubs united into the National Congress of Mothers in 1897. Like the club movement among women, these organizations served to bring women out of themselves, and out of the confinement of their homes. They allowed women to recognize the commonality of their experience. Eventually, the groups permitted women to reach out beyond their class preoccupations and boundaries.

Mothers' clubs were part of women's reactions to the enforced idleness of middle-class life. A club--whether a mothers' group, temperance society, or philanthropic organization--was an escape valve for the more conservative woman; it held an analogous place to the suffrage organization or settlement and social work for the more radical and political woman. The mothers' club evidenced women's need to talk. Through the first decade of the twentieth century, discussion topics were generally limited to questions of child-rearing and to the relation of adopted methods to women and children. A club formed in Abingdon, Virginia, in April 1878 debated the pros and cons of the value of obedience; it weighed the importance of discipline against the

merits of spirited childhood play. Members discussed the appropriate amount of time a mother should spend with her children, and what balance she should leave for herself.[1]

Also in 1878, women organized a mothers' club in Cambridge, Massachusetts, which functioned until 1942. Club members aimed originally at discussing topics of common interest to mothers, and sought as well to establish "and to secure a better acquaintance among its members."[2] Women needed sorely to cultivate friendship, and the most obvious common basis was their mothering experience. The Cambridge group met fortnightly. At one session in 1899, members debated Froebel's principles of kindergarten, and at another meeting, women evaluated methods through which children could learn through self-discovery. In February 1900, members discussed the relative benefits of manners in children.[3]

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[1]Stelia Gilman, Mothers in Council (New York: Harper and Brothers, 1884), pp. 4, 11, 17-18, 173. In 1888, the National Council of Women was established. In 1890, the General Federation of Women's Clubs was formed, with five hundred members. By 1896, it included 20 state federations and represented 495 clubs. See Robert W. Smuts, Women and Work in America, pp. 29-30. Women were converging. If they could not unite on the basis of professionalism, politics, religion, or education (e.g., Association of Collegiate Alumnae, National Council of Jewish Women, Medical Women's National Association, National League of Women Voters, National Women's Trade Union League, Women's Christian Temperence Union), they found the common basis in their motherhood.

[2]Mothers' Discussion Club, Cambridge, Mass. Papers, 1878-1942, Box 1, Folder 1, Manuscript Collection, Radcliffe Institute, Schlesinger Library.

[3]Ibid., Minutes, 1899-1906.

While rearing methodology continued to absorb much of the club's discussion time, in the twentieth century members turned their attentions to the world beyond the home. The group devised a reading list, and discussion revolved around book topics. Guest speakers led discussions on art, medicine, and business. The club members opened a diet kitchen, and became involved in creating programs for underprivileged children in Cambridge.[1] At the end of 1919, members suggested such subsequent discussion topics as "capital and labor," "industrial and social conditions," "good citizenship," and the "eight-hour day in domestic service." In February 1920, Professor Felix Frankfurter of the Harvard Law School spoke to the club.[2]

By 1920, these Cambridge women had incorporated political participation into their maternal responsibilities. For them, motherhood and passivity were no longer synonymous. Club members became advocates of peace. One member spoke before the group of "the men who are misappropriating nearly all the wealth of the country." She rallied women to work for the miscreants' eviction from Congress. "These men know we want peace yet members of both parties are responsible and worked together last year to build up a monster military organization, the biggest on earth, the maintenance of which

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[1]Ibid., Box. 1. [2]Ibid., Minutes, 1917-1935.

will impoverish us."[1] This new political concern contrasts remarkably with the insulation and inner-directedness of similar women twenty years earlier.

The evolution from awareness restricted by gender to political interest and activity is demonstrated on a larger scale by the transition within the National Congress of Mothers. When Mrs. Theodore W. Birney and Mrs. Phoebe A. Hearst founded the national organization in Washington, D.C. in 1897, its purpose was to promote the interests of children. The organization existed for the stated goal of training for motherhood, for the sake of the children.[2]

For the first ten years, leaders of the Congress spoke clichés and platitudes, calling for mothers' professional unity. "The mothers of the past were governed by their instincts. . . . The mothers of the future will find that there are laws to be learned and obeyed in reference to their children as there are those governing the rest of the physical world. Nothing is haphazard."[3] The work of motherhood was holy, but it must be a planned crusade. An address

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[1]Ibid., Box 2.

[2]For the history of the Congress, see National Congress of Mothers and Parent-Teacher Associations, Twenty Years' Work for Child Welfare, 1897-1917 (Washington, D.C.: National Congress, 1917).

[3]Frances S. Bolton, "National Congress of Mothers," Mothers' Journal 8 (May 1898):9.

before the Second Congress in June 1898 stressed the rights of children to play, to "joyousness, innocent fun and frolic."[1]

The theme of women's self-sufficiency ran throughout the first decade of the Congress. Women asked all of themselves and nothing from society but that schools educate women for motherhood. In 1908, at the first international session of the Congress, Mrs. David O. Mears of Albany (a vice president of the national organization) appraised the work of the Congress:

> It has helped to place manual training, cooking and sewing in certain schools, secured better sanitation in school houses . . . provided extra kindergarten materials, equipped a school gymnasium, procured an assembly room in the schools, started mothers' libraries.[2]

In 1902, Mrs. Frederick Schoff assumed the presidency. An untiring national organizer, she established thirty-six state branches. In 1908, the Congress asserted an additional role as the watchdog of children's needs in schools as well as at home. The name of the organization changed, to the National Congress of Mothers and Parent-Teacher Associations.[3] The Congress maintained a guarded

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[1]Address before the National Congress of Mothers, quoted in Helen R. Wells, "Children's Rights," Mothers' Journal 8 (June 1898):65.

[2]National Congress of Mothers, International Congress, p. 139.

[3]Elizabeth Tilton Papers, Box 1, Folder 2, "The National Congress of Parents and Teachers. Its History,

jealousy of the schools' influence; the home still determined human destiny. "What the boy is in the home the man will doubtless be in the State."[1] Mothers found new outlets in the schools. Women's voluntary exaggeration of the influence of the home asked nothing of society, and resulted in the self-imposed burden of child-rearing responsibility. This attitude put no pressure on the political order to restructure life so that women could be successful mothers while simultaneously achieving self-fulfillment.

But once the movement established this empathy for children, people found it difficult to restrict that love to one's own. How often did motherhood mean pain to women? Could mothering really be fulfilling when families were starving? Could mothers be a source of strength, education, and love when they were deprived of a minute's free time? Invariably, women began to ask these questions. Their engrossment in their mothering could not estrange them indefinitely from the mothers surrounding them in tenement ghettos.

By 1910, the Congress' activities included promoting juvenile courts, involvement in the infant welfare movement,

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Organization and Program of Service," Manuscript Collection, Radcliffe Institute, Schlesinger Library.

[1]National Congress of Mothers, International Congress, p. 149.

and active campaigning for mothers' and widows' pensions.[1] Women's unity became political. In the 1920s the National Congress of Mothers developed extensive lobbying skills. Elizabeth H. Tilton, Executive Secretary and National Chairman of Legislation of the National Congress, issued the "Six P's" of the Congress.[2] They were peace, or the reduction of armaments and an international organization; prohibition; protection of women in industry; physical education in support of a program for federal aid to the states (the Fess-Capper Physical Education bill); home economics in the schools; and public support of the Towner-Sterling education bill to give the Department of Education a secretariat in the Cabinet and provide federal aid to schools to train teachers and eliminate illiteracy. The Congress also consistently supported the federal maternity bill, enacted as the Sheppard-Towner Act.

Women who originally sought to make themselves more useful at home had created new participatory roles for themselves. If only to protect their children, they recognized the necessity of political action. By doing this, they saw their sisterhood with the mothers who worked and scrimped to

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[1]Chesser, Woman, Marriage and Motherhood, p. 169. See Chapter X.

[2]"Six P's" of the National Congress of Mothers and the Parent-Teachers Associations, in Tilton Papers, Box 1, Folder 20, 1922.

to feed and raise their children. Women of all classes learned that "if every child is sacred, every mother is."[1]

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[1]C. W. Saleeby, Woman and Womanhood. A Search for Principles (New York: Mitchell Kennerly, 1911), p. 299.

CHAPTER X

GOVERNMENT INTERVENTION: MAKING MOTHERHOOD WORKABLE

> We must accept it as axiomatic that increase of family income makes it easier to ensure the health of children.
>
> --Arthur Newsholme, 1935

> The mother of the working classes cannot exercise the right influence, however much we educate and regulate, until she is liberated from her slavery.
>
> --Laing H. Gordon, 1909

Social stratification predetermines the nature of woman's oppression. Idleness and isolation saturated middle-class women's lives, while lower-class women lived in direct contradiction to prescriptive ideals of womanhood. As industrialism emerged in the United States, cultural and legal structures assumed mothers remained at home, yet the economics of life forced many women out of the house. The adaptation of industry for motherhood and the creation of governmental buffers for child-rearing and maternal health evolved logically from reformers' analysis. Reformers recognized that women's presence in the home could no longer be assumed, however aspirational it might be. Without adequate public

reinforcement, lower-class women could not possibly live up to expectations. Work for middle-class women might indeed provide some kind of liberation, but for poor women, work merely made them industrial slaves alongside their husbands. Housekeeping, child care, and employment imposed irreconcilable demands. At the very least, the Children's Bureau found it "evident that the gainfully employed mother must be relieved of most of her housekeeping duties if she is to have strength and energy to enter into any companionship with her children."[1]

The early twentieth century is as exciting for its conceptual contributions as for its actual advances.

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[1]U.S., Department of Labor, Children's Bureau, Helen R. Wright, Children of Wage-Earning Mothers. A Study of a Selected Group in Chicago, Publication No. 102 (Washington, D.C.: Government Printing Office, 1922), p. 87. See also the discussion of the demand for mothers' assistants or housekeepers in Sophonisba P. Breckinridge, New Homes for Old (New York: Harper and Row, 1921, reprint ed., Montclair, N. J.: Paterson Smith, 1971), p. 43. Ironically, when work lent itself to the raising of children, society attempted to exclude married women. Through 1915, many states and cities forbade married women to teach. In 1915, New York City became the fourth city in the country to permit maternity leaves of absence to public school teachers. Until 1915, the New York City Board of Education refused to give maternity leaves to women teachers. In January 1915, the New York State Court of Appeals ruled against the school board's practice of dismissing women upon childbirth, and women were thereafter permitted leaves of absence. See Letter to the Editor, Grace P. Pollar (of Minneapolis), "Motherhood and Teaching," Survey 30 (May 10, 1913):232; June Sochen, The New Woman in Greenwich Village, 1910-1920 (New York: Quadrangle Books, 1972), pp. 3, 59.

The era was a time of almosts. Social workers confronted the breakdown in family life with analyses that emphasized individual social and economic helplessness. Their attack upon the victimization of human effort--through protective legislation and social insurance schemes--challenged directly the assumptions and prerogatives of privatism. "Liberty," wrote Abraham Jacobi, "must become different from what at present it is to many millions, who have only the liberty to be killed gradually or to starve."[1] Reformers increasingly stressed the positive, that is, freedoms to be healthy or secure rather than the freedoms from. Advocates of change looked to Europe for the experience of state intervention. With women, the comparisons brought the realization that autonomy came not only through attitudinal change, but with institutional readjustments which reconciled the various facets of women's lives.

In the United States, day nurseries did not solve the problems of the working mother. While nurseries had existed in the nineteenth century, until the 1890s they were numerically inconsequential. Administrators concerned themselves primarily with moralism, lest an "unworthy" mother sneak through the door; these attitudes

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[1]Abraham Jacobi, "The Physical Cost of Women's Work," reprinted from Charities and the Commons, February, 1907 (New York: Charity Organization Society, 1907), p. 3.

predominated over institutional endeavors to create structural alternatives for working mothers. The twentieth century saw the nurseries' proliferation. The kaleidoscopic transformation resulting from the impact of maturing industrialization, staffed by a foreign labor force which resided in urban ghettos, engendered fears of family breakdown. Twentieth-century nurseries organized themselves to provide day custodial care for children of working mothers who would otherwise be institutionalized. In 1910, New Yorkers maintained 85 facilities; in 1921 the United States could boast of 550 day nurseries.[1] Even so, American day nurseries never became more than expedient final resorts for working mothers. Day nurseries were relatively expensive, often far from the homes of working women; without central supervision enforcing minimum standards, the facilities' qualities varied markedly.

Private groups (religious and philanthropic organizations or settlement homes) usually ran the nurseries. For the most part, voluntary contributions

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[1]Margaret O'Brien Steinfels, Who's Minding the Children? The History and Politics of Day Care in America (New York: Simon and Schuster, 1973), pp. 34, 37; Phillip Van Ingen, "The History of Child Welfare Work in the United States," in Mazyck P. Ravenel, ed., A Half Century of Public Health. Jubilee Historical Volume of the American Public Health Association. In Commemoratory of the Fiftieth Anniversary of its Foundation, in New York City, November 14-18, 1921 (New York: American Public Health Association, 1921, reprint ed., New York: Arno Press, 1970).

supported them. Yet the majority required that the participating working mother pay for her children's shelter. The charge in New York City varied between one cent a day to the more common fee of five cents daily for each child. The nurseries' administrators considered the fee nominal.[1] Indeed remuneration did not approach the daily cost of child maintenance. Administrators imposed fees to bolster women's dignities, and most probably to ally detractors' charges that nurseries would encourage women to work. Yet as one social worker pointed out, for employed women, who rarely worked but for dire necessity, the maintenance of two children in a center at a cost of 60 cents a week was hardly incidental when weekly wages were merely $6.00.[2]

Nurseries' commonly-imposed restrictions confirm that they never imagined themselves to be more than stop-gap institutions, rather than permanent allies to working mothers. Most only accepted children of widows or

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[1]Abraham Oseroff, "Standards in Day Nursery Work," Jewish Charities 8 (June 1917):64; see American Jewish Yearbook, 1900-1901 (Baltimore: The Lord Baltimore Press, 1910), pp. 355-56, for a description of Brightside Day Nursery, established in 1894 at 132 Attorney Street; Sixth Annual Report of the Silver Cross Day Nursery, April 1895-April 1896, p. 4: "The mothers pay five cents a day, thus making them feel a certain self-respect, and avoiding the bane of the poor--pauperism." Also see Report of the St. Thomas Day Nursery, 1895. This nursery also required a daily fee of five cents, p. 3.

[2]Katherine Anthony, "Mothers who Must Earn. A Study of New York's West Side," Survey 32 (April 4, 1914): 39.

deserted mothers. The limitation of space merely to children of women with no husbands at home meant that nursery staff merely countenanced work for women as a necessary evil.[1] Furthermore, the nurseries, with funding always precarious, minding children from seven in the morning until seven at night, usually in part of a brownstone, could never seek seriously to undertake educational programs.

Margaret Steinfels describes the day nursery after World War I and into the 1920s as an institution of stopgap welfare, designed for families in emergency situations. The transformation of nurseries began when nursery school teachers assumed leadership of individual centers, and excluded infants as uneducable. Immediately, nurseries eliminated their former service of caring, even if only physically, for children of working mothers. No matter what their faults, the facilities had offered unpretentious custodial care to the poor. Once admission of a child depended upon his age, nurseries might be better equipped to serve educational needs, but were no longer

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[1]See description of Brightside Day Nursery in American Jewish Yearbook, pp. 355-56. Twentieth Report of the Kips Bay Day Nursery, 1921, p. 9: "Generally speaking we are reluctant to admit children having an able-bodied father who ought to support them." Not all nurseries, however, imposed this restriction. For example, see Sixth Annual Report of the Silver Cross Day Nursery, 1895-96, and Report of the St. Thomas Day Nursery, 1895.

available to women who had to work.[1]

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[1]Increasingly, the nurseries became social workers' instruments for use in deviant family situations. Women avoided day care, fearing the social stigma of abnormality. The centers declined. They were revived in the 1930s, according to Steinfels, basically to provide jobs for unemployed school personnel. With the abandonment of the Works Projects Administration, they disappeared again. Then, nurseries flourished during World War II, as expedience predominated. The demand for labor during the war exhausted the source of childless women workers. By 1942, day care centers were formed at the local level, so mothers could serve war needs. Cities, state welfare agencies, industries, and the federal government funded the centers. (In July 1942, the Lanham Act provided the first federal appropriation for child care.) It was precisely this divided responsibility which led to the downfall of nurseries in the United States. Legislators terminated all federal monies for day care as of October 1945. (Protest caused President Truman to delay termination until February 1946.) In Britain and the Soviet Union, where the national governments controlled and funded day care, child care assumed fuller and more permanent structure. In May 1943, Britain had more than 5,000 nurseries, compared to 2,200 in the United States. At its peak, collective child care in the United States reached only 139,000 children, compared to the 1,837,480 covered in the Soviet Union. In the United States, the WPA and the Federal Works Agencies, which controlled a major portion of federal funds for day care, urged the notion vigorously but had to contend with potent countervailing lobbies who feared the permanence of women in the labor market. Among these organizations were the United States Children's Bureau, the United States Office of Education, and the Federal Securities Agency. Many private child welfare groups, as well as spokesmen for private industry, joined the agencies in opposition. But the greatest obstacle to permanence was that the centers lacked an ideological framework: "The justification for day care for children of workers was simply that it would increase production for the war; there was no stress on making life easier for working mothers, or providing education for young children." On December 9, 1971, President Nixon vetoed the Comprehensive Child Development Act. See Howard Dratch, "The Politics of Child Care in the 1940s," Science and Society 38 (Summer 1974):8-9, 167, 170, 175, 179, 187-88, 201-03. Contemporary public day care in New

The centers were nobody's bargain. Children, ranging in age from a few weeks to six years and numbering between twenty-five and forty each day,[1] could never receive more than superficial supervision or a nourishing meal. The acceptance of children of disparate ages was

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York City is a function of public finances. In the spring of 1976, approximately 7,200 families peremptorily lost participation, and the city forced many centers to close altogether. Income eligibility limits dropped in the budget crunch; some working mothers insisted that they would be forced to leave work and return to welfare, or else board their children with relatives and visit them on weekends. Others stated that they were compelled to leave work just as they were beginning to provide a decent standard of living for their children. Most missed the income cut-off of $11,411 for a family of four by insignificant margins. Again destitution remains the criterion for public assistance; aid is still not seen as an avenue to rise above poverty but a tool, however ineffective, to deal with it. See New York Times, "7,200 Families Are Taken Off Day Care in Toughening of the Rule on Income," 1 April 1976, p. 35. Steinfels argues persuasively that day care must be "normalized." If it remains a welfare institution, below-standard services will continue. Only when institutions are created for general use is the oversight provided to ensure quality care. See Steinfels, Who's Minding the Children?, pp. 56-58, 61-63, 65-70, 246-47.

[1]Sixth Annual Report of the Silver Cross Day Nursery, 1895-96, p. 4. The nursery, located at 2249 Second Avenue, accepted children between the ages of two weeks and eight years. St. Thomas at 227 East 59th Street, had an age limit of six years. See Report of the St. Thomas Day Nursery, 1895, p. 3. Jacob A. Riis, in The Children of the Poor (New York: Charles Scribner's Sons, 1892), p. 292, listed several available nurseries in the city and their acceptance policy as to age: Bethlehem Day Nursery, 249 East 30th Street, one week to seven years; Grace House Day Nursery, 49 Fourth Avenue, one year to eight years; Manhattan Working Girls' Association, 440 East 57th Street, two weeks to ten years; Riverside Day Nursery, 121 West 63rd Street, one month to eight years; St. Agenes' Day Nursery, 7 Charles Street, eight days to six years.

not the only obstacle to a creative preschool program. The shifting nature of most poor residential areas made daily attendance at the centers highly unstable.

The unwillingness of public authorities to intervene with enforced minimum standards exacerbated the failure of day nurseries to provide more than physical supervision. As a result of a survey into Jewish day facilities conducted by the Bureau of Philanthropic Research, the Committee on Jewish Day Nurseries in New York City met on April 12, 1917 to diagnose their problems. The Bureau singled out the fourteen nurseries under Jewish control, strictly as an organizational category. Among the city's 101 nurseries, these fourteen which served 1,400 children and cost $63,000 a year to operate, were unexceptional. The fourteen stood as typical examples of New York City day care. Children were admitted on the basis of economic need; although the husband's presence in the home was irrelevant to the child's admission, the mother's employment was necessary in all but one nursery.[1]

Jewish Charities reported on the findings of the survey. Notwithstanding the safety, fire, and sanitary

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[1]"First Conference of Jewish Day Nurseries in New York City," Jewish Charities 8 (May 1917):15; Oseroff, "Standards in Day Nursery Work," pp. 63-64: of the 609 day nursery families, in 237 both parents worked. In only 169 cases had women been deserted.

requirements of the Board of Health, investigators found the nurseries in quarters which violated every precautionary and safety protection. The buildings were old, the rooms depressing, and the lavatory facilities unacceptably dirty. Administrators ignored the opportunity to use the child's presence in the center for medical screening. The physical examination, required by the city upon the admission of each new child, was routine, with little effort to treat physical defects.[1] The centers ignored Department of Health regulations requiring daily medical inspections. Worse still, health experts saw the nurseries as potential hotbeds of disease: "In one nursery, due to the absence of beds, children slept on tables. In two others, there was but one bed for every six children; only in one instance was a bed provided for every child."[2]

The fragmentation of government intervention continued as the bane of American social reform. This balkanization converted even the most well-meaning efforts into disorganization, which served to divide even further the lives of the wealthy and the poor. Maladministered child care systems could never attract the interest of

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[1]"First Conference of Jewish Day Nurseries," p. 15.

[2]Oseroff, "Standards in Day Nursery Work," p. 65.

the child-oriented middle class so long as they provided subsistence-level accommodations. The exclusion of children whose parents could pay the center meant the absence of concerned input from women who had the time to be involved in their children's educations. Yet this may well have been moot, for "even if they were given this permission, no intelligent mother would be willing to do so."[1]

S. Josephine Baker, speaking before the Children's Bureau Conference on Child Welfare on the subject of day nurseries, decried the lack of universal standards in American preschool child care. In addition to the national government's lack of concern, many cities were totally uninvolved in their centers. Baker proposed public health laws to forbid nurseries to operate without permits; limit the number of children who might attend; prescribe the nature of the building and room equipment and furnishings; and monitor hygienic maintenance and medical supervision; all to control contagious disease and correct physical defects. She urged that these criteria determine a nursery's existence and continuance.[2]

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[1]Letter to the Editor, Mrs. A. Levitas, "The Baby Garden," Survey 30 (April 26, 1913):150.

[2]U.S., Department of Labor, Children's Bureau, Standards of Child Welfare, A Report of the Children's Bureau Conferences, May and June, 1919, "Day Nurseries,"

Legislatures ignored her call. In 1922, staff of the Children's Bureau investigating the conditions of working women in Chicago noted the heterogeneity among the city's forty-five day nurseries. Some lacked effective ventilation; many did not supply individual cups or towels; a number served poorly-made, low-grade food.[1]

It is hardly surprising that working women responded with little vigor to the opportunity for day supervision of their children. Because work usually began at 7:30 A.M., nursery care meant that mothers had to leave home at dawn in order to drop off the children. Once women decided to use a nursery, they felt pressure

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by S. Josephine Baker, Publication No. 220 (Washington, D.C.: Government Printing Office, 1919), p. 220.

[1]U.S., Department of Labor, Children's Bureau, Children of Wage-Earning Mothers, p. 17. The federal government's aloofness to child-care facilities for children of working mothers compares unfavorably to the European experience. In England, for example, voluntary associations founded most nurseries, but received government grants once they met national standards. See G. F. McCleary, The Maternity and Child Welfare Movement (London: P. S. King and Son, 1935), p. 107. In 1907, the Paris municipal government contributed 180,000 francs as aid to the city's creches. While private groups ran many French nurseries, they did not receive authority to organize without inspection from the prefect of the district. The government imposed stringent regulations on all nurseries, limiting the number of children each center could accept, prescribing the cubic capacity of the rooms, determining and inspecting the amount of heat and ventilation necessary, ensuring a cot for each child and one nurse for every six infants, and mandating weekly weighings. See H. Llewellyn Heath, The Infant, The Parent and the State (London: P. S. King and Son, 1907), pp. 162-64, 166.

to dress and clean their children properly:

> I can imagine no life more abnormal than that of the day nursery mother and child. The mother, weary before the day begins, rises to . . . take them to the day nursery . . . and then her long day's work. She returns in the night to care for the children, take them home to rooms unheated all day, and by the time she has built the fire and made the supper she is too tired to eat. On her only "day of rest," there is washing to do, the cleaning of the rooms and . . . countless [other] things.[1]

The New York Infirmary observed that mothers in its district preferred to leave their children with old women in the tenements rather than in day nurseries. When women offered explanations for their choice, they usually mentioned economy and the neighbors' lack of rigid time constraints.[2] Katherine Anthony visited working women in New York City and found that among the 370 families with a total of 1,321 children, only 40 children below school age went to day nurseries. Relatives or neighbors looked after working mothers' children casually, or formed impromptu nurseries at home.[3] For many women, the final alternative was simply to leave their children at home. Sophonisba Breckinridge related the experiences

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[1]C. Marion Kohn, "The Day Nursery as a Center of Rehabilitation Effort," Jewish Charities 9 (March 1919): 229.

[2]Fifty-ninth Annual Report of the New York Infirmary for Women and Children, Out-Patient Report, 1912, p. 51.

[3]Anthony, "Mothers who Must Earn," p. 40; see also Breckinridge, New Homes for Old, p. 42.

of one social worker working with Lithuanians, who "found many children locked in houses for the day, with coffee and bread for lunch. One child, too small to shift for himself, was found with his day's supply of food tied around his neck."[1]

The plight of poor women and their children moved social reformers in the twentieth century. But their solution did not lie in making work and motherhood compatible. While they fought for better wages, hours, and work conditions, the realignment of family and work structure with new intermediaries to make employment and mothering tenable never became an issue for social workers. In part it may be argued that some social workers recognized that work meant different things for middle- and lower-class women. Eleanor Barton, a leader of the Co-operative Guild in England, understood

> . . . the great difference between the industrial mother and the other mother. The other mother may go to work if she is a doctor or a teacher; but she has her own time each day. The working-class mother has not.[2]

Poor women who spent their lives in industrial and domestic servitude saw the work-liberation equation as absurd. Given the choice between work or mothering,

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[1]Breckinridge, New Homes for Old, pp. 42-43.

[2]Quoted in Children's Bureau, Standards of Child Welfare, p. 229.

"industrial mothers" would likely have chosen the latter. Yet most social reformers did not distinguish between work for poor and middle-class women.

Instead, they recognized the impossibility of child-care, poverty, and gainful employment. This melange resulted in child neglect, filling the juvenile courts with delinquents. Rather than fight for public child care, mothers' housekeeping aids, and part-time work for women, the reformers sought solutions to the poor working mothers' dilemma in state subsidies supposedly designed to eliminate the necessity for work.

The movement for widows and mothers' pensions took successful impetus from the theme of the first White House Conference in 1909. Home life exceeded all virtues; mere poverty could not be allowed to destroy a home. To grant state monies to poor mothers, especially widows, became the first test of social welfare workers' principles. The idea evolved logically and sequentially from their diagnosis; it resulted in the dethroning of an individualistic interpretation of poverty. Yet the implementation of a state-run relief program challenged the professional substructure of privately-grouped social workers. Social workers clashed as the drive to grant government funds to needy mothers split the profession.

Social work emerged in the heyday of voluntarism. The placement of social welfare workers in various private organizations created a competing force to the public social welfare schemes which evolved from the workers' own investigations. Private welfare agencies, accustomed to their counterpoint relationship with limited government, resisted plans for centralized public social welfare.[1] Social workers' insistence that stipends derive from private sources especially hampered the movement for mothers' pensions in New York. Private agencies demanded the continuation of philanthropic aid to widows and the distribution of public funds among private institutions to care for dependent children.[2]

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[1]Roy Lubove, The Struggle for Social Security, 1900-1935 (Cambridge, Mass.: Harvard University Press, 1968), p. 102: "Prior to the twentieth century voluntary association was a dynamic, progressive influence in American life. It not only played a mediating role between the individual and society, but made limited government possible by diffusing power and responding to collective needs. Yet, by the twentieth century the ideology of voluntarism and the vast network of institutional interests which it had nurtured had become retrogressive. . . . Assumptions about the self-sufficiency and superiority of voluntary institutions obstructed adaptation to changing economic and social conditions."

[2]In New York State in 1913, state authorities committed one thousand children to institutions because their widowed mothers were ill; officials placed three thousand more because their parents could not support them. The frequent unwillingness of many private agencies to provide financial help to women thought capable of work exacerbated the problem. See Walter I. Trattner, From Poor Law to Welfare State: A History of Social Welfare in America (New York: The Free Press, 1974), pp. 187-88.

By 1912, nineteen states had mothers' pension legislation in force; the wave began in 1911 when Illinois passed the first such statute.[1] In New York State, however, the bill lay stalled in the legislature. The forefront of opposition to public "outdoor relief" came from New York City, with the two most powerful private social service agencies, the Russell Sage Foundation and the New York Charity Organization Society (COS). Mary Richmond and Edward T. Devine served respectively as their spokespersons.[2]

In New York, private agencies aligned successfully in 1897 to defeat a bill to give the New York City Commissioner of Charities authority to grant widows money allowances, equivalent to the costs of institutional care for their children's support. Then, for three successive years, as Homer Folks proudly boasted, "the united efforts of the general charitable agencies of the city" defeated

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[1]In 1919 thirty-nine states had enacted mothers' pensions laws. By the end of 1921, forty states and the territories of Alaska and Hawaii had such statutes. As of July 1931, only Georgia and South Carolina had no mothers' compensation laws. See U.S., Department of Labor, Children's Bureau, Laws Relating to "Mothers' Pensions" in the United States, Canada, Denmark, and New Zealand, Publication No. 63 (Washington, D.C.: Government Printing Office, 1919), p. 11. U.S., Department of Labor, Children's Bureau, Mothers' Aid, 1931, Publication No. 220 (Washington, D.C.: Government Printing Office, 1933), p. 2.

[2]See Lubove, The Struggle for Social Security, p. 102.

similar bills.[1] The COS defended the arrangement by which private agencies got public funds to care for their indigent charges. The revised State Constitution had, after all, granted the State Board of Charities the right to establish rules, regulations, and restrictions governing private groups receiving public monies. If the state were to administer relief, all efficiency and economy would be lost. Folks defended the cooperation between the COS and the Department of Charities in New York City, under which a COS representative met with Department staff to evaluate applications for the commitment of destitute children to private institutions. "Whenever it is found that the parents are of good character and should be enabled to keep their children at home, the COS takes the case." Among the 1,126 applications for children's institutional commitment between July 1, 1898 and May 1, 1899, the COS found reason to take only 327 cases.[2] Yet private forces contended that the government would not be

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[1]Homer Folks, "Report from New York State to the National Conference of Charities and Correction," Charities 3 (July 17, 1901):6-7. The battle continued into the twentieth century. "The reaction of insurance companies to monopoly state funds in workmen's compensation, of physicians to compulsory health insurance, and of employers to unemployment insurance had a counterpart in the stand taken by private social work agencies against mothers' pensions." Lubove, The Struggle for Social Security, pp. 91-92, 101.

[2]Folks, "Report from New York State," p. 8.

able to manage with the same discrimination and generosity.

Moreover, cynics argued, public relief would lead the poor to think that money stipends were their right and that "the public treasury is inexhaustible."[1] Finally, private groups defended the social work ethic, which traditionally scorned the mere distribution of money. The Society for the Relief of Poor Women and Children, the first charitable organization incorporated and run by women, aided widows. Its charter of 1800 established the Society's perimeters for relief. Aid could be given only to women of good character, willing to accept employment and demonstrating moral rectitude. Evidence of begging would cause immediate withdrawal of help. Moreover, "relief shall be given in necessaries, and never in money."[2] Through the twentieth century, the Society distributed wood, clothing, sugar, tea, and other foods to widows with two or more children. Thus the idea of

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[1]Frederic Almy, "Public Pensions to Widows. Experiences and Observations which Lead me to Oppose Such a Law," Proceedings of the National Conference of Charities and Correction, Cleveland, Ohio, June 12-19, 1912, p. 482.

[2]Constitution of the Ladies Society for the Relief of Poor Widows with Small Children (New York: James Oram, 1800), pp. 6, 8-9; The By-Laws and Regulations of the Society for the Relief of Poor Widows with Small Children (New York: J. Seymour, 1811), pp. 6-8; Society for the Relief of Poor Widows with Small Children, 1797-1922, Historical Sketch (New York: the Society, 1923), pp. 15, 17; 125th Report of the Society for the Relief of Poor Widows with Small Children, December 1922, pp. 5, 8; see also Reports for 1888, 1899 and 1905.

state subsidies to mothers encroached upon an old social work standard. "It [mothers' pensions] is going back to that old dangerous experiment of trying to solve social problems by merely giving money."[1] Money suggested the recipient capable of planning his own life once given the footing; if commodities were the items of charity, social workers would retain a greater degree of control.

Proponents of the widows' pension bill in New York State cited emotional case histories of women doing the impossible, trying to support three, four, and sometimes six children on $5.00 a week.[2] Their arguments included potential tax savings, by avoiding the public

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[1]Discussion, Charles F. Willer in response to Almy, "Public Pensions to Widows," p. 490. See also Frank J. Bruno, Trends in Social Work, 1874-1956. A History Based on the Proceedings of the National Conference of Social Work (New York: Columbia University Press, 1957), p. 180.

[2]State of New York, State Board of Charties, "The Hill-McCue Bill for the Relief of the Children of Widowed Mothers" (Albany: J. B. Lyon Co., 1915), p. 22. See "The Case for Widows' Aid in New York," Survey 33 (February 20, 1915):548: One widow "leaves her home at 5 to get to her work at 6 in the morning. She quits at 5, and to earn a trifle more, cooks supper for another woman. Finally, at 6 in the evening she goes home to cook and care for her children. This widow was not in exceptional plight. . . . The same situation is forced on many women in caring for . . . [their] children." See also letter to the Editor, Clara C. Park, "Motherhood and Pensions," Survey 30 (April 12, 1913):74. (The letter went originally to the Commission to Study the Question of Dependent Minor Children of Widowed Mothers.) The correspondent declared: "It seems to me that taking away the children from a mother, is like taking away her life, for the connection is so close and subtle."

expense of institutional care of sick women, broken in health and spirit by the compelling demands of child care and work. Reliable income to allow women to stay at home would also result in fewer incorrigible, truant, and delinquent children.[1] The advocates' primary argument, however, was the incapacity of non-public resources to provide this assistance, as well as the mothers' right to receive it. Mothers had the right to the regularity and assurance which state grants promised. Private relief agencies could not meet the demand. Their sporadic performance, dependent upon donors' financial whims, would not substitute adequately. Robert W. Hebberd, Secretary of the State Board of Charities in New York, spoke for the social service workers who had carried their analysis to its logical conclusion:

> Society as a whole is responsible for the way in which its individual units live and move. . . . It cannot evade this important issue through the medium of a private charity supported by the ten dollars or more annually contributed by the benevolently inclined.[2]

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[1]Robert W. Hebberd, "New York: Relief to Needy Mothers," Proceedings of the National Conference of Charities and Correction, Memphis, Tenn., May 8-15, 1914, pp. 450-51. See also State Board of Charities, "The Hill-McCue Bill," p. 25.

[2]State Board of Charities, "The Hill-McCue Bill," p. 24; see also "A Year of Mothers' Pensions in New York," Survey 36 (September 16, 1916):596; Elizabeth S. Chesser, Woman, Marriage and Motherhood (New York: Funk and Wagnalls, 1913), pp. 266-67; Lillian Wald to Professor

The New York Association for Improving the Condition of the Poor, administering a program for the material relief of widows, expressed doubt as to the actual capacity of private aid. The Association recognized that however judicious and thorough private agency programs might be, there would always be unfair discrimination. With fragmented agencies distributing the dole, there could be no universality; without apparent reason, women in similar straits would receive different aid:

> While we may be strong in the belief that every effort should first be made to handle the situation through private endeavor before turning it over to city or state, yet unless we can measure up to the needs of the situation, can we allow our theories and opinions as to the merits of one form of relief over another to prevent the adoption of a program whose honest purpose it is to put a stop to the incalculable social loss that is plainly written in the stories of the lives of a large number of women and children?

The Association concluded that to continue private support required much more money, but remained pessimistic about the availability of additional funds.[1] Ironically, social workers, convinced of the paramount value of home life, actually abetted the destruction of poor homes with

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Foerster, Lillian Wald Papers, Box 2, Letters by, 1893-1917, Manuscript Collection, New York Public Library.

[1]New York Association for Improving the Condition of the Poor, Department of Family Welfare, Shall Widows be Pensioned? A Report to the Public of the Service Rendered by the NYAICP to 474 Widows with Dependent Children under its Care on February 1st, 1914, Publication No. 82 (New York: AICP, 1914), p. 36; also pp. 32, 35, 37.

their stubborn refusal to accept government intervention.

The bitter divisions among social welfare workers in New York continued, seemingly without resolve. In 1913, in an effort to clarify the issue, the Legislature created the New York State Commission on Relief for Widowed Mothers to investigate the welfare of widows under private relief and to offer definitive recommendations.

The Commission's 548-page report resulted from nine thousand pages of testimony taken at more than one hundred public hearings. Commission members traveled to New York City, Albany, Troy, Syracuse, Rochester, and Buffalo, as well as to other states and European countries. The report presented an unequivocal indictment of the private relief network as it functioned for widows.[1] Testimony from managers of the state's orphan asylums confirmed the ineffectiveness of private intervention. Private institutions in New York cared for more than two thousand children, confined for no other reason than their mothers' widowhood and poverty; state facilities sheltered another thousand children for the same reason. In New York City alone, six thousand widows annually

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[1] Preliminary Report of the New York State Commission on Relief for Widowed Mothers. Transmitted to the Legislature, March 20, 1914 (Albany: J. B. Lyon Co., 1914), pp. 2, 4, 6. See also "548 Pages All About Widows," Survey 35 (March 18, 1916):730; "Needy Widows in the State of New York," Survey 32 (April 4, 1914):1.

sought assistance from private charities; merely a few received adequate provision. The Commission concluded with a plea for public allowances to widows:

> They cannot be successful mothers because they are too much distracted by wage-earning. They cannot be successful wage-earners because they are too much distracted by the child life in their hearts and homes.[1]

The Legislature, persuaded, passed the Hill-McCue Bill and with Governor Charles Whitman's signature on April 7, 1915, the New York State Child Welfare Act became law. The Act provided that the State Board of Charities assume supervisory control of local administrative agencies, and mandated the creation of local boards of child welfare, to distribute local public monies to worthy widows with one or more children under sixteen years of age.[2] The local boards drew funds from county

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[1] Preliminary Report of the New York State Commission on Relief for Widowed Mothers, p. 1; also, pp. 2-3.

[2] State of New York, No. 1694, Int. 1444, An Act to provide for the establishment of local boards of child welfare empowered to grant relief to children of widowed mothers. The statute established local boards of child welfare in each county of the state and in cities which contained one or more counties. On the county level, the boards consisted of the county superintendent of the poor and six non-paid members chosen by the county judge; in cities, the mayor appointed a ten-member board. The Legislature subsequently amended and amplified the 1915 law. By 1922, in addition to widows, mothers with husbands in insane asylums or state prisons could also receive payment. In that year, the residency requirement was shortened to one year and the husband no longer had to be a citizen as long as he had resided in the county for two

or city tax levies. The statute permitted allowances only after careful scrutiny of need and proof of the mother's "suitability" as child-rearer. For one child, allowances could not supersede $20.00 per month; if a mother had several children, she could not receive more than $15.00 per month for the second or $10.00 per month for each additional child. Whatever the case, allowances to any one woman might not exceed $60.00 a month.[1] (In

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years. By 1927, widows, mothers deserted for five successive years, and mothers whose husbands were under medical treatment with tuberculosis or prematurely incapacitated, were also eligible for aid. The law now allowed relatives caring for the children of deceased mothers to receive the benefits of the Act. By 1930, a mother needed only to be deserted for two successive years; relatives could receive public allowances if mothers, alive, were insane or physically incapacitated. See Board of Charities, "The Hill-McCue Bill," p. 1; U.S., Department of Labor, Children's Bureau, Public Aid to Children in Their Own Homes. A Tabular Summary of State Laws in Effect November 1, 1922, by Lulu I. Eckman (Washington, D.C.: Government Printing Office, 1923), p. 16; U.S., Department of Labor, Children's Bureau, A Tabular Summary of State Laws Relating to Public Aid to Children in Their Own Homes in Effect January 1, 1929 (Washington, D.C.: Government Printing Office, 1930), p. 18; U.S., Department of Labor, Children's Bureau, A Tabular Summary of State Laws Relating to Public Aid to Children in Their Own Homes in Effect January 1, 1934 (Washington, D.C.: Government Printing Office, 1934), p. 24.

[1]State of New York, An Act for the Establishment of Local Boards of Child Welfare, p. 5. The New York law was one of the more conservative enactments of mothers' pensions. For example, the Illinois act, passed on July 1, 1911, did not restrict funding only to widows, but allowed destitute and capable parents to apply for aid. Also, while the Illinois act denoted local county boards to raise the funds, the Juvenile Court fixed and mandated

early 1916, when the Survey assayed the performance of the New York City Board of Child Welfare, it found the average pension to be $24.77 a month; the maximum of $60.00 had been granted only once, to a mother with seven children.)[1]

The Act authorized local boards to evaluate acceptability for motherhood, to inquire into the capacity, "mentally, morally, and physically," of each woman applying for aid. To qualify, women must have lived in the county at least two years and been married to a citizen of the United States who resided in the state at the time of his death. Investigation would have to confirm that mothers, if not reimbursed, would be forced to apply for the child's institutionalization. At all times, the decision as to size of the subsidy would be based upon an appraisal of the costs of institutional care, never to

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money allocations. See Hon. Merrett W. Pinckney, "Public Pensions to Widows. Experiences and Observations which Led me to Favor Such a Law," Proceeding of the National Conference of Charities and Correction, at the 39th Annual Session Held in Cleveland, Ohio, June 12-19, 1912, p. 473.

[1]"Widows' Pensions Money all Allotted," Survey 35 (March 18, 1916):725. In February 1914 in Massachusetts, after the state's mothers' pension act had operated less than a year (the law passed in June 1913), findings showed the average weekly allowance to be $5.42. See David F. Tilley, "Adequate Relief to Dependent Mothers in Massachusetts," Proceedings of the National Conference of Charities and Correction at the 41st Annual Session, pp. 453-54.

exceed that amount. No more than six months could elapse before the board reviewed each case, to determine if aid should continue.[1]

The New York law suffered serious limitations which neutralized the sponsors' intent. The Act passed only after vituperative debate, mitigating its reform effects. State Senator William H. Hill of Lestershire, a sponsor of mothers' pension legislation, wrote to Governor Whitman while the bill was before the Legislature:

> There need not be the slightest fear of an open or concealed avenue to a dangerous class of socialism, paternalism, nor loss of personal responsibility on the part of those to whom relief is afforded.[2]

Demonstrations that state stipends would be cheaper than institutional costs bolstered such arguments. Predictably, allowances were minimal.

The major shortcoming of all state mothers' pension legislation lay in its retention of a nineteenth-century moralistic posture. The realization that poverty was impervious to personal efforts prompted the notion of pensions. Yet the implementation of the idea required that women be deemed "fit" to receive aid. Review of each case every six months in New York (often at shorter

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[1]State Board of Charities, "The Hill-McCue Bill, pp. 3-4.

[2]Ibid., p. 12.

intervals in other states) kept the recipient alert, always "grateful," in the suspense of investigation and scrutiny of behavior. The nineteenth-century social work concept of "friendly visitors" recast itself in new mold. Moral overtones shrouded the right to a decent life.

Subjective value judgments of the laws' administrators sometimes superseded the objective reality of economic need. In Massachusetts, for instance, the state board provided assistance only to families who provided a "proper environment for dependent children." The board judged the presence of male boarders incompatible with good home life. This policy cut markedly into a major source of income for immigrant women, particularly, who sought to perpetuate their domestic roles while adding extra income to the family.[1] The decision as to acceptability depended upon the peculiar background and sensibility of each state agent.

In New York, the Act continued social service fragmentation. The law sidestepped centralization by creating county boards, making individual stipends dependent upon local generosity and wealth. Allowances did not reflect the collective wealth; widows' residences thus determined the level of their relief. A study of the

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[1]Tilley, "Adequate Relief to Dependent Mothers in Massachusetts," p. 455.

homes of 101 widows receiving grants from the New York City Board of Child Welfare discovered that 55 percent of the women found it necessary to continue working. Those who did not work attributed their unemployment to the demands of young children at home or to their own illnesses.[1] The Survey reported that the New York City Board asked for $400,000 in appropriations to aid 5,880 applicants, but received only $100,000. Aid to widows in New York City was a constant juggling process, in which administrators struggled to make the best of a bad situation.[2]

Mothers' pension acts, with their diversity of provisions, underscored the limitations of state social welfare legislation in a federal system. Relatively insignificant social happenstance determined women's welfare. Some states reimbursed only widows, while others extended assistance to mothers whose husbands were in prison or insane, to guardians and grandparents, or to unmarried mothers. By 1931, a few states' pension laws benefited expectant mothers.[3] Likewise, residence

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[1]Leonard M. Wallstein, A Test Survey of the Homes and Related Conditions of Widowed Mothers Receiving Allowances (New York: Commission of Accounts, 1917), p. 3.

[2]"Widows' Pension Money all Allotted," p. 725.

[3]U.S., Department of Labor, Children's Bureau, Laws Relating to "Mothers' Pensions" in the United States, Canada, Denmark, and New Zealand, Publication No. 63 (Washington, D.C.: Government Printing Office, 1919), p. 12; U.S., Department of Labor, Children's Bureau, Laws Relating to "Mother's Pensions" in the United States

requirements varied widely, from one year in a county to two years, or even three or four, in the state.[1]

The statutes posed no standard definition of poverty among the states. Destitution was the bottom line in some states, while others required merely that a mother be completely dependent upon her own capacity for support. In Illinois, aid could not be given if a woman possessed any property other than everyday household equipment. The New York law was by far the most conservative, demanding a demonstration that the refusal of aid would be tantamount to a child's institutionalization. In Idaho, Illinois, Missouri, New Hampshire, South Dakota, and Utah, allowances turned on mothers' abstention from work.[2] The minimal nature of assistance,

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Denmark, and New Zealand, Publication No. 7 (Washington, D.C.: Government Printing Office, 1914). In 1931, three states--Michigan, Nebraska and Tennessee--allowed the unmarried mother to apply for aid; seven others--Colorado, Louisiana, Missouri, Pennsylvania, South Dakota, Virginia and Wisconsin--made the expectant mother eligible for benefits. See Children's Bureau, Mothers' Aid, 1931, p. 3.

[1]Children's Bureau, Laws Relating to Mothers' Pensions, No. 63, p. 14. Residence requirements varied among the states. Oregon and Washington required three years, Florida demanded four years, and New Jersey provided for five years' residence in the county. In New York and New Jersey, the husband also had to be a resident of the county at the time of his death.

[2]Children's Bureau, Laws Relating to Mothers' Pensions, No. 7, pp. 9-10; Children's Bureau, Laws Relating to Mothers' Pensions, No. 63, p. 13. The Children's

falling below the income necessary for a decent standard of living, also narrowed the laws' effects. With some counties overburdened with applicants and others relatively free, stipends often had no relation to real economic need.

In 1931, the Children's Bureau collected data from the states' pension administrations. The national monthly average stood between $20.00 and $30.00. Massachusetts offered the highest average monthly allowance at $69.31; in Rhode Island the average grant was $55.09 and in New York it was $52.62. Grants were much lower in the South. In Mississippi, the median allowance was $11.11, and in Arkansas (the state providing the least assistance) it was $4.33.[1] One sociologist found this lack of unity among the states particularly striking: "The experience of one state seems to have little appreciable effect upon the evolution of laws in others."[2]

Bureau compared the laws in the United States to those of Denmark and New Zealand. The Danish law, for example, established a minimal income level, tailored to the size of the family, necessary for a mother to raise her family successfully. A widow falling below the income category received aid. "The aim . . . in the Danish law is to prevent destitution instead of making this condition a requirement for the granting of assistance." Laws Relating to Mothers' Pensions, No. 7, p. 11.

[1]Children's Bureau, Mothers' Aid, 1931, pp. 17, 24; Children's Bureau, Laws Relating to Mothers' Pensions, No. 63, p. 18.

[2]Ada J. Davis, "The Evolution of the Institution

Despite the extension of coverage to other categories of mothers, as the Children's Bureau scanned the state pension systems in 1931 it discovered that 82 percent of the aid nonetheless went to widows.[1] All but six states provided the Bureau with a breakdown of assistance according to race. Of the total of 46,597 families aided, 96 percent were white:

> Comparison of the percentage of Negro families in the total population of the counties reporting race, with the percentage of the families aided that were Negro, shows that provision for Negro families was limited in a number of states. The disproportion between probable need and provision is even greater when the lower income level of Negro families is taken into consideration.[2]

With local administration, no authority countermanded local predilection.

The fact that the statutes withdrew aid when children reached working age meant that legislative draftsmen did not hope to raise these dependents above their class. With the usual small grants, the typical household had no appreciable sum to permit children to

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of Mothers' Pensions in the United States," The American Journal of Sociology 35 (January 1930):587.

[1]Children's Bureau, Mothers' Aid, 1931, p. 11. Families with deserting fathers made up 5 percent of the group; in 4 percent of the cases, the father was physically incapacitated; in 2 percent of the cases the parents were divorced; 3 percent of the families revealed fathers mentally incapable; and another 3 percent had fathers in prison.

[2]Ibid., p. 13.

acquire any meaningful skill. The Massachusetts state board justified its policy:

> It is the feeling of the Board that it is hardly fair to expect public funds to support a child through the high school, and that while we are in sympathy with children receiving all the education possible, where the child is going to high school the support should come from private sources.[1]

The movement for mothers' pensions suggests a curious afterthought. While social workers and reformers recognized the inability of working women, particularly widows, to care properly for their children, the contemporary solution attempted to graft a middle-class lifestyle without providing sufficient economic resources for its sustenance. Reformers' successful efforts meant that women remained at home with assistance which never allowed them to rise above subsistence; there was no reorganization which would permit women to work, secure in their knowledge that their children were well cared for. The legislation, intended to prevent single mothers' abandonment of their children through work, never achieved its sponsors' goals. This was undoubtedly unintentional yet it resulted in the expedient use of women in the labor market.

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[1]Tilley, "Adequate Relief to Dependent Mothers In Massachusetts," p. 456.

The replacement of philanthropic action by state aid, the principle underlying mothers' pensions, represented the culmination of social thinking which saw the individual as much (if not more) a product of social condition as heredity, family, or capacities. The ideology of reform in Europe and the United States invested the social order with new responsibilities and individuals with new rights. "The community is performing a duty, not bestowing a charity, in providing itself with the bare necessities for tolerable existence."[1] This premise underlay the drive for social insurance, a movement which affected women in a primal sense with its demand that women receive protection--medical and financial --in childbearing.

Original attention to maternal care mitigated collective responsibility by making education the panacea in reversing infant and maternal mortality rates. A comfortable philosophy, relatively unchallenging, blamed children's poor survival on mothers' ignorance. The early conclusions of the Children's Bureau placed the burden of baby-saving squarely on the mother:

> The most important factor in the solution of this problem is the mother. She is the natural

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[1]The Women's Co-Operative Guild, Maternity Letters from Working-Women (London: G. Bell and Sons, Ltd., 1915), p. 17.

> caretaker of her baby. A lower death rate among the babies can only be accomplished through intelligent motherhood, maternal nursing, cleanliness and fresh air, and pure food and properly prepared milk for babies who have to be artificially fed.[1]

A modicum of education could go long distances in a middle-class population, with the resources available to apply knowledge. But for working mothers, the advice literature and pamphlets lecturing on the necessities of balanced diet, sanitation, healthy exercise, freedom from nervous anxiety and overwork, and the requirements for extra sleep would be read like a utopian vision. With poverty, the truths of science alone had little value. Only society's intervention could make science work. Homer Folks commented on the maternity advice of public health agencies. From where was the nourishing food to come, the extra eggs and buttermilk, the rest, the avoidance of climbing? He equated the advice to expectant mothers with the advice which health works

> . . . used to give to tuberculosis patients when the poor man who was unable to work came in and we told him tuberculosis was perfectly curable; it only needed three square meals a day, absolute rest, freedom from worry, sleeping out of doors. . . . He might as well have been told to take a trip to the North Pole. We have to face the fact

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[1]U.S., Department of Labor, Children's Bureau, Baby-Saving Campaigns. A Preliminary Report on What American Cities are Doing to Prevent Infant Mortality, Publication No. 3 (Washington, D.C.: Government Printing Office, 1913), pp. 47-48.

> that this baby-saving business means money, and means interference with the ordinary methods of earning money, and that interrupted earnings have to be made up somehow if the baby is going to be saved. In other words we must study maternity insurance, and the many economic aspects of baby-saving.[1]

Advocates gradually saw heavy factory work by expectant mothers as inimical to the health of infants both before and after birth, at least for the first three crucial months of nursing. Mrs. Nathan Maud, president of the New York State Consumers' League, and Florence Kelley, testifying before the New York State Factory Commission in 1912, called for the elimination of work for pregnant women for two to three months before and after birth.[2] In the United States between 1912 and 1913, four states (Massachusetts, New York, Vermont, and Connecticut) enacted laws regulating employment of pregnant women. The statutes, with some variation, forbid the knowing employment of pregnant women immediately

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[1]Homer Folks, "Address," American Association for the Study and Prevention of Infant Mortality, Transactions of the Fifth Annual Meeting, November 12-14, 1914, pp. 273-74.

[2]Testimony by Mrs. F. Kelley and Mrs. Nathan Maud, State of New York, Preliminary Report of the Factory Investigating Commission, Transmitted to the Legislature, March 1, 1912, pp. 14, 16, 1599. See also John Spargo, Socialism and Motherhood (New York: B. W. Huebsch, 1914), pp. 12-14, 19, 21-22, 25, 28: He asked: "Why in our social economy the maternal function of building up the body and soul of the child should be subordinated to the production of commodities?" p. 28.

before childbirth and upon delivery.[1] Women themselves exacerbated the inherent difficulty of enforcement; notwithstanding the rest which the laws afforded women, without money benefits and mandatory reinstatement at work, they could not afford to comply. Edward Phelps, an advocate of compulsory and uniform maternity insurance among the states, commented:

> It is futile to attempt to debar from work [women] . . . many of whom have no other source of income than the wages which they thereby earn. . . . And it is inevitable that women so

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[1]The Massachusetts statute regulating the employment of pregnant women became law in January 1912. Section 1 read: "No women shall knowingly be employed in laboring in a mercantile, manufacturing or mechanical establishment within two weeks before or four weeks after childbirth." The New York law, passed on April 19, 1912, provided that "it shall be unlawful for the owner, proprietor, manager, foreman or other person in authority of any factory, mercantile establishment, mill or workshop to knowingly employ a female or permit a female to be employed therein within four weeks after she has given birth to a child." Similar laws forbade the employment of pregnant women two weeks before and two weeks after delivery in Vermont (enacted in 1912) and four weeks before and four weeks after birth in Connecticut (enacted in 1913). See Mrs. Max West, "The Development of Prenatal Care in the United States," Transactions of the American Association for the Study and Prevention of Infant Mortality, Fifth Annual Meeting, Boston, Mass., November 12-14, 1914, pp. 74-75; "Massachusetts Maternity Law," Survey 26 (May 20, 1911):307; Lee K. Frankel, "Maternity Insurance," Read at meeting of the National Association for the Study and Prevention of Infant Mortality, Philadelphia, Nov. 10, 1915, reprinted from the New York Medical Journal, December 1915 (New York: A. R. Elliott Publishing Co., 1915), p. 6; Edward B. Phelps, "The New Statute for the Protection of Child-Bearing Factory-Workers and Means of Making it Effective," Second Report of the New York State Factory Investigating Commission, January 15, 1913 (Albany: J. B. Lyon Co., 1913), p. 1277.

> unfortunately situated will work up to practically the last minute before childbirth, and drag themselves back to work at the very first opportunity after it, whatever the physical results to them and their babies may be.[1]

Only European nations moved beyond earlier voluntary and nebulous protections to guaranties which safeguarded women's health and pocketbooks.

In Europe, public protection of maternity combined diverse systems which incorporated a central unity. Insurance strove to free women from basic anxiety with material or medical benefits and periods of rest before and after confinement. The plans among different countries varied considerably. Some nations ignored the national financial substructures and granted every woman a lump sum payment upon the birth of her child. Other countries established voluntary or compulsory insurance systems for defined categories of wage-earners, with required dues contributed by employers, employees, and often the state. Lump sum payments assumed that women attended to their own medical care. Insurance plans offered the option of medical aid and a more limited cash benefit. Wives of insured wage-earners usually received coverage, although less substantial than the coverage received by the employed female. The benefit fluctuated

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[1]Phelps, "The New Statute for the Protection of Child-Bearing Factory-Workers," p. 1280.

among nations to between 50 and 75 percent of the wages.[1] Collectively, maternity insurance attempted to spare women's health through rest and insure infants' survival by guarantying the mother's presence at home for four to six weeks after birth. Despite the drain of national resources during World War I, most insurance plans, including maternity provisions, grew.[2]

Germany boasted the oldest system of compulsory health insurance, adopted in 1883.[3] Wage levels determined maternity and general illness benefits; the state did not contribute, and all funds came from employers and workers. Compulsory insurance covered all manual employees and others earning less than $600.00 annually.

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[1]U.S., Department of Labor, Children's Bureau, Maternity Benefits in Certain Foreign Countries, by Henry J. Harris, Publication No. 57 (Washington, D.C.: Government Printing Office, 1919), pp. 9, 11-14.

[2]International Labour Office, The Protection of Women in Industry and Commerce Before and After Childbirth. A Comparative Study of Legislation (Geneva: International Labour Office, 1929), p. 1; Grace L. Meigs, "Infant Welfare Work in War Time," Proceedings of the National Conference of Social Work at the 44th Annual Session, Pittsburgh, Pa., June 6-13, 1917, p. 193.

[3]Before insurance in Germany, the industrial code of 1878 required that women could not work for three weeks after confinement. But the law provided no compensation and women and employers ignored it. The 1883 insurance code made maternity benefits an option of local sick-funds. See Victor Von Borosini, "What European Nations are Doing in Maternity Insurance," Survey 31 (March 14, 1914):744.

The German maternity insurance clause allowed local administrative boards the option to include the wives of insured men. Beneficiaries chose between monetary sums for two weeks before and six weeks after delivery, or free medical attendance for confinement and half the cash benefit.[1] Eligibility merely required completion of a ten-month membership waiting period in the insurance plan; the plan's rules mandated that the woman refrain from work. She could return to work after four weeks only with written authorization from a physician attesting to her recovery. The termination of work two weeks before expected confinement followed a physician's estimate of chronology, which if miscalculated worked in women's favor, entitling them to full benefits beyond eight weeks. Women earning more than the maximum base could voluntarily insure themselves; instead, however of the normal contribution of two-thirds by employer and one-third by worker, the woman carried the monthly premiums

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[1]American Association for Labor Legislation, Tendencies in Health Insurance Legislation (New York: Published by the organization, 1917), pp. 2-3; Children's Bureau, Harris, Maternity Benefits in Certain Foreign Countries, p. 49; International Labour Office, The Protection of Women in Industry, pp. 33-34. The Austrian law, enacted in 1888, was similar. The fund came from employer and employee contributions; the state paid nothing. Insured women received obstetrical care and material benefit for four weeks after delivery. See American Association for Labor Legislation, Tendencies in Health Insurance, pp. 3-4; Frankel, "Maternity Insurance," p. 15; International Labour Office, The Protection of Women in Industry, p. 12.

herself.[1]

Health insurance in Great Britain became law in 1911 and began operation the following year. The plan covered all manual employees between sixteen and seventy years, as well as all other employees earning no more than $768 annually. Funds came from a flat rate imposed on employers, employees, and the government. The English system, in contrast to the German, only provided women with a lump sum payment for childbirth (in 1911, $7.20 for insured women or wives of insured men and $14.20 if both husband and wife were insured). The comparative advantage of the British system lay in the universality of the allowance, while the benefit received by German women depended upon the wages they earned. Maternity insurance in Great Britain, however, did not require that benefits be applied to medical services; future legislation, unrelated to insurance, would have to provide public maternity medical care.[2]

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[1]Frankel, "Maternity Insurance," pp. 5, 12; International Labour Office, The Protection of Women in Industry, p. 34; Borosini, "What European Nations are Doing in Maternity Insurance," p. 744.

[2]American Association for Labor Legislation, Tendencies in Health Insurance, pp. 3-4; Borosini, "What European Nations are Doing in Maternity Insurance," p. 744; Frankel, "Maternity Insurance," p. 18. Maternity insurance in Australia and Italy consisted of lump sum payments at birth, with no medical provision. See Harris, Maternity Benefits in Certain Foreign Countries, pp. 67, 72, 92; International Labour Office, The Protection of

The inclusion of a maternity benefit in the British insurance act resulted in large measure from the campaign of the Women's Cooperative Guild, a part of the Co-Operative Movement. After Parliament passed the insurance act, complete with maternity provisions, the Guild lobbied for legislation to distribute maternity services, unrelated to ability to pay, to every county. The Guild also published an emotional volume of collected letters from working women concerning the physical and psychological nature of their pregnancies.[1]

Women in Industry, p. 35; Louis S. Reed, Health Insurance. The Next Step in Social Security (New York: Harper and Brothers, 1937), pp. 223-24. Arthur Newsholme criticized the British maternity benefit system, urging that its unconditional quality was government abdication of supervision. According to Newsholme, the government gave up the opportunity to make sure women would receive proper medical attendance. Lump sum payments were no guaranties that the money would be used to promote better health. See Public Health and Insurance: American Addresses (Baltimore: The Johns Hopkins Press, 1920), pp. 34, 95, 111.

[1]The Women's Co-Operative Guild, Maternity Letters from Working Women (London: G. Bell and Sons, Ltd., 1915). The letters tell of miscarriages, stillbirths, and an infant death rate under one year of twice the national average. "Of the 348 mothers who replied to questionnaires, 148 (42.5%) had stillbirths or miscarriages. Twenty-two percent had both stillbirths and miscarriages." Ibid., p. 194. Collectively, the women wrote of varicose veins (the result of working throughout pregnancy), falling wombs, and sporadic and unidentified bleeding. A typical letter (Ibid., p. 19) reads: "For twenty years I was nursing or expecting babies." The Co-Operative Guild fought for improved maternity care, on the premise that it would not come easily from the private sector: "The cry of a woman in travail has become a

The first national legislation from the Guild's efforts to follow up maternity insurance with medical provisions came in 1914, with the Maternity Act, establishing grants-in-aid to local sanitary authorities and voluntary agencies for maternal and child welfare programs approved by the Local Government Board. After Exchequer grants to local authorities stimulated the growth of local and voluntary maternity and child welfare centers,[1] the landmark in British maternal welfare came in 1918 when Parliament passed another maternity and child welfare act. The new law gave authority to local governing seats to do anything, with the sanction of the Local Government Board, to further the health of expectant mothers, nursing mothers, and children under five years of age. The outstanding feature of the act was the role of the central government, which furnished 50 percent of the funds appropriated for maternal and child welfare. Local authorities could budget the salaries of midwives for needy women and

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commonplace in literature, and the notion that pain and motherhood are inevitably connected has become so fixed that the world is shocked if a woman does not consider the pain as much a privilege as the motherhood. And this attitude of the world towards the pain of travail has been extended to all the sufferings attending motherhood. These letters show that this is the view of women themselves, for which doctors have been largely responsible." (pp. 3-4).

[1]See McCleary, The Maternity and Child Welfare Movement, pp. 17-18, 23, 46.

on-call physicians for midwives, the expense of lying-in hospital confinement for complicated cases, or the cost of day nurseries and child clinics, all with the assurance that sole dependence on local resources was unnecessary.[1]

System designers outside America, who included maternity guaranties in health insurance, predicated the structure on knowledge accumulated in the preceding years of public health work. Studies had determined unequivocally that women who worked to term often delivered prematurely or with complications from malpresentations of the fetus. Their infants, when born alive, were smaller and had less capacity for post-uterine survival. Women who returned promptly to work often suffered abdominal diseases resulting from their lack of rest and the failure of the uterus to involute normally. The women became invalids, jeopardizing future pregnancies.

Health sponsors in the United States understood these points. They easily recognized sickness as "a sign

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[1]Ibid., pp. 21-22; Children's Bureau, Standards of Child Welfare, pp. 169, 272-73; Newsholme, Public Health and Insurance, pp. 84-85, 350. While France lacked a national medical insurance program, laws passed between 1913 and 1926 provided substantial protection to women in industry and commerce before and after childbirth. Norway, Denmark, Sweden, Belgium, the Soviet Union, Spain, and Portugal also implemented maternity provisions to remove as much insecurity in childbirth as possible.

of morbid social condition."[1] Economists and special study commissions had demonstrated the inadequacy of workers' incomes, which could hardly sustain subsistence, let alone medical accident. One economist plotted the wage-earner's standard of living (his wages against the cost of living) from the final decade of the nineteenth century through 1920. The wage-earner's status could not even be characterized as static, for the economist showed that it became markedly worse over the thirty-year period:

> The purchasing power of an hour's wage was 20.7 percent less in 1918 than it had been during the years 1890-1899, and . . . the purchasing power of full-time weekly earnings was 29.6 percent less than during this period.[2]

Inflation overcame and surpassed wage increments in two stages, first between 1907 and 1912, then in 1916 and 1917. While weekly earnings between 1907 and 1912 increased by 7 percent, retail food prices in those same years soared 22 percent, so that purchasing power, measured by hourly wages against the price of food, decreased

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[1]Sidney E. Goldstein, "Hospital Social Service; Principles and Implications," Proceedings of the National Conference of Charities and Corrections, 37th Annual Session, St. Louis, Mo., May 19-26, 1910, pp. 342-43. (Goldstein was director of social services at the Free Synagogue in New York City.)

[2]Paul H. Douglas, The Worker in Modern Economic Society (Chicago: University of Chicago Press, 1923), p. 308. Douglas, of course, later United States Senator from Illinois, became one of the intellectual draftsmen of New Deal policies.

substantially; between 1916 and 1917, the decrease was almost twice as severe.[1]

The very fact of the enormous medical achievement of the preceding decades highlighted the discrepancies of medical distribution. Observors saw quickly that average means denied the potentials of preventive medicine to those who could not meet individual payments. Isaac Rubinow, one of America's most vocal and persistent advocates of compulsory health insurance, estimated that from two-thirds to three-quarters of all gainfully-employed individuals in the United States depended on wages or small salaries for their livelihoods. And "from four-fifths to nine-tenths of the wage-workers receive wages which are insufficient to meet the cost of a normal standard of living of health and efficiency for a family."[2]

The compulsory health insurance movement in the United States stressed as its theme the birthright of all people to fundamental security. Minimum human decency, the proponents of insurance insisted, did not come automatically from industrial economics; equity demanded that capitalism be adapted. Any interruption in the

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[1]Ibid., pp. 308-09.

[2]I. M. Rubinow, Social Insurance (New York: Henry Holt and Co., 1913), pp. 43-44.

wage-earner's income flow ipso facto meant family disintegration. Insurance advocates urged that a group or social congregate is measured by its collective strengths and weaknesses. If sickness were acknowledged as a collective flaw, then the individual alone could not be asked to bear the costs. The whole felt the impact of individual illness, making it in the interests of all to prevent debilitation. Proponents argued that "sickness is the largest single factor in dependence, causing seven times as many appeals to charity as do industrial accidents."[1]

In this theoretical framework, the needs of the group necessarily subordinated individual liberties, whether of doctors, employers, or more affluent workers. The loss of one section of the population should be distributed among the remainder, since the accruals enrich the whole community.[2] Advocates were quick to outline their perceived priorities for tolerable existence. Health was basic. Frederick Almy, Secretary of the

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[1]American Association for Labor Legislation, Health Insurance. Statements of Prominent Persons (New York: published by the Association, 1919), p. 18: "Sickness surveys in many cities show that about one-third of those too sick to work are without medical care."

[2]Isaac M. Rubinow, "Health Insurance," Proceedings of the National Conference of Charities and Correction, at the 43rd Annual Session, Indianapolis, Indiana, May 10-17, 1916, p. 436.

Buffalo Charity Organization Society, maintained that

> . . . the tenement father who sees his boy go through the grammar school, and then die of tuberculosis, would rather have a live son than a wise one. The wages of unskilled labor in the tenements do not allow health.[1]

Mere subsistence was insufficient; at best, the workers who "got by" without charity lived with a constant, static level of undernourishment.[2]

Notwithstanding European social welfare advances, which cushioned the impact of industrialism's arbitrary dictation of individual security, American reformers remained oblivious to the issue of social insurance until the creation of the American Association for Labor Legislation ("AALL") in 1906. This group, founded by social scientists, labor leaders, and social workers, formed the American adjunct of the International Association for Labor Legislation. It boasted such notables as Richard Ely, John R. Commons, Edward T. Devine, and Lillian Wald. Its tireless spokesman for health insurance was Isaac M. Rubinow, a Russian emigré to the United States. Until his death in 1936, Rubinow reminded Americans with unrelenting pressure that their faith in voluntarism was misplaced, insensitive, and outmoded. Anarchy resulted

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[1]Editorial, Frederick Almy, "Free Health," Survey 26 (May 13, 1911):270.

[2]Douglas, The Worker in Modern Economic Society, pp. 283-84.

from voluntary relief; only state intervention could insure reliability.[1]

The social insurance movement in the United States began with seeming strength, as state after state passed workmen's compensation laws.[2] The optimism which surrounded the second campaign, for health insurance, however, should have been subdued. The compensation campaign was less a victory than many thought. The laws were as conservative as possible, excluding many categories of workers and placing a disproportionate burden of the coverage on those who were included. Legislation made cash benefits, low to begin with, subject further to constricting conditions such as waiting periods. Moreover, compensation failed to cover occupational diseases.[3]

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[1]After Rubinow emigrated to the United States in 1898, he became a doctor. His practice in the New York City slums convinced him of the impossibility of human fulfillment in working-class life. He gave up medicine. While he took up the cause of social insurance, he worked as chief statistician for the Metropolitan Life Insurance Company. In 1913, he published what became an American classic, Social Insurance. Lubove commented on Rubinow: "His socialist convictions and encyclopedic knowledge of European welfare legislation made him an impatient, if not contemptuous, critic of American commitments to collective action under voluntary auspices." See The Struggle for Social Security, p. 35, also pp. 29-30, 34; Trattner, From Poor Law to Welfare State, p. 152.

[2]Between 1909 and 1920, forty-three states passed compensation laws. Trattner, From Poor Law to Welfare State, p. 152.

[3]Lubove, The Struggle for Social Security, pp. 45-46, 52, 57: "Far from being a triumph over voluntarism,

The AALL was ready with a new agenda item, health insurance, in 1915, when it published a model compulsory health insurance act. The draft statute admittedly emulated British and German examples. The model act set up a compulsory scheme for all manual workers and other employees earning less than $1,200 a year (e.g., casual and domestic workers). Like European plans, voluntary insurance was available to any other worker. The insured wage-earner's family would receive medical assistance in illness, but only the wage-earner himself would get both medical and cash benefits, since "his illness is normally an economic as well as a physical misfortune."[1] With the exception of maternity insurance, coverage commenced at the moment of membership. A cash benefit, equivalent to two-thirds of the weekly wages, would continue from the fourth day of illness for thirteen weeks if necessary. The plan provided medical benefits for twenty-six weeks of the year. If hospital treatment were required, the weekly cash benefit decreased to a third of weekly wages.[2]

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it was devised, in large measure, by voluntary interests. Its origins helps to explain why compensation succeeded while the other social insurances failed."

[1]American Association for Labor Legislation, Health Insurance. Standards and Tentative Draft of an Act (New York: published by the Association, November 1915), p. 6.

[2]Ibid., pp. 9-10.

The draft outlined a triangular contribution scheme, with employees and employers each contributing two-fifths and the states one-fifth. Basing its estimates on the German experience, the Association suggested that the costs of insuring a worker earning $600.00 a year would be approximately $24.00 a year, or $2.00 a month. Broken down in thirds, the wage-earner would pay 80 cents a month, as would the employer for each employee; the state would remit 40 cents a month for each individual compulsorily insured. In blunt language, the Association defended the financial burden it sought to place on industry:

> The share of industry in causing sickness is well recognized. Not only the more clearly defined industrial diseases like lead poisoning and caisson sickness, but also general diseases, tuberculosis, anemea, digestive and nervous disorders, are partly or wholly caused by dust, speeding up, monotony, long hours. . . . Aside, therefore, from the advantages of interesting the employer financially in decreasing sickness . . . and from his gain in a healthier working force, there is ample justification in requiring industry as such to contribute to the insurance.[1]

The employer's liability extended further in the model bill. If wages dropped below $9.00 a week, the worker's cost for coverage would decrease by ten percent for every $1.00 a week he received under $9.00; commensurately, the employer's cost would increase by the same amount. The sponsors of health insurance concurred

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[1]Ibid., pp. 11-13.

that workers in low-paying industries should not be penalized any further.[1] To assuage predicted criticism, the standard health insurance bill proposed local administration of health insurance and the right of the beneficiary to choose freely among doctors who volunteered to serve under the plan.[2]

The model health insurance bill incorporated a maternity benefit. This inclusion with sickness insurance momentarily put sponsors on the defensive, since almost everyone saw pregnancy and childbirth as normal physiological processes. Yet proponents justified its integration into health insurance on the basis that in working-class homes, childbirth often carried with it the same "physical and economic effects" as illness.[3] The draftsmen saw the maternity provision as preventive, rather than curative. Rubinow understood that "in the life of the working-class maternity has proved a fruitful source of destitution."[4] Three years later, still defending the assimilation of maternity benefits in health insurance

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[1]Ibid., p. 13.

[2]Ibid., p. 15. See also James G. Burrow, AMA: Voice of American Medicine (Baltimore: The Johns Hopkins Press, 1963), p. 137.

[3]American Association for Labor Legislation, Standards and Tentative Draft of an Act, p. 8.

[4]Rubinow, Social Insurance, p. 273; see also pp. 274-77.

coverage, Rubinow declared: "I . . . know that if wage-work of mothers is undesirable it is one hundredfold more undesirable during the few months immediately preceeding and succeeding the act of childbirth."[1]

Finally, when the public recognized that paying even full wages to pregnant wage-earners for ten weeks would not cost more than one percent of the payroll of all female factory workers, advocates of maternity insurance felt certain that its inclusion would receive endorsement. Edward Phelps, a statistician who participated in the work of the New York State Factory Investigating Commission, as early as 1912 urged uniform national statutory protection for pregnant wage-earners. Based upon the census of 1900, which tallied the annual number of births in the United States at 2,644,512 and the approximate number of married women of child-bearing age (16-44 years) at 9,791,272, assuming the general birthrate per 1,000 married women (ages 16 to 44 years) to be 270 and further assuming that there were probably 139,291 married women of child-bearing age among a female work force in manufacturing and mechanical industries of 1,071,467, Phelps calculated the probable number of births from this group at 37,609 a year. Using a mean female income of $312.00 per annum ($6.00 weekly), Phelps calculated the total

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[1]Rubinow, "Health Insurance," p. 443.

annual payroll of the 1,071,467 female employees to be $334,297,704.00. Hence the "total annual cost of payment of full wages at $6.00 per week for ten weeks to each of the 37,609 women employed in manufacturing and mechanical pursuits presumably bearing children is $2,256,540.00." If an additional cost is added for the expenses of collection and bookkeeping, maternity insurance would require $2,820,675, or approximately 0.84 percent of the total annual payroll.[1] Would the nation be this extravagant on account of its women?

The maternity benefit included in the draft health insurance legislation fell short of the ten-week and full salary provisions of Phelps' hypothesis. The model statute based itself on the premise that women withdraw from work for eight weeks (two before birth and six after). Insured women and wives of insured men would be supplied with the necessary medical, surgical, and obstetrical care at confinement; in addition they would receive a weekly benefit equivalent to sick pay.[2]

Health insurance and maternity protection failed in the United States. Between 1915 and 1920, proponents

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[1]Phelps, "The New Statute for the Protection of Child-Bearing Factory-Workers," pp. 1285-86; see also pp. 1280, 1287-88.

[2]American Association of Labor Legislation, Standards and Tentative Draft of an Act, p. 10.

introduced compulsory health insurance bills in sixteen state legislatures. None was enacted. In California and New York, where the prospects for the bills apeared most propitious, voluntary social service agencies united as never before into successful lobbying efforts against the bills. In New York State, the Davenport-Donahue health insurance bill received Governor Alfred E. Smith's endorsement and passed the State Senate in 1919, only to fail in the Assembly.[1] By 1922, two more states (Missouri and Washington) passed laws prohibiting pregnant women's employment immediately before and after delivery. Yet these statutes offered no material provision for women. Simply put, they were effectively useless.[2]

The underlying assumptions inherited from the voluntary tradition of relief persisted even when the state interfered. Officials in Massachusetts, where legislation outlawed the employment of women directly before and after birth, but offered no substitute-wage stipend or job guarantee, saw no need to change. A commission on health insurance studying a proposed bill

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[1]Michael M. Davis, Medical Care for Tomorrow (New York: Harper and Brothers, 1932), p. 273; George Rosen, A History of Public Health (New York: Medical Publications, Inc., 1958), pp. 451-53; Lubove, The Struggle for Social Security, pp. 82, 89.

[2]International Labour Office, The Protection of Women in Industry, p. 75.

including maternity benefits was satisfied with the status quo:

> We . . . find that these disasters [high mortality rates of women and infants] are not due to poverty of the afflicted families nor to their social status, but rather to their ignorance of hygiene. We are therefore forced to the conclusion that no sufficient relief would result from the distribution of maternity benefits in the form of cash . . . as proposed in various bills submitted to us for consideration.[1]

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[1] "Massachusetts Maternity Law," p. 27. In June 1974, the United States Supreme Court ruled in a six to three decision that states could deny women disability benefits for absence from work because of pregnancy. The issue was whether a California statute denying disability payments to working women on account of pregnancy was constitutionally discriminatory. In dissent, Justice Brennan "noted that the [California] program protects men when they are incapacitated by prostate trouble or circumcision, which affects only members of their sex, and hemophilia and gout, which are largely confined to males." See "Court Says States Can Bar Job Benefits in Pregnancy," New York Times, 18 June 1974, p. 1; also "Sick Leave Pay Still an Issue Where Pregnancy is Concerned," New York Times, 4 April 1974, p. 41. In December 1975, the Court ruled more favorably for women, holding that states may not refuse unemployment benefits to women during three months before delivery and six weeks after. The Court overturned Utah's denial of unemployment benefits to laid-off pregnant women, on the purported grounds that they could not work anyway. The essence of the decision is that women are presumed capable of working before and after pregnancy and therefore entitled to unemployment compensation. In December 1976, the Supreme Court held six to three that private employers could refuse disability payments to women for absence from work because of pregnancy; six federal courts of appeals as well as the Equal Employment Opportunity Commission had ruled that the exclusion of pregnancy coverage violated Title VII of the Civil Rights Act of 1964 (which prohibits discrimination in employment based on race, religion, national origin and sex). However, the Court ruled that pregnancy disability benefits could only be required through union collective bargaining. Otherwise, Congress

The defeat of health insurance was a victory for the American Medical Association. It gave the organization new confidence in its ability to direct politics in its interests. Sensing its popularity and inevitability, the Association had been mildly receptive to health insurance before 1920. But the successful efforts of voluntary agencies against insurance gave strength to the faction within the AMA which was always opposed to state intervention in medicine. In 1920, the Association officially declared its opposition to any form of insurance, on the grounds that it depreciated medical standards.[1]

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could revise Title VII. "The Court found in essence that pregnancy is a unique condition: that refusal to cover it is not a refusal to cover people because of their sex but instead a refusal to cover a special condition." See "Supreme Court Rules Employers May Refuse Pregnancy Sick Pay," New York Times, 8 December 1976, pp. 1, 13; see also "Women Vow to Fight for Pregnancy Pay," New York Times, 9 December 1976, p. 19. The Pregnancy Disability Act, which would amend Title VII of the 1964 Act to prohibit sex discrimination on the basis of pregnancy, is pending before the 95th Congress. It aims to overturn the 1976 Supreme Court decision, and to require employers to cover pregnant workers under temporary disability and health insurance plans. See "100 Bills Affecting Women are Still Before Congress," New York Times, 8 July 1977, p. A8.

[1]Lloyd C. Taylor, Jr., The Medical Profession and Social Reform, 1885-1945 (New York: St. Marten's Press, 1974), p. 100; Burrow, AMA, pp. 21, 47, 67, 70, 93, 105, 139-40, 142, 146, 150, 157; Rosen, A History of Public Health, pp. 458-60. The AMA continued and still continues to fight health insurance. It successfully prevented the inclusion of health insurance in the Social Security Act. It fought the Wagner-Murray-Dengell Bill of 1945, which Truman supported, but which died in the Eisenhower

Its position against government intervention solidified. This stand became so adamant that the AMA bitterly opposed the Sheppard-Towner Act of 1921, a relatively unthreatening and stingy piece of legislation.

Administration. It opposed the Kennedy-Johnson efforts which resulted in Medicare. On December 7, 1976, the AMA House of Delegates finally, and after bitter division, endorsed a national health insurance program, but it chose the most conservative of all proposals. The plan would use private insurance companies with employee participation voluntary; it would project a minimum of federal involvement and would not impose an extra social security tax. "Critics of the Association's position charged that the action would be 'conditional surrender' that would inevitably lead to Government regulation of American medicine." The AMA opposed the labor-endorsed Kennedy-Corman bill, which provided for mandatory insurance and federal involvement. See "AMA Delegates, after Long Debate, Back a Conservative National Health Insurance Plan," New York Times, 8 December 1976, p. A11.

CHAPTER XI

SHEPPARD-TOWNER: A TYPICAL AMERICAN COMPROMISE

And then sometimes
I think of the President
and other men,
who practice the law,
who revere the law,
who make the law,
who enforce the law
who live behind
and operate through
and feed themselves
at the expense of
starving children
because of the law,
men who sit in paneled offices
and think about vacations
and tell women
whose care it is
to feed children
not to be hysterical as in the word
hysterikos, the greek for
womb suffering,
not to suffer in their
wombs,
not to care,
not to bother the men
because they want to think
of other things
and do not want
to take the women seriously.
I want them
to take women seriously.

--Susan Griffin
I Like to Think of Harriet Tubman, 1970

The Sheppard-Towner Act, the first federal social welfare measure in the United States, found its genesis in the work of the Children's Bureau. In 1917, Julia

Lathrop urged Congress to grant federal funds to be matched by the states for maternity and infant welfare. She cited British grants-in-aid to local governing units for the same purpose, and the precedent of state and federal matching grants established by the Smith-Lever Act of 1914 for agricultural training and home economics education for rural families. Lathrop proposed that the thrust of the new Act be the non-urban mother and child, for whom health safeguards were appallingly deficient.[1] In July 1918, Representative Jeanette Rankin introduced Lathrop's recommendations in the 65th Congress as the Rankin-Robinson bill. Although the House Labor Committee reported favorably on the measure in 1919, the session ended and the bill died. It was not until November 1921 and three different Congresses that the essence of Lathrop's proposals passed as the Sheppard-Towner Act.[2]

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[1]Josephine Goldmark, Impatient Crusader, Florence Kelley's Life Story (Urbana: University of Illinois Press, 1953), pp. 104-05; Joseph Chepaitis, The First Federal Social Welfare Measure: The Sheppard-Towner Maternity and Infancy Act, 1918-1932, Ph.D. Dissertation, Georgetown University, May 9, 1968, p. 17; J. Stanley Lemons, The Woman Citizen: Social Feminism in the 1920s (Urbana: University of Illinois Press, 1973), p. 154.

[2]Morris Sheppard, Democratic Senator from Texas, and Horace Towner, Republican Congressman from Iowa introduced the bill. Chepaitis, The First Federal Social Welfare Measure, pp. 8, 33-34, 40, 45; Lemons, Woman Citizen, pp. 154-55; Anne Martin, "Every Woman's Chance to Serve Humanity," Good Housekeeping 70 (February 1920): 144.

Enactment would likely have failed had the female vote been a known quantity in 1920. On one level, the statute's history and life-span bears testimony to women's political potential and ultimate political failure. Sheppard-Towner passed because women formed an impressive, belligerent, and confident lobbying bloc. They allowed the bill to cut across political party lines and ideological and ideosyncratic differences among their organizations as they wrote, spoke, and personally confronted and challenged congressmen to vote the measure into law.

A subcommittee of the Women's Joint Congressional Committee, headed by Florence Kelley and representing some fourteen constituent women's organizations, including the Women's Christian Temperance Union, the National League of Women Voters, the National Consumers' League, the General Federation of Business and Professional Women, the Council of Jewish Women, the Young Women's Christian Association, the National Women's Trade Union League, and the National Congress of Mothers and Parent-Teachers Associations, engineered the bill through Congress. Men ran scared. One reporter for the Ladies' Home Journal revealed that

> Senator Kenyon told me that if the members of Congress could have voted on the measure in their cloak rooms it would have been killed as

> emphatically as it was finally passed in the open under the pressure of the Joint Congressional Committee of Women.[1]

When politicians assessed women's impact on electoral politics in 1922, congressmen relaxed. Women's replication of their husbands' votes, rather than bloc behavior, doomed the Act.

The Sheppard-Towner Act established a scheme of grants to states for the establishment of programs to promote welfare and hygiene in maternity and infancy. The legislation provided funds, to states which had taken preliminary steps to secure grants, for the establishment of unfettered state programs, with additional sums on a matching basis. The statute forbade the application of monies to capital construction and explicitly proscribed state and federal officials from entering "any home over the objection of the owner thereof," or taking charge of

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[1]Charles A. Selden, "The Most Powerful Lobby in Washington," Ladies Home Journal 39 (April 1922):5, 95; U.S., Congress, House, Committee on Interstate and Foreign Commerce, A Bill for the Public Protection of Maternity and Infancy and Providing a Method of Cooperation Between the Government of the United States and the Several States, Hearings Before the Committee on Interstate and Foreign Commerce of the House of Representatives, July 12-16, 18-23, 1921 on H.2366, 67th Cong., 1st sess., 1921, p. 66: statement on behalf of the Women's Committee on the Sheppard-Towner Bill; see also "Congressional Committee of Representatives," Medical Woman's Journal 28 (February 1921):39; Lemons, Woman Citizen, pp. 155, 167; William Henry Chafe, The American Women. Her Changing Social, Economic and Political Roles, 1920-1970 (New York: Oxford University Press, 1972), pp. 27-28.

any child over his parents' protest.

The Act provided modest funding, with each state granted $10,000 outright in the first year and $5,000 in each of the five succeeding years. Its terms appropriated an additional one million dollars for the start up and each of the next five years, to be distributed on a dollar-for-dollar basis to states offering matching appropriations, with each such state receiving five thousand dollars and the balance to be distributed among those states in proportion to their respective populations. The Act prescribed administration by the Children's Bureau, and created a Federal Board of Maternity and Infant Hygiene, empowered to approve plans and budgets offered by states in order to receive funds. Appropriations ceased, by the Act's terms, on June 30, 1927.[1]

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[1] Text of the Act for the Promotion of the Welfare and Hygiene of Maternity and Infancy and of Supplementary Legislation, U.S., Department of Labor, Children's Bureau, The Promotion of the Welfare and Hygiene of Maternity and Infancy. The Administration of the Act of Congress of November 23, 1921, for the Fiscal Year Ended June 30, 1926, Publication No. 178 (Washington, D.C.: Government Printing Office, 1927), pp. 85-87. The Federal Board of Maternity and Infant Hygiene consisted of the Chief of the Children's Bureau, the Surgeon General of the Public Health Service and the United States Commissioner of Education. The Board defined the term "infancy" as continuing through the preschool period. It also ruled that federal grants and state funds gathered to match federal monies could not be distributed to private agencies. Ibid., p. 3.

The Act, supported by virtually every major women's group, illuminates the common responsive cord which maternity and child welfare work struck among women. On the other hand, the congressional hearings and public debate over the Act reveal vividly the antinomy between rhetoric and systematic capacity for effective change.

Committee testimony in the 65th Congress favoring the short-lived Rankin bill plodded along in rational description and reiteration of the rural necessity for better obstetrical and child-health care, reciting the preventable deaths in both areas. Witnesses, still hopeful that the bill might pass, did not become rancorous. Caroline Fleming of the Children's Bureau restated the figure of 16,000 women (a low estimate) who died every year from causes connected with childbirth (23,000 women died in 1918, the year of the influenza epidemic), with "uncounted thousands suffer[ing] impairment of health from causes related to maternity." The dark picture of American maternal mortality, a rate worse than seventeen of twenty leading nations, appeared more dismal when broken down. Puerperal fever, a disease almost entirely preventable, caused at least seven thousand deaths. Eighty percent of women had no prenatal advice or care. Fleming summarized the findings of the preceeding years. Poor care during the puerperal period also caused at least

50 percent of the deaths of the 250,000 infants who died annually before reaching one year, since half the infant deaths occurred in the first six weeks of life and stemmed directly from the lack of care, undernourishment, and overwork of women while pregnant. Of the annual infant deaths, 68,509 followed natal and prenatal conditions, while deaths from gastrointestinal, respiratory, and epidemic diseases had receded to 39,162, 23,716, and 13,620, respectively. On the basis of data compiled from the United States birth registration area in 1916, ten major nations showed better infant mortality statistics than did the United States.[1]

Dr. Anna E. Rude, Director of the Children's Bureau's Division of Child Hygiene, drew attention to rural responsiveness to available health facilities. At Children's Bureau child-health conferences, even in the

> . . . most primitive homestead States, where the conference center was a hundred miles from the railroad and people had to drive 20 and 30 miles to the conference center, we had 100 percent attendance; that is every family who had young children to be examined brought them to the conference center.

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[1]U.S., Congress, House, Committee on Labor. A Bill to Encourage Instruction in the Hygiene of Maternity and Infancy and to Extend Proper Care for Maternity and Infancy, Hearings before the Committee on Labor, on H.R. 12634. 65th Cong., 3rd sess., January 15, 28, 1919, statement of Caroline Fleming, pp. 5, 7, 11, 12, 17, 23, 28; also "The Sheppard-Towner Bill," Medical Woman's Journal 28 (January 1921):13-14.

She continued to depict rural poverty, the inability of rural states to fund health programs alone, and the greater expense of initiating such programs in nonurban areas because of scattered populations.[1]

The only conflict among the Act's sponsors related to the designation of state administrative agencies. The Children's Bureau favored the creation of new state boards, on the theory that members of existing bodies generally lacked expertise in matters of maternal and infant health. Opponents of the creation of new state machinery, who included S. Josephine Baker, then President of the American Child Hygiene Association, and Lee K. Frankel, President of the American Public Health Association, fought successfully for the bill's revision to make existing state agencies responsible for the Act's direction in their states.[2]

After the failure of the Rankin bill and the embodiment of the proposal in Sheppard-Towner, debate became emotionally charged. By 1920, activists urged female mobilization and demonstration of women's power. In 1920, an article in Good Housekeeping juxtaposed the federal government's expenditure of $47,000,000 in

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[1]U.S., Congress, House, Hearings Before the Committee on Labor, 65th Cong., 3rd sess., statement of Dr. Anna E. Rude, pp. 34-36.

[2]Ibid., pp. 39, 44, 57.

previous years to ensure farmers for losses of livestock and corn against the allocation of not a penny to prevent the avoidable losses of mothers and children.

> A bill now before Congress . . . will stop it if it is enacted into law. . . . It is a good bill and should pass. But it won't pass unless the women of the country let Congress know it must pass. Through lack of public interest a similar bill died in the 65th Congress.

The author contrasted public assistance to maternity and infancy in foreign countries against the shallow work, essentially no more than data collection, in the United States.[1] Articles in Good Housekeeping argued bitterly that sentimental reverence of women provided an excuse for indifference to their suffering.[2] Women began to understand that easy palliative words collided with meaningful works.

Another contributor to Good Housekeeping queried how the gentlemen of Congress, men who prided themselves upon their capacities for unemotional judgment, did not take time to weigh and assess the "fact" of war casualties against maternal and infancy losses. Eighteen months of war showed that the home front did worse than the battlefront. Yet the men of war received all the benefits

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[1]Martin, "Every Woman's Chance to Serve Humanity," pp. 20-21, 144, 147.

[2]Anne S. Monroe, "Adventuring in Motherhood," Good Housekeeping 70 (May 1920):28, 129; Editorial, "Herod is not Dead," Good Housekeeping 71 (December 1920):4.

of medical knowledge, with free surgical and hospital care.[1] S. Josephine Baker repeated the reality to members of the House Committee on Interstate Commerce in 1921:

> During the eighteen months we were at war, according to the official figures issued by the Government, thre were some 37,000 or 38,000 men . . . actually killed in action or who died as a result of wounds received in action. During that same eighteen months' period 300,000 babies under one year of age died in the United States, and we know, without any equivocation whatever, that with the use of the methods advocated in this bill at least a half of those lives could have been saved. Worked out in terms of figures, one can say it was eight times safer to be a soldier in the trenches in the greatest war of all history than it was to be a baby in the cradle in the United States. During that same eighteen months for every soldier killed in action or who died as a result of wounds received in action, one mother died of childbirth in the United States--the two numbers are almost identical.[2]

The Medical Women's National Association, incorporated in 1919, manifested female enthusiasm for the Sheppard-Towner Act. The National Association began as the Women's Medical Association of New York, chartered by the state in 1909 but actually an outgrowth of the Alumnae Association of the Women's Medical College of the New York Infirmary for Women and Children.[3] The

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[1]Mary S. Boyd, "Let's Stop Now the Casualties of Motherhood," Good Housekeeping 71 (December 1920):43.

[2]U.S., Congress, House, Hearings Before the Committee on Interstate and Foreign Commerce, 67th Cong., 1st sess., statement of S. Josephine Baker, p. 14.

[3]Women's Medical Association of New York City,

Association served originally to supply female physicians with a professional forum and opportunity to share medical knowledge, necessary because of their systematic exclusion from medical societies.

The early meetings of the New York Medical Woman's Association essentially lacked political content. Meetings revolved around official business, evaluation of the status of women in the profession, and the presentation and discussion of scholarly papers. Yet by 1921, the Association emerged from its academic shell, supporting the Sheppard-Towner Act strongly.[1] The group had decided to "take some action to show our legislators our

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Collected Papers, Manuscript Collection of the New York Academy of Medicine (herafter "NYAM"), Box 3, Program at the dinner celebrating the 50th Anniversary of the Women's Medical Association of New York City, November 4, 1959; Ester O. Lovejoy, Women Physicians and Surgeons, National and International Organizations. Book One: The American Medical Women's Association, The Medical Women's International Association (New York: American Medical Women's Association, 1939), pp. 3, 5. In 1937, sponsors renamed the Association the American Medical Women's Association. See also Medical Women's National Association, Year Book, July 1928, pp. 2-3.

[1]Constitution and By-Laws of the Medical Women's National Association Organized at Chicago, November 18, 1915 (Chicago: Rausbeck and Co. Printers, 1916), pp. 2, 6; Medical Women's Association, Year Book, 1928, p. 5. Members amended the constitution in the 1920s to incorporate political goals in the Association's functions. The charter provided that the purposes of the Association included the sponsoring of programs "to forward constructive movements such as conducting relief work, engaging in public health work, and such other and incidental purposes relating thereto, as may be properly endorsed by the medical profession." See Collected Papers, NYAM, Box 3.

indignation over putting politics, as it were, before the lives of countless mothers and children." The Association resolved to deluge congressmen with letters favoring the Act.[1] The Medical Woman's National Association thus collided head on with the American Medical Association.

A number of the nation's most conservative groups, including the National Association Opposed to Woman Suffrage, the Woman Patriots, the Daughters of the American Revolution, and the Sentinels of the Republic, joined the AMA in opposing the Act. Objections ranged from charges of fiscal extravagance, through fears of jeopardizing states' rights and visions of communist conspiracy, to the AMA's allegations that the Act was a surreptitious first step in the federal design to control medicine.

The bill's sponsors included most women's organizations and such eminent public health figures as Nathan Straus, Jr., Dr. Royal Copeland (Health Commissioner of New York City), Dr. Philip Van Ingen, and Dr. S. Josephine Baker. In New York City, advocates formed the Sheppard-Towner Emergency Committee to publicize the need for the

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[1]Women's Medical Association, Collected Papers, NYAM, Box 1, Minutes of Meetings, 1902-1931, Meeting of Association, October 19, 1921, pp. 135-136.

bill's enactment and counter the AMA's assertion of unilateral medical opposition. In the battle for governmental intervention in maternal and infant health, voluntary agencies now came to the fore. Even the American Federation of Labor favored the bill.

Proponents argued that the general welfare clause of the Constitution invested the federal government with power to allocate money for preventive health care.[1] Before the House Committee in the 66th Congress, Lathrop defended the bill as respectful of state authority. The act would enlist existing state health machinery, and federal funds would be spent by state employees. But

> . . . there should be a central source affording to the different States, when they make their plans, the best experience of all of the other States and of the world, and a central body competent to assure taxpayers and the special beneficiaries of the measure that its spirit is effectively carried out and that intelligent use is made of every dollar.[2]

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[1]U.S., Congress, House, Hearings Before the Committee on Interstate and Foreign Commerce, 67th Cong., 1st sess., p. 266; U.S., Congress, House, Committee on Interstate and Foreign Commerce, Hearings on the Extension of Public Protection of Maternity and Infancy Act before the Committee on Interstate and Foreign Commerce on H.R. 7555, 69th Cong., 1st sess., 1926, pp. 2-3; Chepaitis, The First Social Welfare Measure, p. 158; Lemons, Woman Citizen, p. 164.

[2]U.S., Congress, House, Committee on Interstate and Foreign Commerce, Hearings before the Committee on Interstate and Foreign Commerce on H.R. 1255, 66th Cong., 3rd sess., testimony of Julia Lathrop, p. 7.

The bill did not survive the 66th Congress; proponents reintroduced it in the new session in April 1921.

In the 67th Congress, the Senate Committee on Education and Labor reported favorably on the Sheppard-Towner bill. The Committee sought to appease states' rights advocates with an amendment protecting family privacy from undesired intrusion by state or federal agents. Under the amendment, no government employee could enter homes over parents' objections. The committee concluded with recommendations for general acceptance:

> Heretofore Congress has appropriated large sums for hogs and cattle. It is not because men think more of hogs and cattle than they do of babies that they vote $47,000,000 for them and nothing for the little ones, but because they have been thinking of the father's end of the problem. They have not seen that there was another side to the problem that was just as much the public business, namely, right conditions surrounding mothers and babies at home. Mothers will always think of the baby first. They are made that way; that is why it is a good thing for women to be in politics at this particular stage of the world's history, when conservation of life is so important.

The Senate passed the Sheppard-Towner bill on July 22, 1921 by a vote of sixty-three to seven. The bill then went to the House Committee on Interstate and Foreign Commerce.[1]

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[1]U.S., Congress, Senate, Committee on Education, Hearings before the Committee on Education on Report No. 61, 67th Cong., 1st sess., 1921, pp. 1-3.

At first, proponents believed that the bill had no chance in the House. The Committee chairman, Samuel Winslow, an anti-suffragist whose strong personal distaste for Julia Lathrop abetted his conservatism, refused from April to hold hearings. Women's political pressure, first on President Harding through Harriet Taylor Upton, and then from Harding to Winslow, reversed the situation.[1] Still, as one opposition witness paraded after another, the bill's chances hardly appeared promising.

States' rightists insisted that the bill was unconstitutional. For instance, when the bill's backers challenged Congressman Thomas Sisson of Mississippi for inconsistency, that is, his prior winning arguments for federal appropriations of $50,000 for rural sanitation, he replied that since that bill originated in the War Department "and was justified originally to keep healthy the soldier" its constitutionality was not at issue. Sisson discounted the demand for the maternity act. "Good mothers, I mean real mothers, mothers who have babies--I am talking about mothers who have a household to look after, who love their husbands; I am talking about real mothers" had no interest in the measure. Not having any "real mothers" on hand, he helpfully spoke for them: "I

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[1]Chepaitis, The First Social Welfare Measure, pp. 54, 58; Lemons, Woman Citizen, pp. 156-57.

am unwilling to have it [the home] invaded by the Federal Government or by any of its agents."[1]

The Commonwealth of Massachusetts, which never accepted Sheppard-Towner funding, sent several representatives to the House Committee hearings to speak against the bill. Mrs. Albert T. Leatherbel, speaking for the Massachusetts Anti-Suffrage Association, saw "bureaucratic control of family life," in the Sheppard-Towner proposal, the first conscious step to a socialist takeover.[2]

In the 1921 hearings, advocates now confronted their adversaries head on with charges of hypocrisy. On the state level, Elizabeth Tilton, National Legislative Chairman of the National Congress of Mothers and Parent-Teacher Associations, defended the bill's methods:

> No one called it Bolshevism when the rich states put up money that the federal government passed over to the poorer states in order that they might make good roads. . . . No one calls the Farm Bureau work of Massachusetts Bolshevism, they call it business efficiency.[3]

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[1]U.S., Congress, House, Speech of Hon. Thomas U. Sisson of Mississippi, "Maternity Bill," 66th Cong., 3rd sess., November 19, 1921, pp. 2, 3, 5, 7.

[2]U.S. Congress, House, Hearings Before the Committee on Interstate and Foreign Commerce, 67th Cong., 1st sess., p. 68.

[3]Statement of Mrs. Elizabeth Tilton before the Massachusetts General Assembly at hearings on the Sheppard-Towner Bill, January 23, 1922, in Elizabeth

Why ample funds to livestock industries to prevent diseases, yet tugging and pleading to get stingy stipends for the health of women and children? This question, of course, goes beyond the topic at issue, and becomes symbolic of the dilemma of American reform.

S. Josephine Baker attributed the national discrepancy in health to uneven income distribution. New York City, with all of its congestion and its variegated population, had managed to reduce its maternal mortality rate to the lowest of any metropolitan area in the nation. Nationally, women and children died needlessly, merely from the lack of organizational effort and dearth of funds.[1] Edward S. McGrady, National Legislative Representative of the American Federation of Labor, assured the House Committee that lest there be any reservation that the bill was solely a measure for women, it was as much a man's:

> I do not suppose that there is any class in the world where the . . . husband and wife are closer together and have more in common than is the wage earner and his wife. They go through all kinds of trials and tribulations together, not very far removed from the poor house many times. She goes hungry when he does not work, and if

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Tilton Papers, Radcliffe Institute, Schlesinger Library, Manuscript Collection, Box 1, Folder 17.

[1]U.S., Congress, House, Hearings Before the Committee on Interstate and Foreign Commerce, 67th Cong., 1st sess., statement of S. Josephine Baker, pp. 9, 13.

> anything happens to her it means disaster to him. . . . We know that too often amongst the poorly paid workers the women are prone to die in childbirth, and we know that in a great many cases the children are liable to die before the first year. . . . We have hoped . . . for the passage of this kind of bill that might help the American worker.[1]

None of this argument or rhetoric moved the medical profession. At the House hearings, state medical societies voiced medical opposition. Dr. George W. Kosmak, the most influential physician to testify against the bill, claimed to have only one objection. Indeed, he was more than willing to concede the need for equitable distribution of maternity and infant health care, and he did not minimize American mortality statistics. What troubled him, he insisted, was that the bill portended lay usurpation of medical authority. He deplored the bill's directing powers in the hands of the Children's Bureau, a "department . . . which has shown itself extremely partial to labor as an entity, which furthered . . . class consciousness." The measure, he claimed, would subordinate medical therapy to sociological experimentation. Physicians would be subjugated to the likes of social workers and visiting nurses.[2]

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[1]Ibid., statement of Edward S. McGrady, p. 58.

[2]Letter to the editor, George W. Kosmak, "The Sheppard-Towner Bill," JAMA 76 (May 7, 1921):1319. Also

Speaking before the Winslow Committee in defense of the American Gynecological Society's resolution against the Sheppard-Towner bill, Kosmak said:

> We feel . . . that turning over such important matters into the hands of what we . . . consider lay people, will act to the discredit of the medical profession and also as a bar to its development. . . . [Today] there are scarcely 150,000 physicians. If by legislative enactment you are going to turn over an important part of their work into the hands of nurses . . . you will at once interpose a stumbling block to the progress of medicine, because young men will not compete under those circumstances with trained nurses.[1]

Dr. Charles E. Humiston, president of the Illinois State Medical Society, and Dr. Charles E. Morgan, representing the Somerville, Massachusetts Medical Society, endorsed Kosmak's reactions.[2] The Kosmak issue became a matter of debate when some witnesses suggested amending the bill so that the Public Health Service would administer the program. Yet the measure remained essentially unchanged, as women defended the Children's Bureau's direction, insisting that the agency had earned their confidence.[3]

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see letter to the editor, George W. Kosmak, "Sheppard-Towner Bill," New York Times, 5 August 1921, n.p.

[1]U.S., Congress, House, Hearings Before the Committee on Interstate and Foreign Commerce, 67th Cong., 1st sess., statement of George W. Kosmak, p. 100.

[2]Ibid., pp. 82, 88, 115-16.

[3]Ibid., statement of Mrs. Maud Wood Park, president of the League of Women Voters, p. 256.

The Committee resolved the issue by leaving daily administration to the Children's Bureau while superimposing a Federal Board, consisting of the chief of the Children's Bureau, the Surgeon General of the United States, and the United States Commissioner of Education, with power to approve or veto any state plan. The Winslow Committee at long last reported the measure to the House favorably.

> It is a startling and a disgraceful fact that in this enlightened age and in this prosperous country more women between the ages of 14 and 45 lose their lives from conditions connected with childbirth than from any other cause except tuberculosis. . . . It is practically certain that 25,000 mothers will lose their lives from causes arising out of motherhood, although we know that at least one-half of these could be saved by advice, care, and timely help.[1]

On November 19, 1921, the House passed the Sheppard-Towner Act by a vote of 279 to 39, with 113 abstentions. The Senate passed the House-amended bill on November 23, 1921, and Harding signed it into law the same day.[2]

On February 5, 1921, the Journal of the American Medical Association railed editorially against the Act.

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[1]U.S., Congress, House, Hearings Before the Committee on Interstate and Foreign Commerce, 66th Cong., 3rd sess., p. 6, see also p. 4.

[2]Chepaitis, The First Social Welfare Measure, pp. 66, 73.

At its convention in 1922, the AMA officially disapproved of the legislation. Thenceforth, editorials discredited federal involvement in public health, urging delegation of such matters to local and state governments instead. The Journal belittled the apparent panic over the United States' mortality standing among leading foreign countries, questioning the validity of the statistics. Finally, and without providing substitute methods, it derogated the form of the Act with claims that it would not adequately meet needs.[1]

The American Medical Association, founded in 1847 to stymie what doctors saw as unhealthy competition among themselves, had joined with government through the early twentieth century to standardize medical practice. The AMA needed the government to establish uniform training criteria and state licensing. While it did not approve of the anarchy within the discipline, the first threats to superimpose control (i.e., the compulsory health insurance plan) turned the Association away from the central government. The AMA position against the Sheppard-Towner Act continued through the twenties, became stronger when the Act's sponsors sought an extension,

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[1]Editorial, "The Sheppard-Towner Bill," JAMA 76 (May 28, 1921):1504.

and finally peaked successfully to kill the law.[1] The AMA continued to read the Act as the "crowning effort" of the government "for federal supervision of child-bearing."[2]

Although the arguments opposing the Sheppard-Towner Act prophesized the doom of the social order's fabric and integrity, the Act had benign effects. Unlike health insurance, which theoretically meant income redistribution, albeit minimal, the Sheppard-Towner Act never touched upon American income structure or its medical substructure. The Act did not provide for substitute free care in the form of hospitals or clinics, and never challenged the fee-for-service principle of American medicine. It embodied the earliest tenet of the public health movement; that is, the notion that wider

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[1]James J. Walsh, History of Medicine in New York. Three Centuries of Medical Progress, 5 vols. (New York: National Americana Society, 1919), 1:162; Lemons, Woman Citizen; James G. Burrow, AMA: A Voice of American Medicine (Baltimore: The Johns Hopkins Press, 1963), pp. 162-63, 394-95. While Burrow sees the AMA's departure from progressivism in the 1920s as somewhat of an abberation, in that the Association had worked for pure food and drugs, vital statistics legislation, and a national department of health, in reality the Association's stance in the 1920s is not so startling. The organization never supported a reform cause which was not directly in its interests. It never supported the movement for workmen's compensation. It had no interest in labor legislation, and it ignored the drive to protect women industrial workers.

[2]"Still Harping on the Federal Maternity Law," JAMA 79 (November 18, 1922):1788-89.

dissemination of knowledge would narrow the cleavage between the haves and the have-nots. The Children's Bureau explained the limited scope of the Act:

> The maternity and infancy act makes possible a type of work which is thoroughly in agreement with the fundamental American principle of providing education for the people. . . . The types of work undertaken in the states are quite uniformly educational.

The Bureau's 1927 fiscal report described the Act simply as a "logical extension of the American principle of providing free public education for the people."[1]

Work in the states actually initiated through Sheppard-Towner funds fell into three general categories: first, individual clinical instruction to mothers to care for themselves during pregnancy and their children (doctors, nurses, and visiting nurses gave instruction at itinerant health conferences, permanent health centers, and in home visits); next, group instruction via lectures, films, exhibits, and classes for adolescent girls, teachers, midwives, nurses, and physicians; and third, distribution of educative literature. Kosmak's fears

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[1]Children's Bureau, The Promotion of the Welfare and Hygiene of Maternity and Infancy, the Administration of the Act, 1926, p. 6; U.S., Department of Labor, Children's Bureau, The Promotion of the Welfare and Hygiene of Maternity and Infancy. The Administration of the Act of Congress of November 23, 1921, for the Fiscal Year ended June 30, 1927, Publication No. 186 (Washington, D.C.: Government Printing Office, 1928), p. 4.

that social workers would subordinate physicians proved unfounded as the personnel involved consisted predominantly of doctors, nurses, dentists, dental hygienists, nutritionists, and statisticians.[1]

The Act aimed primarily to create greater demand for services; it provided no medical care except for health consultations in which defects might be discovered. The correction of the defects fell without the Act's scope; workers simply urged treatment, with follow-up nurses' visits, in the hope that concerned pressure would impel medical solution. In its mandatory annual assessment of the work under the Act, the Children's Bureau reassured Congress that conference work

> . . . is not a clinic for sick children nor an obstetric clinic but an opportunity for the mother to have explained to her how to keep her baby and herself well by using intelligently the available medical service and also by improving the home care she gives to her children and herself.[2]

Many states employed federal monies to offer graduate courses for obstetricians and pediatricians, in order to keep them abreast of the latest techniques.[3]

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[1]Children's Bureau, The Promotion of the Welfare and Hygiene of Maternity and Infancy, the Administration of the Act, 1926, p. 6.

[2]Children's Bureau, The Promotion of the Welfare and Hygiene of Maternity and Infancy, the Administration of the Act, 1927, p. 6.

[3]U.S., Department of Labor, Children's Bureau,

States also used funds to stimulate additional public health nursing, but in no state did the Act's appropriations challenge the domain of the private physician. If anything, the grants encouraged more people to trust medicine.

In spite of the long and often hostile Congressional history, the states received Sheppard-Towner benefits gratefully. By the end of fiscal year 1927, only three states (Connecticut, Illinois and Massachusetts) had refused federal grants. Within a year of the law's enactment, forty-one state legislatures passed enabling statutes to permit their states' participation. While some states could receive no more than the $5,000.00 initial no-strings grant, states increasingly put up money to be matched by federal appropriations. In 1926, the Act's sponsors persuaded the 68th Congress to allow the Territory of Hawaii to avail itself of the law's benefits.[1]

The Promotion of the Welfare and Hygiene of Maternity and Infancy. The Administration of the Act of Congress of November 23, 1921, for the Period March 20, 1922 to June 30, 1923, Publication No. 127 (Washington, D.C.: Government Printing Office, 1924), pp. 32-33; see also Children's Bureau, The Promotion of the Welfare and Hygiene of Maternity and Infancy, the Administration of the Act, 1926, pp. 7-20.

[1]Ibid., p. 1; Chepaitis, The First Social Welfare Measure, pp. 161-62, 164.

New York State did not participate in the federal-state maternity program in the early stages. The Legislature, prompted by Republican Governor Nathan Miller, who was staunchly opposed to Sheppard-Towner, refused to join the program. Women in New York State did not overlook Miller's approval of a bill granting $125,000 for the state fairgrounds to construct a hog barn and his rejection of the federal-state arrangement for women's and children's health on the basis of fiscal irresponsibility.[1] While Miller persisted, intractable, the Legislature listened to women's demands. To assuage women, legislators argued that the state could do as well alone. In 1922, New York State established, through the Davenport-Moore Act, a Division of Maternity, Infancy and Child Hygiene to replace the Division of Child Hygiene. Appropriations for preventive health work rose from $30,000 to to $130,000, and now included the protection of motherhood. With this money, the State Department of Health hoped to stimulate local communities to form maternal and child health programs, with the assistance of state-employed personnel sent "on loan" to local regions to plan projects, rather than through monetary contributions.[2]

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[1]Lemons, Woman Citizen, p. 170.

[2]Anne E. Rude, "The Sheppard-Towner Act in Relation to Public Health," JAMA 79 (September 16, 1922):959;

Women's insistence, however, did not abate with the Davenport-Moore Act, which essentially gave nothing to counties but outside encouragement. After Al Smith ousted Miller in the election of November 1922, the New York Legislature, with Smith's prodding, accepted the Sheppard-Towner Act in 1923. With matching monies, midwife supervision reached new heights in New York State.[1]

Although both Connecticut and Illinois refused federal cooperation and aid, each had established state machinery for maternal and child health. These state agencies, while operating on lower budgets than would have been available with Sheppard-Towner funds, still recognized that this field of preventive health demanded a special state apparatus. In Massachusetts, however, where local politicians opposed the Sheppard-Towner Act on the grounds that it violated the Tenth Amendment, no such state provision obtained.

The only two legal challenges to the law involved Massachusetts. In one, Massachusetts v. Mellon,

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Florence L. McKay, "New York State Program for Maternal and Child Hygiene," Medical Woman's Journal 30 (January 1923):10-11.

[1]See Elizabeth M. Gardiner, "Maternity and Infancy Work in New York State," Medical Woman's Journal 34 (March 1927):72-74; Children's Bureau, The Administration of the Act, 1926, pp. 55-57; U.S., Congress, House, Hearings Before the Committee on Interstate and Foreign Commerce, 67th Cong., 1st sess., pp. 43-46.

Massachusetts taxpayers sued the Secretary of the Treasury. Harriet Frothingham, president of the Woman Patriots, filed the second, Frothingham v. Mellon. On June 5, 1923, the Supreme Court threw out both actions on technical jurisdictional questions which did not reach the constitutionality of the Sheppard-Towner Act. Notwithstanding the Supreme Court's disclaimer, observers saw the cases as an admission of the constitutionality of the principle of grants-in-aid.[1] Ironically, as the Children's Bureau reported, in Massachusetts at the time of the suits:

> The [Massachusetts] State department of agriculture was receiving Federal funds which were classified under the following heads: white-pine rust, European corn borer, marketing work, soil survey; the State department of conservation under the following: Suppression of gypsy and brown-tailed moths, prevention of forest fires; the State department of education for vocational education and vocational rehabilitation education; the State Agricultural College under Morrill Funds and under the Adams, Nelson and Smith-Lever Acts; the State nautical school, the division of highways and the State militia also accepted Federal subsidies.[2]

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[1] "The Sheppard-Towner Act," Medical Woman's Journal 30 (March 1923):93; Chepaitis, The First Social Welfare Measure, pp. 1, 180, 203, 214; Children's Bureau, The Administration of the Act, 1922-1923, pp. 38-39. At the least, the decisions represent a legal stand-off, since they have the effect of precluding state challenges and federal taxpayers suits against federal grants-in-aid. 262 U.S. 447 (1923)

[2] Children's Bureau, Administration of the Act, 1922-1923, p. 38.

While Congress had designated the Sheppard-Towner Act as permanent legislation, its terms provided that funding after June 30, 1927 would depend upon Congressional decision. Hence, the Children's Bureau reported Sheppard-Towner accomplishments in each annual report, as much to enhance future funding possibilities as for any other reason.

The birth registration area had widened significantly, and the expansion yielded increased mortality statistics, primarily because newly included states tended to have large black populations. Comparison, however, of the birth registration area of 1922 with the same geography in 1927 showed a reduction of infant mortality from seventy-six deaths of infants under one year per thousand live births to sixty-five in 1927. Between 1922 and 1927, 24,500 babies, who would have otherwise died in 1922, survived.[1] Even more significant was the reduction in black infant mortality in the years in which the Act operated:

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[1]Children's Bureau, The Administration of the Act, 1927, p. 41; U.S., Department of Labor, Children's Bureau, The Promotion of the Welfare and Hygiene of Maternity and Infancy. The Administration of the Act of Congress of November 23, 1921, for the Fiscal Year ended June 30, 1928, Publication No. 194 (Washington, D.C.: Government Printing Office, 1929), p. 31; U.S., Congress, House, Report No. 2751 on the Extension of the Maternity and Infancy Act, Submitted by Mr. Newton, from the Committee on Interstate and Foreign Commerce, February 26, 1929, 70th Cong., 2d sess.

> A comparison of infant mortality rates in the expanding birth-registration area for white and colored babies shows a reduction among both groups in 1927 as compared with 1922. The rate for the area as a whole was 73 for white babies in 1922 and 61 in 1927. For colored babies the rate was 110 in 1922 and 100 in 1927.[1]

Likewise, new efforts reduced maternal mortality from 66.4 deaths of mothers from puerperal causes per 10,000 live births in 1922 to 64.7 in 1927; the rural rate fell from 59.5 in 1922 to 55.3 in 1927. Curiously, while deaths from puerperal albuminuria and convulsions dropped markedly, the data reflected no progress toward reduction in deaths from septicemia.[2]

The Children's Bureau sought to demonstrate the program's success through the states' voluntary receptivity to the Act. Between 1922 and 1923, states substantially increased their appropriations for the Act. In fiscal year 1922, fifteen states qualified to receive the minimum of $5,000 in unmatched federal funds. In 1923, six states were limited to outright $5,000 grants. Yet by 1924, all of the states participating in the Sheppard-Towner plan had allocated state funds to be matched with additional federal monies.[3]

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[1]Children's Bureau, The Administration of the Act, 1928, p. 31.

[2]Ibid., pp. 32-33.

[3]Children's Bureau, The Administration of the Act,

The outlay in state appropriations, supported by the federal government at least up to $5,000, led to the growth of prenatal and child-health conferences and permanent centers. In 1923-1924, the states reported 6,088 prenatal conferences with a total attendance of 38,662 women. During the five-year period July 1, 1923 to June 30, 1928, sponsors conducted a total of 119,000 prenatal and child-health conferences, leading to the establishment of 2,700 permanent centers. Visiting nurses made 2,500,000 home visits which included individual instruction of the mother. In the one-year period from July 1924 to July 1925, workers gave 5,500 classes for mothers and 4,200 classes for midwives under the Act. They distributed about sixteen million pieces of literature. In a three-year period alone, between July 1, 1925 and June 30, 1928, health personnel reached 500,000 women and approximately 3,000,000 infants and preschool children.[1]

1922-1923, p. 32; Children's Bureau, The Administration of the Act, 1928, p. 31.

[1]U.S., Department of Labor, Children's Bureau, The Promotion of the Welfare and Hygiene of Maternity and Infancy, The Administration of the Act of Congress of November 23, 1921, for the Fiscal Year ended June 30, 1924, Publication No. 146 (Washington, D.C.: Government Printing Office, 1925), p. 9; U.S., Congress, House, Report., 70th Cong., 2d sess., 1929, pp. 2-3.

The Children's Bureau concluded its 1927 report, satisfied that the states' integrity and independence had not been jeopardized. The writer found it impossible to typify services under the act:

> These have varied with climatic conditions, geographical barriers and means of communication, economic condition, race, nativity, and density of population, availability of medical and nursing service, and the existing local child-health activities.[1]

Although the Children's Bureau did not identify the point, one important result nonetheless emerges in retrospect. The new public health services funded by additional federal appropriations worked to open health services to the states' minorities. In the Northeast, the funds served new immigrants; Southwestern states concentrated as never before on the Spanish-speaking population; Minnesota initiated health work with the Chippewa Indians, including training Chippewa women for nursing careers; and in the South, probably for the first time since Reconstruction, states spent public monies on the welfare of blacks.

Organized women physicians remained stalwart supporters of the Act. As debate over refunding resumed, the Medical Woman's Journal ran a series of articles in 1926 and 1927 detailing the progress in maternity and

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[1]Children's Bureau, The Administration of the Act, 1927, p. 4.

infant hygiene in the individual states accepting Sheppard-Towner matching subsidies. The articles, by state directors of Sheppard-Towner programs, support the contention that the Act's most notable achievement was its grass-roots contact with the poor, with whom the states' health apparatus had little prior contact.

The state child welfare chiefs in Virginia, South Dakota, and Kentucky reported that before Sheppard-Towner monies became available, their states had no involvement at all in the areas of maternal and child health. Mary E. Brydon, director of the Child Welfare Bureau in Richmond, Virginia, revealed that in most counties courses in prenatal care (and the care itself) did not exist before 1922; by 1927, even midwives led prenatal programs. Brydon pointed proudly to a decline in puerperal septicemia rates from 6.0 in 1922 to 4.6 in 1925.[1]

In Kentucky, where before 1922 no state program provided preventive health activities geared toward the mother and infant, workers peformed 35,152 examinations of infants and children under 6 between 1922 and 1925; 8,555 expectant mothers received instruction; staff

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[1]Mary E. Brydon, "Virginia's Maternity and Infancy Program," Medical Woman's Journal 34 (July 1927): 207; see also Clara E. Hayes, "Sheppard-Towner Work in South Dakota," Medical Woman's Journal 34 (May 1927):145; Annie S. Veech, "Summary of Three and One-Half Years' Work in Kentucky, July 1, 1922 to January 1, 1926," Medical Woman's Journal 33 (November 1926):38.

members delivered 2,274 child health and maternity lectures before 99,688 people; the program reached 300,000 school children through school health education work; mothers' and midwives' classes totaled 93 and 96 respectively; and the state established 182 permanent child health centers.[1]

In states which already boasted programs in maternal and infant welfare work, the Act permitted the extension of services into rural sections where they had been absent.[2] Sheppard-Towner's boost to birth registration itself provided a mechanism for preventive medicine, as states began sending health materials to parents upon the birth of a child. Often agencies sent a new pamphlet each month until the child reached age one.[3]

Workers in the South accomplished their most innovative work among blacks. Margaret Koenig, head of

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[1]Veech, "Summary of Work in Kentucky," p. 318.

[2]Mary R. Noble, "Sheppard-Towner Work in Pennsylvania," Medical Woman's Journal 34 (January 1927):16; E. H. Lauer, "The Operation of the Sheppard-Towner Act in Iowa," Medical Woman's Journal 33 (September 1926):266; Cora S. Allen, "Resume of Work in Wisconsin Under the Sheppard-Towner Act," Medical Woman's Journal 33 (August 1926):234.

[3]Ellen M. Crough, "Child Hygiene Program Made Possible by The Sheppard-Towner Act, New Hampshire," Medical Women's Journal 34 (February 1927):46; Lillian R. Smith, "Activities in Michigan Under the Federal Maternity and Infancy Act," Medical Woman's Journal 33 (October 1926):294-5.

the Arkansas Bureau of Child Hygiene (established in 1922, only when the state accepted Sheppard-Towner cooperation), asserted that the supervision of midwives was the state's greatest achievement since joining the federal government in maternity work.[1] In the South, focus upon the midwife was synonymous with attention to black women and children.

In Alabama, work to control midwives began first with Sheppard-Towner matching grants. The state program director listed the two key areas of emphasis: bringing health instruction to "the negro race" and improving birth registration. It was one thing when the Children's Bureau showed concern for black mortality, yet quite another when a southern official recognized with sympathy that "the hazards of motherhood are almost twice as heavy among the colored as among white women."[2]

Mississippi also turned new ground in midwife control. Its state health director made the midwife problem the primary target.[3] In South Carolina, 6,000 black

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[1]Margaret W. Koenig, "Maternal and Child Hygiene in Arkansas," Medical Woman's Journal 34 (May 1927): 143.

[2]Jessie L. Marringer, "Survey of Work in States Functioning Under the Sheppard-Towner Act: Alabama's Maternal and Infant Hygiene Program," Medical Woman's Journal 33 (July 1926):198.

[3]F. J. Underwood, "The Development of Midwifery in Mississippi," Medical Woman's Journal 33 (December 1926):345.

women practiced midwifery, delivering 50 percent of the babies born; broken down, midwife deliveries constituted 80 percent of the black births and 20 percent of white births. The director attributed the state's record low infant mortality rate (91.4 in 1925) to the enforcement of strict licensing and instruction of midwives. Nonetheless, the state's rate stood notably above the national average, a situation largely the result of the black infant death rate. It became the admitted goal of the state maternity bureau to achieve a better standing through heightened educational work with midwives and the establishment of more prenatal clinics for blacks.[1]

Georgia also had six thousand practicing black midwives, who attended a third of the state's births:

> We can judge of the results of this condition by the fact that annually 4,000 babies were born dead, and that an equal number die the first year of life. Last year 500 mothers made the supreme sacrifice while giving birth to these babies.

With Sheppard-Towner funds (the Georgia state director admitted frankly that if the money were withdrawn, the state could not finance the work alone), midwives and state authorities worked together, with the state government distributing silver nitrate without charge to all

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[1]Ada T. Graham, "South Carolina and the Sheppard-Towner Act," Medical Woman's Journal 34 (January 1927): 8.

certified midwives. Since the Sheppard-Towner Act, four thousand midwives had become duly licensed. The state employed black nurses, and in areas where the state recorded vital statistics accurately, black infant mortality fell 52 percent between 1923 and 1927.[1]

States which offered little in the way of preventive health services for women and children before 1922 increased their annual monetary outlays. Between 1921 and 1925, state expenditures increased from $13,050 to $23,098 in Alabama, from $2,750 to $7,253 in Arizona, and from nothing in Arkansas and Colorado to $8,500 and $5,000 respectively. Similarly, Georgia, which spent $6,664.51 in 1921, disbursed $23,490 in 1925 with the impetus from the federal government. The upgrading in health expenditures went from $14,983 in 1921 to $20,000 in 1925 in Indiana, and from nothing in 1921 to $21,213 in 1925 in Iowa.[2]

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[1]Alva Givin, "Sheppard-Towner Work in Georgia," Medical Woman's Journal 34 (March 1927):78-79. See also the description of work with blacks in North Carolina and Louisiana in H. A. Taylor, "Activities of Maternity and Infancy Bureau in North Carolina," Medical Woman's Journal 34 (May 1927):146; Agnes Morris, "Louisiana's Problems in Maternity and Infancy Work," Medical Woman's Journal 34 (February 1927):47. In Pennsylvania the new work with midwives had principal effect in the state's anthracite and soft coal regions, previously ignored by health workers. See Noble, "Sheppard-Towner Work in Pennsylvania," p. 17.

[2]U.S., Congress, House, Hearings Before the

Moreover, the Sheppard-Towner Act benefited female physicians substantially. In 1927, Sheppard-Towner funds employed forty full-time and three part-time women doctors. Women physicians assumed the directorship of sixteen state administrative agencies.[1]

With the varied accomplishments before them, proponents of the Act (scheduled to lose its funding on June 30, 1927) decided to move for renewal authorization a year earlier, in 1926. Upon the recommendation of the Secretary of Labor, the Act's sponsors proposed to Congress that appropriations equal to the amount first authorized be continued for fiscal years 1928 and 1929. The proposal went before the Senate Committee on Education and Labor and the House Committee on Interstate and Foreign Commerce. In order to justify the renewal, the Children's Bureau urged that five years was simply too brief a period in which to implement the programs firmly and permanently.

> To discontinue cooperation now would result in loss of time and money spent in preliminary work. Some states had no child-health work under the State's government before this Act was passed. Foundation work has been completed

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Committee on Interstate and Foreign Commerce, 69th Cong., 1st sess., 1926, testimony of Grace Abbott, p. 11.

[1]Quarterly Bulletin of the Medical Woman's National Association (July 1927):21.

> in nearly all the States, so that actual developments on a state-wide scale will soon be under way.[1]

The old battle lines formed again. The Journal of the American Medical Association warned that

> . . . the greatest pressure yet brought to bear on legislation by women is predicted to occur at the next session of Congress, when practically every major woman's organization will support the reenactment of the Sheppard-Towner Act. More than four million women, it is reported, will mobilize in this drive under the leadership of the General Federation of Women's Clubs, The National League of Women's Voters and other women's organizations."[2]

The Journal was correct. Women were again ready to fight for the Act's life. Popular women's magazines enlisted journalists to stir female action. A reporter for Good Housekeeping maintained that while pioneer conditions had been modified in practically every realm of American life, the old ways still persisted in obstetrics, where thousands of women sacrificed their lives to the doctrine of self-sufficiency.[3] Proponents asked women to organize and lobby anew.

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[1]Children's Bureau, The Administration of the Act. 1926, pp. 82-83.

[2]"Four Million Women to Push Maternity Act," JAMA 87 (October 30, 1926):1488; Editorial, "Re-enactment of the Sheppard-Towner Act," Medical Women's Journal 33 (November 1926):327.

[3]K. Glover, "Making America Safe for Mothers," Good Housekeeping 82 (May 1926):98, 270, 273-74.

Testifying before the House Committee in the 69th Congress, Grace Abbott, Chief of the Children's Bureau, called the Act a success to the extent that it initiated programs on a scale never before seen in the United States. The Act's acceptance by many states otherwise involved in protecting themselves from federal encroachment demonstrated mothers' desires for health information. Yet in spite of the United States' gains, Abbott maintained, medical benefits remained too widely diffused. In the areas of infant and maternal mortality, the United States still ranked behind Australia, Canada, Denmark, England and Wales, Germany, Norway, Switzerland, and Sweden. If the states of Minnesota, Washington, and Oregon could lower their infant mortality rates to sixty, well below the national average of seventy-three, there was no reason why every state could not be capable of the same.[1]

Ms. Abbott held no illusions. A two-year extension would not be sufficient. Yet she supported the recommendation of the President and the Secretary of Labor in the hope that the achievements of the next two

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[1]U.S., Congress, House, Hearings Before the Committee on Interstate and Foreign Commerce, 69th Cong., 1st sess., 1926, pp. 8-9, 11-12, 52, 55-56; U.S., Congress, House, Report from the Committee on Interstate and Foreign Commerce, 70th Cong., 2d sess., 1929, pp. 13, 16; Children's Bureau, The Administration of the Act, 1926, p. 83.

years would speak for themselves. She was wrong.

Representatives of Massachusetts surfaced once again in opposition to the extension. Mrs. Frances E. Slattery, President of the League of Catholic Women of Boston, saw all that was antithetical to America in federal aid to maternity and infancy. The Act followed "pagan philosophy"--child robbery. When asked if she doubted the privilege of the Commonwealth of Massachusetts to receive federal assistance for road construction, she answered in the negative: "Is it not specified in the Constitution some place that the Government may do that sort of thing?"[1]

Thomas F. Cadwalader, a member of the Sentinels of the Republic, wondered where the self-reliance of the nation's original settlers had gone. "They had no public health nurses or doctors to look after them." Yet they created the great nation. If anyone needed any intervention in health, he considered it a function of local charity. As to his view if local aid could not meet the demand, he asserted that it was a community and not a national problem. Asked then to bring his thinking to a personal level, whether he could easily

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[1]U.S., Congress, House, Hearings Before the Committee on Interstate and Foreign Commerce, 69th Cong., 1st sess., pp. 21-24, colloquy between Mrs. Slattery and Representative Newton.

countenance a child's suffering, he answered: "There are a great many sufferings that have to occur in this world by the nature of things that cannot be remedied by anything." When asked if he extended his theory to arid lands capable of irrigation only through the efforts of the federal government, he claimed ignorance. His examiner persisted: "So you could have those lands lie out there waste without the ability of man to cultivate them because the State in which they might be located could not irrigate them?" Cadwalader did not reply.[1]

In spite of opposition testimony before the House Committee, the full House was more amenable during this round in the debate than in 1920 and 1921. On January 13, 1927, the extension bill passed by 218 to 44.

The AMA remained determined that the Sheppard-Towner Act not become permanent. William C. Woodward, executive secretary of the Bureau of Legal Medicine and Legislation of the Association, claimed that the move to extend the Act for two years was part of the effort to make the measure a fixture of American law. Once created, the argument went, a bureaucracy seeks its own self-perpetuation. Congress ignored the AMA's warnings in 1921, and this was the inevitable result. Therefore, he

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[1]Ibid., pp. 41-42. Representatives Shalenberg and Barkley questioned Cadwalader.

insisted, the law must be stopped now. Woodward questioned the value of the Sheppard-Towner clinics and conferences whose existence, he maintained, did not constitute any real achievement. Furthermore, he contended, the federal government was no more equipped to lead educational activities than the states. Finally, Woodward sought to discredit international statistics which placed the United States so poorly in the mortality contest. Even if rates were as bad as the emotional Sheppard-Towner advocates insisted, and he doubted that strongly, he found no justification for federal intervention. It served no purpose.[1]

The Journal of the American Medical Association recited the farrago of examples of bureaucratic paternalism which would follow the Act's renewal. It accused the Children's Bureau of diverting funds from mothers and infants for the use of older children. It charged that women shunned real facts to allow themselves to become victims of "emotional appeals on behalf of mothers and babies." It claimed that the Sheppard-Towner Act represented a threat to the entire system of government, an attempt of the federal government to "buy off the

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[1]William C. Woodward, Further Fallacies of the Sheppard-Towner Propaganda (Chicago: AMA, 1926), pp. 1-4.

states."[1] Mrs. William Lowell Putnam agreed with the AMA. Maternity care was not a question of social policy, she said, but a medical issue, "pure and simple." In its absurdity, her argument ironically brought her to the same position as her opponents. She wrote, tautologically: "There are practically no more maternal deaths in childbirth among poor women than there are among rich women, so long as they get equally good medical care."[2]

American medicine revealed itself in the fact that the medical elite, embodied by the AMA, felt so free to disregard and lampoon the opinions of millions of women. In archetypical arrogance, the AMA's stance essentially denied women the right to make, and doctors the obligation to listen, to medical statements concerning their babies, their pregnancies, and their lives.

The Senate Committee sought to circumvent the two-year extension with a proposal for a one-year funding

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[1]Editorial, "The Perpetuation of the Sheppard-Towner Idea," JAMA 87 (November 27, 1926):1833; Editorial, "Protest the Sheppard-Towner Act," JAMA 89 (February 6, 1926):421; Editorial, "Again, Protest the Sheppard-Towner Act," JAMA 86 (May 8, 1926):1458; "Sheppard-Towner Bill Side-tracked," JAMA 87 (July 3, 1926):41; "Women's Clubs Urge Extension of the Sheppard-Towner Act," JAMA 87 (December 11, 1926):2008.

[1]Speech by Mrs. William L. Putnam, "Why the Appropriations for the Extension of the Sheppard-Towner Act Should Not Be Granted," 1926, in Alexander Lincoln Papers, Folder 10, Manuscript Collection, Radcliffe Institute, Schlesinger Library.

grant. Finally, legislators compromised on a two-year extension which carried an automatic repealer on June 30, 1929. On January 13, 1927, the Senate passed the measure and on January 19, the House accepted the compromise version. President Coolidge signed the bill on January 22.

It took little prescience for the AMA to interpret the congressional action as "a victory for the opponents of this legislation." By 1926, the Act's enemies found themselves firmly grounded, as women's vote turned out merely to be a numerical ingredient, divided on party lines. The progressives in Congress had dwindled, and Coolidge's leadership carried none of the equivocal liberalism of Harding's. While Coolidge recommended to Congress that the two-year extension be passed, he made clear his sympathy that this prolongation be synonymous with termination, and his hope that the future would see a "gradual withdrawal of the federal government from this field." Ironically, in 1926, the federal government spent a total of $1,108,000 on maternal and infant health through the Sheppard-Towner Act, at the same time spending $75,000,000 for roads and $5,000,000 for agricultural assistance.[1]

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[1]"Senate Extends Sheppard-Towner Act with Amendment," JAMA 88 (January 22, 1927):253-54; Coolidge quoted in Editorial, "The President and the Sheppard-Towner Act," JAMA 87 (December 18, 1926):2097; Lemons, Woman Citizen, 174.

On June 30, 1929, federal financing for the health of mothers and infants terminated. Although the State of Georgia requested that unexpended Sheppard-Towner funds be left to the states, United States Comptroller General McCarl ordered that the unused balance be returned to the Treasury. With undisguised glee, the Journal of the American Medical Association reported that "the effect of this decision will be to shut off . . . all federal money for this work, both at Washington and through the country."[1]

Feminists and progressives did not leave the Sheppard-Towner Act to die alone, without attempts to continue its essence. Mary W. Taylor, of the Elizabeth McCormick Memorial Fund in Chicago, warned of the gap which the withdrawal of federal funds would leave in rural states, where many counties lacked even a lone physician. Federal money was necessary to bring local physicians up to date on medical advances with post-graduate courses in obstetrics and pediatrics. Taylor reported that

> many states tell us that they will be forced to practically discontinue the activities if federal aid is discontinued. Almost every

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[1]"Decision on Sheppard-Towner Act," JAMA 90 (May 19, 1928):1636.

> state says that it will mean serious loss if they have to continue individually rather than as a part of a national program.[1]

With the hope that Congress would react more tractably to the maternity measures before it, Alfred E. Smith appealed in the Ladies' Home Journal to the pragmatic, rather than the "emotional," instincts of members. He reminded congressmen of the embarrassing results of the World War I draft:

> Thousands of men passed into review before these boards for physical, mental and moral judgment of their fitness for service. The physical examination of these young men between the ages of 21 and 30 revealed a startling condition. In New York State alone considerably more than 30 percent of the youth and flower of manhood were physically unfit to fight.[2]

Representative Walter H. Newton of Minnesota initiated the first attempt to attenuate the expiration of the Sheppard-Towner Act. In May 1928, he introduced the Newton bill, a plan to appropriate $1,000,000 a year to the Children's Bureau to foster child welfare services in the states. The Journal of the American Medical Association editorialized vehemently, calling the Newton bill even more radical than the Sheppard-Towner since it

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[1]Mary W. Taylor, "Applying a Maternity and Infancy Program to Rural Sections," Proceedings of the National Conference of Social Work, 55th Annual Session: Memphis, Tennessee, May 2-9, 1928, pp. 211-12.

[2]Alfred E. Smith, "Safeguarding our Assets--the Children," Ladies' Home Journal 46 (October 1929):3.

made federal appropriations permanent and not dependent upon state acceptance or matching ability. Under the bill, need rather than population determined the quantum of aid. On November 2, 1928, the AMA Board of Trustees recommended to the House of Delegates the passage of a resolution authorizing the Bureau of Legal Medicine and Legislation to fight the enactment of the Newton bill.

Kosmak's opposition to the Newton bill was less hesitant than his resistance to Sheppard-Towner. He mocked the advocates' emotional use of mortality statistics. The decision to legislate medicine threatened democracy insidiously; it meant "the transformation of a nation of individualists into a nation of collectivists, and a final resort to law to overcome what cannot readily or quickly enough be done by persuasion or instruction."[1] The Newton bill died in committee in March 1929.

On April 18, 1928, Senator Wesley L. Jones and Representative John G. Cooper, Republicans from Washington and Ohio, introduced companion bills to renew the Sheppard-Towner concept. The measure proposed that each

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[1]Editorial, "The Attempt to Perpetuate the Sheppard-Towner Act," JAMA (December 1, 1928):1721; "The Sheppard-Towner Maternity Act," JAMA 92 (June 1, 1929): 1852; Letter to the Editor, George W. Kosmak, "The Newton Bill for the Children's Bureau," JAMA 92 (January 5, 1929):74; Taylor, The Medical Profession and Social Reform (New York: St. Marten's Press, 1974), p. 109.

state receive $15,000 outright, from an appropriation of $1,000,000. The state grant had to be matched in full, as the unmatched federal donation had been withdrawn. The bill carried no time limitation.

The Medical Women's National Association again asked women to coalesce around the bill. Elizabeth Tilton, of the National Congress of Mothers and Parent-Teachers Associations, wrote to the organization's state presidents, seeking grass-roots support of the Jones-Cooper bill: "Please write your Senators and Congressmen a short letter, giving the name of the bill and urging its report out of committee and its passage." As vigorously as women supported the bill, the AMA fought it. Unless the bill were defeated, the AMA Journal warned, "the mothers and infants of the nation are forever to be wards of the Federal government, to be cared for under an extra constitutional agreement between it and the several states."[1]

Most congressmen had little patience for the proposal. "The present bill," one representative asserted,

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[1]Chepaitis, The First Social Welfare Measure, pp. 278-80, 286-87; Editorial, "Child Welfare Legislation," Medical Woman's Journal 38 (January 1931):14; Letter, May 26, 1930, from Elizabeth Tilton to state presidents of the National Congress of Mothers and Parent-Teachers Associations, Elizabeth Tilton Papers, Box 3, Folder 43, Manuscript Collection, Radcliffe Institute, Schlesinger Library; "Sheppard-Towner Extension Bills," JAMA 92 (May 4, 1929):1526.

"is a good illustration of the difficulty of stopping any Federal activity when it is once started."[1] In the middle of the nation's most severe depression, those words rang true. In January 1931, the bill passed the Senate in the 71st Congress. The House passed an amended version, which went back to the Senate. Back in the Senate, however, it died, the result of a fillibuster led by David Walsh of Massachusetts and Millard Tydings of Maryland. On March 4, 1931, H. G. Torbert, Executive Secretary of the Sentinels of the Republic, wrote to the organization's president, Alexander Lincoln, that "it was a great relief to be able to wire you this noon that the Maternity Bill was dead and Congress had adjourned."[2]

The end of federal spending for mothers and children did not itself terminate state allocations for maternal and infant health. Yet most state programs suffered severe budgetary cuts. Of the forty-five states which cooperated in the Sheppard-Towner program in 1929, only sixteen could manage to maintain their

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[1]U.S., Congress, House, Report of the Committee on Interstate and Foreign Commerce, 70th Congress, 2d sess., 1929, pp. 21-22.

[3]Editorial, "The Maternity and Infancy Bill," Medical Woman's Journal 38 (April 1931):96; Chepaitis, The First Social Welfare Measure, pp. 310, 318, 326; Letter, March 4, 1931, from H. G. Torbert to Alexander Lincoln, in Alexander Lincoln Papers, Folder 10, Manuscript Collection, Schlesinger Library, Radcliffe Institute.

share of expenses for maternity programs after federal withdrawal. The seemingly bottomless, unfathomable depression meant further state restrictions, often with money diverted into other, more established health programs.[1]

Title V of the Social Security Act of 1935 authorized the Children's Bureau to spend $5,820,000 in grants-in-aid to the states for maternal and infancy health, determined on the basis of state populations, fiscal standing, and rurality, with authorizations of $3,870,000 for crippled and blind children and $24,750,000 for assistance to dependent children.[2] Historians have argued that this subsequent embodiment and enlargement of the ideas of Sheppard-Towner represents its ultimate victory--i.e., the Act was the stronghold of progressivism in the 1920s and a bridge to broader welfare

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[1]Chepaitis, The First Social Welfare Measure, p. 354; Lemons, Woman Citizen, p. 175.

[2]U.S., Congress, An Act to Provide for the General Welfare by Establishing a System of Federal Old-Age Benefits and by Enabling the Several States to Make More Adequate Provision for Aged Persons, Dependent and Crippled Children, Maternal and Child Welfare, Public Health and the Administration of their Unemployment Compensation Laws; to Establish a Social Security Board; to Raise Revenue; and for Other Purposes; Title IV: Grants to States for Aid to Dependent Children; Title V: Grants to States for Maternal and Child Welfare; Title VI: Public Health Work.

legislation of the New Deal.[1] Notwithstanding the Act's status as a viaduct between two ages of transition, the question inevitably arises as to what kind of victory it posed for women and children. In view of the results of government intervention in Europe, which rapidly cut through death rates, the substance of American accomplishments, including the Social Security Act, shrinks.

The Social Security Act's provision for women and children represented no enormous gain, since the Sheppard-Towner Act was essentially conservative, limited legislation. The 1921 Act meant victory only in terms of existing opposition to its rather mild innovations. In light of contemporary proposals for health insurance and pregnancy compensation to working mothers, the Sheppard-Towner Act did not measure up to the potentials for reform which the period's ideology offered.

The Social Security Act was itself relatively restrained. The legislative scheme taxed workers for their

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[1] Lemons, Woman Citizen, pp. 175-76; "The maternity bill was a link in a chain of ideas and actions from Roosevelt to Roosevelt, which began with the White House Conference on Child Welfare Standards in 1909 and ended with the Social Security Act of 1935." Ibid., p. 153; see also Sam Shapiro, Edward R. Schlesinger, and Robert E. L. Nesbitt, Jr., Infant, Perinatal, Maternal, and Childhood Mortality in the United States (Cambridge, Massachusetts: Harvard University Press, 1968): p. 225; Walter I. Trattner, From Poor Law to Welfare State: The History of Social Welfare in America (New York: Macmillan Co., 1974), p. 187; Chepaitis, The First Social Security Measure, pp. 368-69.

security, with the hardship of the tax levy falling most heavily upon less affluent workers. The plan paid benefits on past earnings, rather than need, again penalizing poorer members of the work force. Weak unemployment coverage included short benefits and small payments. European legislation went much further. As a result, it remained, as now, easier and healthier to be a mother, both at home and at work, in other parts of the developed world than in the United States.[1]

Women still suffer, perhaps in less aggravated form, because their individual resources cannot meet medical expenses. Women's pocketbooks and their geographic station in America often foreclose the high-level

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[1]High quality, equitably distributed maternity care has never become a right in the United States. While the potential exists, it has only been approached to suit the convenience or perceived welfare of the government. See Taylor, The Medical Profession and Social Reform, and his discussion of the program for the wives and children of servicemen initiated during World War II. The federal government appropriated $1,200,000 for maternity and child health care; wives of servicemen received free delivery services. When the war ended, the program lapsed. Compared to Sweden, American commitment to motherhood aid appears minimal. Until 1974, Sweden granted six months' sick leave to working mothers at birth; it then extended the leave to seven months, and to fathers as well. If fathers and mothers both work, they can divide the time off from work. The innovation will cost the government more, since men traditionally earn more than women. The funds come from large government grants and smaller employer contributions. The benefit for maternity leave is 95 percent of the salary. See "Seven Months with New Baby. Parent Leave is Hit in Sweden," New York Times, 7 December 1976, p. 55.

and life-saving advances of obstetrics and child care. Medicine continues to lack consistency; without a uniform legal code, state welfare laws catering to women and children are often as diverse as the states themselves. Aid remains a function of destitution. Support generally maintains women in poverty, rather than helping them rise above it.

CHAPTER XII

THE MATURATION OF MEDICINE--WITH LESSONS UNLEARNED

> I beg you to remember that this was what was supposed to be the Experience of My Lifetime. My Fulfillment, etc.; so how come I felt like a loony in a loony bin? I didn't feel like a woman in the fullness of her time, angels singing, etc.; I felt like a dependent, demented child, isolated, incarcerated, but not protected. . . . I think I'm describing panic.
>
> --Barbara Grizzuti Harrison, 1973

Notwithstanding the widespread public health campaign of the first three decades of the twentieth century which prompted a socio-medical confrontation and accommodation to America's diverse ethnic, geographic, and class composition, medicine remained a stratified distribution system. As medical sophistication mounted and physicians could unabashedly assume the posture of scientists, the costs of medical care skyrocketed. Fee-for-service requirements stunted and qualified the powers of emerging specialists, equipped with x-ray and transfusion techniques, antisepsis, sulfa drugs, and later with antibiotics and penicillin.

The principal achievement of the public health movement was its insistence that medicine serves most

beneficially in the preventive realm. While new discoveries in the curative sphere were a welcome necessity, the physician's major tool was still his ability to discern and eliminate the preconditions for disease. If payment for services depended upon individual wealth, physicians' guides must necessarily be their pocketbooks. Medical need would be secondary. Invariably, practitioners would see the fee before the patient.

Preventive medicine cannot survive in this framework. From the patient's viewpoint, fee-for-service posed a barrier to any deterrent health care. Periodic physical check-up did not become routinized except among the highest income brackets; free medicine never lost the stigma of charity.[1]

The fundamental significance of the defeat of the American health insurance movement in the early part of this century lay in its failure to equalize medical costs, diminishing the return value of new scientific potential. Without change in payment methods and a redistribution of

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[1]Today, in spite of the prevalence of voluntary health insurance plans, some 24 million Americans have no coverage whatsoever. Even among those covered, 100 million get no benefits unless they enter a hospital. And even with this insurance, few can afford preventive therapy in hospitals, where the daily bed rate alone far exceeds the maximum per diem benefit of most plans. The available forms of voluntary insurance today thus conspire against preventive health surveillence. See Edwin Hoyt, Your Health Insurance: A Story of Failure (New York: John Day Co., 1970), p. 35.

the costs of medical care, a marked rise in the economic hazards of illness accompanied the accelerated capacity of science. Had the logic of public health been carried to its conclusion, medical socialism would have resulted. Yet in the United States medicine remained "an economic commodity. . . . The amount (and quality) of care received by people varies with their economic status: in general the poor get least, the rich most."[1]

In the twentieth century, developing medical technology differentiated the hospital's diagnostic and therapeutic capacities from home and dispensary care. Hospitals became medical centers for the middle and upper classes. Public hospitals, the remaining dispensaries, and increasingly popular hospital out-patient clinics served as the poor's resort. By the turn of the century, the poor had become medically obsolete, at least for organized medicine. Once the medical profession had a ready body of wealthy, paying clients at hand, willing to use hospitals, the system made working-class and indigent patients expendable.

Hospitals' new capacities to save lives thus shoved the poor, who had always formed the clinical backbone of medicine, aside medically. Scientific

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[1]Louis S. Reed, Health Insurance. The Next Step to Social Security (New York: Harper and Brothers, 1937), p. 26.

advancements resulted in the hospital's predominance, with wealthy citizens anxious for medical benefit. The displacement and ultimate elimination of another key nineteenth-century institution which had served the medical needs of the working class, the dispensary, also resulted substantially from this change.

The American dispensary traced its genesis to the late eighteenth century. In the nineteenth century, dispensaries served, more or less equally, the needs of the urban working class and rising doctors, anxious for clinical work.[1] While dispensaries often presented certain inconveniences (long lines in crowded waiting rooms were not unusual), they offered services commensurate with contemporary medical ability. For the physician, dispensary service was an emblem of status which promised entre into a wealthy practice. Unlike his twentieth-century successor, the dispensary practitioner enjoyed a reciprocal relationship with his patients. Pedagogically, the doctor could receive no better training.

Once, however, the dispensary ceased to serve the career aims of the young doctor, its downfall became unavoidable. In the twentieth century, doctors'

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[1]Charles E. Rosenberg, "Social Class and Medical Care in Nineteenth-Century America: The Rise and Fall of the Dispensary," Journal of the History of Medicine and Allied Sciences 29 (January 1974):32-54.

requirements for clinical participation found satisfaction most readily in hospital wards during internship and residency; involvements with "needy" patients could be fulfilled, if necessary, in a fast round of assignments to the hospital out-patient clinics. Therefore, with mounting regularity, the out-patient clinic overshadowed the dispensary as an independent health center.[1]

Unfortunately, physicians' indifference to dispensary practice lacked a concomitant diminution of need. In 1871, New York City had twenty-six dispensaries; in 1893, the city provided sixty-four.[2] Assessing the value of dispensaries in 1910, Michael Davis, director of the Boston Dispensary, examined the populations of Boston, New York, and Chicago. Estimates from the three cities showed 45 percent of Chicago citizens relying on dispensary care, with at least 33 percent usage in New York and Boston.[3] By 1920, New York City boasted 153 of the State's 213 dispensaries. Forty-eight were City Department

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[1]Ibid., pp. 50-51: "Shorn of its relevance to the career needs of aspiring physicians, the dispensary was left with the clearly residual function of providing public health--charity--medical care, in itself a low-status occupation throughout the nineteenth century."

[2]John Duffy, A History of Public Health in New York City: 1866-1966 (New York: Russell Sage Foundation, 1974), pp. 185-86.

[3]Michael M. Davis, Jr., "The Efficiency of Out-Patient Work," JAMA 59 (November 9, 1912):1689.

of Health clinics; of the 105 units outside the Health Department, out-patient departments of hospitals made up 65, 6 were college dispensaries, and only 34 clinics remained as detached dispensaries.[1]

These ambulatory centers became the targets of criticism by public health advocates. Dispensaries in the nineteenth century were often no more than drug distribution centers (in 1874-75, the Mount Sinai Dispensary treated 4,666 people and issued 22,013 prescriptions; in 1878-79, doctors became a bit more discriminating, treating 22,958 patients and writing 25,437 prescriptions, with "as many as 156 having been given out in one day to 126 applicants").[2] Besides minor surgery, correction of fractures, and vaccination work, drug prescription coincided with the prevailing mode of therapy. In the twentieth century, however, when medical potential reached greater heights, the dispensary as well as new city and hospital clinical facilities failed to mature. E. H. Lewinski Corwin, of the New York Academy of Medicine's Public Health Relations Committee, asked:

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[1] "The Service of the Dispensary. A Report by the Public Health Committee of the New York Academy of Medicine, New York City," Modern Medicine 2 (March 1920):254.

[2] Annual Report of the Directors of the Mount Sinai Hospital, January 1874--January 1875; January 1875--January 1876, p. 20; Annual Report of the Directors of the Mt. Sinai Hospital, 1878-1879, p. 5.

"Are the dispensaries anything more than wholesale druggists?"[1]

Overcrowded dispensaries provided ideal sites for cross-infection. A survey of dispensaries in New York City in 1914 found thirty-six patients waiting in one room in a children's clinic. A return visit revealed that one child in the group had been sitting with diphtheria and another two children had exposed the others to scarlet fever.[2] By 1914, the year of that study, medical science knew enough about the causes of contagious diseases to make this situation inexcusable.

Generally, the group most critical of dispensary and out-patient practices included professionals who saw the greatest opportunity for medical and social collaboration in the facilities. Used properly, the clinic could reach the patient and his family in a more fundamental way than the hospital. This group included Michael Davis, who deplored the clinics' conditions, particularly their overcrowding, understaffing, and hasty treatments--as the chief factors estranging immigrants from organized medical service. While hospitals suffered from a rigidity

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[1]E. H. Lewinski Corwin, "The Dispensary Problem in New York City," Survey 27 (February 17, 1912):1770.

[2]"Disease Spread as Well as Cured in Hospitals," Survey 31 (January 31, 1914):515.

bordering on the militaristic, dispensaries alienated people with their disorganized and frenzied atmospheres.[1] The carelessness with which free facilities often operated served to remind that their clientele merely received the patrons' grace.

The public soon learned to distrust the medical therapeutics of free facilities. Understaffing made dispensaries incapable of treating chronic disease, especially rheumatism, the bane of the working class. Virtually no clinic offered intensive treatment, and the harried and distracted staffs, serving largely without remuneration, generally provided hasty and often inaccurate diagnoses. Staff morale could hardly be high, for example, when caseloads required two doctors to treat 162 cases (105 new ones) in 90 minutes.[2] Earlier, Elizabeth Blackwell saw this problem:

> In the treatment of the poor, an immense demand is made upon our pity, patience and courage. These poor victims of our social stupidity are often extremely trying! The faulty arrangements which compel us to see thirty, fifty even, in an hour, exhaust the nervous system of the doctor. It requires faith and courage to recognize the real equal human soul under the terrible

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[1]Michael M. Davis, Jr., Immigrant Health and the Community (New York: Harper and Brothers, 1921), pp. 328-30, 334, 338-39.

[2]Heinrick R. Wolf, "Medical Aid of Relief Societies," Survey 30 (September 20, 1913):739; "Disease Spread as Well as Cured in Hospitals," p. 515.

> mask of squalor and disease, in these crowded masses of poverty, and to resist the temptation to regard them as "clinical material." The attitude of the student and doctor to the sick poor is a real test of the true physician.[1]

Twentieth-century changes accentuated the problem Blackwell described. As urban populations swelled with new immigrants, clinics became even more unmanageable. At the same time, physicians sensed their burgeoning professional and financial powers, and had little patience for dispensaries' impositions on their time. As long as a tiered medical system continued, with patients separated into paying and unremunerative groups, the latter would be shuttled through treatment as expediently as possible.

A 1914 survey of New York City's dispensaries reported that many patients stood waiting almost six hours for their prescriptions to be filled. Especially for women with young children, long waits proved ample discouragement to seeking regular medical treatment. When investigators questioned the clientele, they launched into attack: "One woman, at 303 Broome Street, whose child was suffering from burns, said that the dispensary treatment was so careless that blood-poisoning developed." Patients also revealed that doctors freely exploited them

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[1]Elizabeth Blackwell, The Influence of Women in the Profession of Medicine. Address Given at the Opening of the Winter Session of the London School of Medicine for Women (Baltimore: n.p., 1890), p. 12.

with assertions that proper treatment was unavailable at the dispensary, and that the situation required the aid of a private physician. Invariably the dispensary physician was ready with a list of referrals.[1] Perfunctory inspections of dispensaries permitted prevailing practices to continue.

Immigrants avoided dispensaries as much as they could. An investigation and family-to-family canvass of the Lower East Side and the area west of 6th Avenue between 14th and 40th Streets revealed that people treated approximately 90 percent of all sickness, including typhoid, scarlet fever, diphtheria, and tuberculosis, at home.[2]

The poor recognized the shoddy manner in which they were treated in clinics. Cognizant of the implicit condescension among public or charity health care personnel, dispensary patients asserted the prevention of humiliation as a central reason for avoiding clinic care.[3] The medical system saw dispensary and out-patient clientele as mere unnecessary appendages; the snap diagnoses and the

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[1]"Home Centers to Oversee Care of Sick at Home," Survey 31 (January 3, 1914):369-70.

[2]Ibid., p. 369.

[3]F. C. Theodore Kruger, "Charities and Dispensaries," Charities 3 (July 22, 1899):16; "Dispensaries of Today and Tomorrow," Survey 36 (May 20, 1916):207.

stiff and cold questioning to determine if patients were poor enough to receive the care bore witness to the parsimonious service available. Physicians, who could obviously do better in private practice, offered treatment to the poor which was, even optimally, reluctant and patronizing.

Twentieth-century dispensaries and out-patient clinics operated on the principle of haste. Even if diagnosis and treatment were accurate, abysmal record-keeping made health monitoring impossible. Social workers' untiring investigations to ascertain applicants' poverty and eligibility exacerbated the impersonality of the endeavor to provide free care.[1] Notwithstanding the abusive medical ambiance, many physicians in New York City interpreted dispensary maltreatment as their own injury. The theme of "dispensary abuse" got a second run in the city in the years between 1910 and 1928. For the doctors partisan to this outlook, the system victimized hard-working physicians who lost patients, able to pay, to free clinics, not dispensary clients.

The dispensaries' defenders, among them Richard Cabot, Assistant Professor of Medicine at the Harvard Medical School and Assistant Visiting Physician to the

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[1]For descriptions, see, for example, Michael M. Davis, Jr., Medical Care for Tomorrow (New York: Harper and Brothers, 1955), p. 143.

Massachusetts General Hospital, his student Michael Davis, and J. Whitridge Williams, reviewed evidence of the earning capacities (or incapacities) of industrial workers, of whom three-quarters earned less than $750.00 in 1916. In Williams' "experience [as chief of the obstetrical division of the Johns Hopkins Hospital], married workers who earn less than $750.00 a year cannot afford to make any considerable expenditure for medical services."[1]

Richard Cabot persistently advocated the dispensaries' rehabilitation. He deplored the wasted potential of ambulatory care, and envisioned the clinic capable of performing what a hospital ward could never do. Unlike hospital treatment, which was curative, used to its fullest capacity the clinic served as the chief instrument of preventive medicine. With roots in the neighborhoods, employing the antennae of social workers, the dispensary might truly check disease. Unlike the hospital, where costs forbade the regular treatment of chronic cases, the clinic provided an ideal place to treat rheumatism, varicose veins, pelvic disorders, and anemia (all more

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[1]J. Whitridge Williams, "Dispensary Abuse and Certain Problems of Medical Practice," JAMA 66 (June 17, 1916):1902-03. Williams based his estimates of workers' earnings on a Scott Nearing study; Nearing approximated that less than one-tenth of the industrial force made more than $1,000. Therefore, Williams concluded that only one-tenth of the industrial work force could be involved in dispensary abuse. See also Davis, Medical Care for Tomorrow, p. 141.

prevalent among the lower classes) and to study patients' progress. Instead, Cabot acknowledged the dissipation of the dispensary's potential; clinic practice was farcical. "We are content that hospitals should spend at least twenty times as much for the care of a ward patient as they do for the care of a dispensary patient."[1] (In 1916, the City Department of Public Charities spent over $2,250,000 for the destitute sick in hospitals it maintained; in the same year the city paid more than $5,500,000 to private charitable institutions for the care of the sick poor.)[2]

A tiered medical business made the neglect of ambulatory possibilities inevitable. In 1926, the vast majority of the 2,500 doctors serving New York City's clinics worked as volunteers without compensation.[3] In

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[1]Richard C. Cabot, "Out-Patient Work. The Most Important and Most Neglected Part of Medical Service," JAMA 59 (November 9, 1912):1688-89.

[2]Humanizing the Greater City's Charity. The Work of the Department of Public Charities of the City of New York (New York: Public Welfare Committee, 1917), pp. 210-13; p. 21: "The Bureau of Social Investigation registered approximately 140,000 needy persons seeking aid from the City in 1916. This number would populate the city of Syracuse."

[3]"Report of the Out-Patient Committee. Presented to the Association at the 28th Annual Conference, September 27th to October 1, 1926, Atlantic City, New Jersey." Bulletin of the American Hospital Association 7 (November 1926):5.

any economic endeavor, voluntary work invariably carries low status, and hence out-patient work became increasingly a part-time occupation, done with the altruism of the physician. In 1916, Dr. Williams commented:

> Now, except for distinctly personal reasons, no city physician has any hesitancy in refusing to attend undesirable or unremunerative patients, but refers them to the nearest hospital or dispensary, and feels he will give his charity the next day in the shape of a few hours of hospital or dispensary service.[1]

Cabot's dream of the ambulatory clinic as neighborhood health center, an integration of medical and social work, of individual and family health, proved futile, as clinics failed to locate or move with demographic shifts and concentrations. In 1927, 62 percent of New York City's clinical services, including Health Department clinics, dispensaries, and hospital out-patient departments, was located in Manhattan, with a declining 30 percent of the city's population. "The facts of geographic distribution," wrote Michael Davis, "suggest that the development of these health services has followed the needs or interests of agencies rather than the needs of the city as a whole or of its several boroughs."[2] This

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[1]Williams, "Dispensary Abuse and Certain Problems of Medical Practice," p. 1903.

[2]Michael M. Davis and Mary C. Jarrett, A Health Inventory of New York City. A Study of the Volume and Distribution of Health Service to the Five Boroughs,

left little room for planned coordination and meant duplication and waste in Manhattan.

The problem, then, in New York City (and presumably a greater problem elsewhere, in less sophisticated, progressive, or wealthy cities) was that good medical care was too expensive. On the surface, the city provided abundant facilities for low-income groups. Yet broken down, a considerable portion of the population found these services inaccessible and medically below the level of contemporary professional skill. Physicians failed to earn the trust of their clientele and did not get it. Dr. Alice Hamilton reflected upon the value of free

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Study 1 of the Research Bureau of the Welfare Council (New York: Welfare Council of New York City, 1929), pp. 43-44; 59-60. In 1927, the population of New York City was 5,970,800; broken down as follows: Manhattan, 1,814,600; Bronx, 926,100; Brooklyn, 2,274,400; Queens, 809,100; Richmond, 146,600. The preponderance of free medical facilities in Manhattan was true also for municipal hospitals. In 1924, in Manhattan, 50 percent of the hospital beds were private with 46 percent municipal and 4 percent proprietary; in Brooklyn, private hospitals provided 55 percent of the total beds, municipal 40 percent, and proprietary 5 percent; in the Bronx, 87 percent of the beds were in private hospitals, with 9 percent in municipal hospitals; in Queens, 69 percent of hospital bed space was in private institutions, 14 percent in municipal, and 17 percent in proprietary hospitals; in Richmond, 73 percent of hospitalization was in public wards, since the borough housed Seaview Hospital, a tuberculosis Sanatorium. See Public Health Committee of the New York Academy of Medicine, prepared by E. H. Lewinski Corwin, The Hospital Situation in Greater New York. Report of a Survey of Hospitals in New York City (New York: G. P. Putnam's Sons, 1924) p. 35.

services:

> What about the medical care of the poor? If we should put the question to the visiting nurses and other social workers they would at once speak of the public hospitals and the free wards of private hospitals, of the dispensaries and finally of kindly physicians who are willing to give a certain, or uncertain part of their time to charitable work. The provision for medical care seems at first ample, even generous. But if we should ask . . . "What good came out of it all?" the answer often would not be so prompt.[1]

Until 1929, New York City public hospitals, under the jurisdiction of three separate agencies, operated without adequate administrative cohesion. The City Department of Health handled hospitals for contagious diseases. In 1902 the city transferred Bellevue and other municipal hospitals in Manhattan and the Bronx from the authority of the Department of Charities (later the Department of Welfare) to the jurisdiction of a board of trustees appointed by the mayor. The Department of Charities controlled the hospitals on Blackwell's

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[1]Alice Hamilton, "Unpaid Medical Service," Survey 30 (September 20, 1913):727. In January 1978, the New York City Health and Hospitals Corporation announced a major revision of the clinic system. Under the new system, clinics will no longer be staffed merely by interns and residents. Rather, "group practices" will be established, with physicians employed in much the same way private practice is organized, at competitive salaries. See "City Hospital Clinics to Upgrade Staffs," New York Times, 10 January 1978, pp. 1, 40. For a contemporary portrait of medical care available to the poor, see "No Doctor Hears Cries of the Ailing in South Bronx," New York Times, 15 December 1978, p. 31.

Island, as well as several others scattered around the city.[1]

In 1914, the Hospital Investigating Committee of the New York Board of Estimate and Apportionment, charged with studying the children's services at municipal general hospitals in Manhattan and the Bronx, issued a report written by Henry C. Wright. The Committee found that public pediatric services compared unfavorably to those in voluntary institutions. The report alleged that public hospitals made people sick; cross-infection, resulting in part from poor bed spacing, was rampant. With the exception of Bellevue Hospital, which boasted a top-quality pediatric ward, the institutions maintained an unpardonable ratio of nurses to children. At City Hospital the ratio was 1 to 5.33; at Harlem and Metropolitan Hospitals, the ratios stood at 1 to 8.66; at Fordham it was 1 to 12.4; and at Gouverneur it rose to 1 to 13. In Babies' Hospital, a privately-supported institution, there was one nurse to every three children.[2]

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[1] E. H. Lewinski Corwin and Elizabeth V. Cunningham, Thirty Years in Community Service, 1911-1941. A Brief Outline of the Work of the Committee on Public Health Relations of the New York Academy of Medicine (New York: New York Academy of Medicine, 1942), pp. 6-17. In 1929, the creation of the Department of Hospitals established administrative unity over all municipal hospitals. Hospitals for contagious diseases remained under the supervision of the Department of Health.

[2] "Disease Spread as Well as Cured in Hospitals," p. 514.

Maternity care became a function of both private and public hospitals. In 1926, New York City's hospitals delivered 52,000 patients, or 40 percent of the total births. Physicians staffing home delivery services attended another four thousand women. The city listed 10,900 licensed physicians. Licensed midwives, who delivered 21,000 women in 1926, totaled 1,262. But midwifery was on the down-swing. In 1927, the Bellevue Training School for Midwives enrolled only twenty-eight midwives, with thirty-three in 1928.[1]

Michael Davis, who conducted a health inventory of New York City in 1927, found hospitals' focus on maternity services the most fundamental change of the preceding decades. "The hospital is now the predominating type of agency furnishing obstetrical and prenatal services." Of the seventy-eight hospitals in the city with maternity beds, fifty-eight provided prenatal clinics, representing two-thirds of the obstetrical clinics in the city (there

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[1]Davis and Jarrett, A Health Inventory, pp. 92-93. The increase in hospital confinement rose progressively in succeeding decades. However, the progression varied according to a state's wealth and urban concentration. In New York State in 1940, 87 percent (or 171,288 births) occurred in hospitals. In Pennsylvania, 62 percent of the births took place in hospitals, in Missouri, 48 percent, in Alabama, 20.5 percent, and in Mississippi, only 13.4 percent. See U.S., Department of Labor, Children's Bureau, Births, Infant Mortality, Maternal Mortality, 1940, Publication No. 288 (Washington, D.C.: Government Printing Office, 1940), p. 5A.

were ninety-one).[1] For poor women, this transference of services to hospitals meant a reduction in the opportunity for outside midwife delivery if they also desired prenatal observation. As hospitals replaced independent maternity clinics (which had worked with midwives for complete pregnancy coverage), they and their staffs expected women using hospital prenatal services to use hospital-provided attendants for delivery. The commensurate decline in hospital home service meant that women would increasingly enter hospitals for confinement.

Davis' inventory of maternity clinical facilities revealed that 82 percent of the visits to the 91 clinics came from mothers seeking prenatal care; only 18 percent of the visitors to maternity clinics sought postnatal care. Annually, 36,600 patients visited the 77 maternity clinics outside the Department of Health and 3,330 women received pregnancy supervision through the Department's 14 maternity centers. To the private free clinics, patients made an average of four visits, with five appearances the average at the municipal centers. In

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[1]Davis and Jarrett, A Health Infentory, pp. 91-94. Of the ninety-one clinics in the city, the Department of Health operated fourteen. Of these clinics, six were located in Manhattan, three in Brooklyn, two in the Bronx, two in Queens, and one in Richmond. Voluntary agencies, including hospitals, ran seventy-seven maternity clinics. The geographic distribution of these clinics showed forty-six in Manhattan, twenty-one in Brooklyn, five in the Bronx, three in Queens, and two in Richmond.

both, the majority of patients entered treatment in the latter months of pregnancy.[1]

Nurses and social workers made up the clinics' only full-time personnel, with doctors serving exclusively part time. The Department of Health hired only 6 part-time physicians for its maternity clinics; hospital and voluntary ambulatory centers enlisted 204 doctors, of whom only 19 were compensated. A full-time nurse headed each of the fourteen Health Department facilities, while only eight full-time nurses and nine full-time social workers staffed the seventy-seven clinics outside municipal jurisdiction.[2] With the passage of the provision of maternity services from maternity health organizations and the Department of Health to hospitals, Davis asked whether hospitals could be trusted to set quality, uniform standards, especially when maternity care was only one of their many functions. Evidence of skimpy and unscientific record-keeping, in the process of becoming notorious, added to Davis' doubts.

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[1]Ibid., pp. 94-95. Davis and Jarrett studied intensively some twenty clinics serving 6,450 patients. Eleven percent of the patients registered before the fourth month; 8 percent enrolled in the fourth month, 13 percent in the fifth month, 20 percent in the sixth month, 25 percent in the seventh month, 17 percent in the eighth month, and 6 percent in the ninth month.

[2]Ibid., p. 95.

Another survey of hospitals in New York City found that although prenatal clinic case records indicated that staff members measured pelvic dimensions, the records did not show the actual measurements. This study also discovered extremely superficial clinical diagnoses, either failing to do urinalysis, or at least not recording the procedure.[1] The woman, then purportedly ready for hospital delivery, carried with her a record card which was utterly meaningless to her attendant. Free clinical observation gave the future obstetrician little guide for safe delivery. Without laboratory records and pelvic measurements, there would be no alert signal for toxemia, or for bone malformation threatening cesarean section.

This hospital survey, conducted by E. H. Lewinski Corwin of the New York Academy of Medicine's Committee on Public Health Relations, questioned the validity of any strong generalization about the city hospitals' maternity care. "Hospital statistics which are generally lax are particularly so in the obstetrical service." The hospitals had no uniform system of statistical compilation. Statements on maternal mortality lacked precision and thus often meaning, as hospitals failed to note if deaths occurred in primiparae or multiparea women. There was no

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[1]Ibid., pp. 100-01; Lewinski Corwin, The Hospital Situation in Greater New York, pp. 321-22.

sure way of knowing the number of babies delivered, as some hospitals counted births by the number of women it delivered regardless of multiple births, while others counted actual live births.[1] Making as much sense of the numbers as he could, Dr. Lewinski Corwin found the lowest mortality for mothers and infants in the hospitals which offered only maternity care. The voluntary private hospitals ranked second, with municipal hospitals revealing the highest mortality. "In partial extenuation of the higher mortality in the municipal hospitals," he explained,

> . . . it must be said that may cases mishandled by midwives or physicians are brought to these hospitals in desparate condition; the municipal hospitals have no private patients and deal, as a rule, with women of the lower ranks of society, many of whom are diseased and mistreated.[2]

Some hospitals made accommodations to their new supremacy. Swayed by the efforts of Richard Clarke Cabot at the Massachusetts General Hospital, twentieth-century hospitals increasingly appended social service departments to retain the social involvement of the former dispensary and city clinic work. Social service departments functioned among both ward and out-patient

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[1]Lewinski Corwin, The Hospital Situation in Greater New York, p. 322.

[2]Ibid., pp. 318-19.

clientele, to bridge the gap between social environment and medical malaise.

Cabot criticized physicians' ignorance of social psychology and their subordination of the social and economic contributory causes of disease to rigid medical diagnosis. He proposed the addition of full-time paid social workers to hospital staffs. A patient's medical work-up and history, he contended, was incomplete without a social analysis of his or her living environment. In 1905, the Massachusetts General Hospital's out-patient facility established a social service department.[1]

Cabot charged hospital treatment "with the same stereotyped kindness, the same military precision, or worst of all, the same dull inattention." Even if measured in the most caustic way--in terms of money--hospitals were on the losing end, in paying for free care only to send patients back to sickness-ridden and disease

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[1]Lloyd C. Taylor, Jr., The Medical Profession and Social Reform 1885-1945 (New York: St. Marten's Press, 1974), pp. 15, 17-18; Richard C. Cabot, "Humanizing the Hospitals," in Sophonisha P. Breckinridge, ed., The Child in the City, A series of Papers Presented at the Conferences Held During the Chicago Child Welfare Exhibit (Chicago: Department of Social Investigation, Chicago School of Civics and Philanthropy, 1912, reprint ed., New York: Arno Press, Inc., 1970), p. 47. (The forerunners of hospital social services were the visiting nurses and doctors, employed by many nineteenth-century hospitals and dispensaries.) It was not until 1919 that the Massachusetts General Hospital itself, as opposed to its out-patient department, established an official Social Service Department.

engendering environments. If physicians' narrowness of focus resulted inevitably from their long educations, then there was more reason for supplementary personnel to achieve a full medical profile. For Cabot, the social worker would become the synthesizer in the medical process, the intermediary between patient and doctor. He called for an end to medical myopia, and for new ingredients to soften an impersonal system:

> In my medical work at the Massachusetts General Hospital I used to see about 30 patients a day, or 3,000 in my four months' service. As I sit in my chair behind the desk, Abraham Cohen, of Salem Street, approaches, and sits down to tell me the tale of his sufferings; the chances are ten to one that I shall look out of my eyes to see, not Abraham Cohen, but a Jew; not the sharp, clear outlines of this unique sufferer, but the vague, misty composite photograph of all the hundreds of Jews who in the past ten years have shuffled up to me.[1]

Miss Garnet Isabel Pelton, who headed the Massachusetts General Hospital's out-patient social service division for its first six months of operation, maintained that clinics and dispensaries could become more than drug therapy centers only through the alliance of the doctor and the social worker. This kind of integration was available at maternity specialty hospitals, for example, the New York Lying-In Hospital and the New York Nursery

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[1]Richard C. Cabot, Social Service and the Art of Healing (New York: Moffat, Ward and Co., 1914), p. 4; see also pp. 16, 20, 172, 174, 176, 178-81.

and Child's Hospital, but not, as Pelton wished, in general hospitals.[1] Sidney Goldstein of the Free Synagogue in New York City agreed: "The family should be the unit of treatment." He questioned the validity of a completed case unless "the patient and the family are socially rehabilitated and re-established."[2]

In 1906 the Bellevue Social Service Department opened; Mount Sinai established a similar department the following year.[3] However, Cabot's hopes that physicians and social workers would form a winning team against social and medical pathology were not fully realized. As a report of the American Hospital Association outlined, even hospitals which had adopted social service programs did not use hospital social workers' potential to the fullest. The report listed the fundamental ways in which social workers could be put to use in hospitals. After understanding the personality and environmental factors

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[1]Garnet Isabel Pelton, "Hospital Social Work," Survey 24 (May 14, 1910):281, 288; Garnet Isabel Pelton, "The History and Status of Hospital Social Work," Proceedings of the National Conference of Charities and Correction, 37th Annual Session, St. Louis, Missouri, May 19-29, 1910, p. 332.

[2]Sidney E. Goldstein, "Hospital Social Service: Principles and Implications," Proceedings of the National Conference of Charities and Correction, 37th Annual Session, 1910, pp. 342-43.

[3]Pelton, "The History and Status of Hospital Social Work," pp. 337-38.

relating to a patient's physical status, the social worker might assume the role of mediator in surmounting any barriers to fruitful medical treatment. He could intercede with arrangements for convalescent or child care when necessary or, working individually with a patient, might encourage the patient's cooperation with prescribed medical therapy. On a more functional level, social workers could be put to work in admitting offices, as interpreters, dispensary managers, patient escorts to treatment centers, and as community advisers on local medical and social resources.[1] Notwithstanding the advantages of hospital social service and its introduction in the United States fourteen years ealier, the Committee for the American Hospital Association making a Survey of Hospital Social Service found that social workers still played peripheral roles in their hospitals and that only three hundred hospitals (of approximately seven thousand) had established social service departments by 1920.[2]

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[1]American Hospital Association, Report of the Committee Making a Survey of Hospital Social Service, Bulletin No. 23 (Cornwall, New York: The Cornwall Press, Inc., 1920), pp. 3-5.

[2]Ibid., p. 1. For a description of hospital social service, see also American Hospital Association, Report of the Field Secretary to the Committee of the American Hospital Association Making a Survey of Hospital Social Service, Bulletin No. 24 (Cornwall, New York: The

Thus the efforts to meld social workers and physicians in a medical setting were never fully realized in the United States. In 1952, among 4,832 hospitals responding to an American Hospital Association questionnaire about the existence of organized social service, only 723 (or 17.5 percent) reported that they had social service departments; those which did were primarily large institutions.[1] The blame cannot be placed totally upon the medical establishment. Part of the failure lies in the historical development of professional social work in this country. Influenced by Freudian psychiatry, social work took a conservative turn in the 1920s. Individual circumspection replaced environmental inspection and manipulation. Earlier social workers sought to readjust environmental forces which broke down the human endeavor to survive. In the twenties, the emotional ambiance of the individual interested social workers more, and their work ultimately aimed at adjusting inner psychological structures to the outside world, however unbalanced that

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Cornwall Press, Inc., 1921). For a listing of New York City's social service departments, see American Hospital Association, Directory of the Social Service Departments in Hospitals and Dispensaries of Canada and the United States, prepared by Ida M. Cannon, Bulletin No. 43 (Chicago: Hospital Social Service Press, 1922).

[2]Michael M. Davis, Medical Care for Tomorrow, p. 773.

world might be.[1]

The United States, and particularly large cities, did not lack medical facilities for people with low incomes.[2] Yet available services were fragmented, with the care rushed, impersonal, and humiliating. Ironically, while the poor received certain services, albeit haphazard, people of moderate incomes found themselves priced out of hospital care. Low- and middle-income groups, who shunned out-patient care (which connoted pauperism), seemed to lose their niche in the medical framework. In the nineteenth century, hospital care served the destitute, and independent dispensaries met working-class needs at

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[1]For discussions of the shift in social workers' concentration and methodology, see Walter L. Trattner, From Poor Law to Welfare State: A History of Social Welfare in America (New York: The Macmillan Co., 1974); Robert H. Bremmer, American Philanthropy (Chicago: University of Chicago Press, 1960); Roy Lubove, The Struggle for Social Security, 1900-1935 (Cambridge: Harvard University Press, 1968); Robert H. Bremmer, From the Depths. The Discovery of Poverty in the United States (New York: New York University Press, 1956); Frank J. Bruno, Trends in Social Work, 1874-1956. A History Based on the Proceedings of the National Conference of Social Work (New York: Columbia University Press, 1948).

[2]Davis and Jarrett, A Health Inventory, pp. 68-69, 76. The New York City Department of Health maintained 105 baby health, 21 preschool, and 9 school clinics. Voluntary agencies operated thirty-seven baby health, twenty-one preschool, and nine school clinics. Three-fourths of the child health work was in Manhattan, both Brooklyn and the Bronx carried an eighth of the work and Richmond four percent; Queens offered no services. In the clinics, doctors saw approximately twelve babies per hour.

least through the 1880s;[1] the plethora of doctors meant that moderate-income groups could find private aid at home. Practitioners, whether physicians or midwives, fulfilled women's basic need for medical care during confinement at home.

In the twentieth century, however, when serious illness occurred, hospitals truly had the therapeutic upper hand over ambulatory services or home care by private doctors. With the demise of the midwife, the disappearance of the doctor surplus, and the tendency of physicians to seek hospital affiliations, families needed cash to meet the costs of illness and confinement.

By 1915, the hospital had become the city's predominant medical institution. Concerned health spokesmen recognized that a large segment of the middle class could not afford hospital care. Dr. George W. Kosmak, speaking before an annual gathering of the American Association for

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[1]See Rosenberg, "Social Class and Medical Care in Nineteenth-Century America." Early twentieth-century public health activists noted the reluctance and unwillingness of moderate income groups to use free facilities and their inability to afford hospital treatment. In response to this phenomenon, some health workers advocated the imposition of fees in dispensaries in order to eliminate the association of charity and free health care. Paid dispensaries, according to this group, would solve the problem of "those who must depend upon clinics for assistance since they cannot pay the prices of private physicians; yet who are unwilling to be 'charity patients,' and who consequently often remain untreated rather than attend a free clinic." See "Dispensaries of Today and Tomorrow," Survey 36 (May 20, 1916):206-07.

the Study and Prevention of Infant Mortality, depicted the hospital situation in New York City:

> In a rather extensive investigation of the subject in New York City, which contains over five million inhabitants, I was much surprised that all the hospitals of Greater New York afforded less than 100 beds at prices including and below fifteen dollars [a week].[1]

According to Dr. Lewinski Corwin, the failure of hospitals to provide moderately-priced accommodations affected 54.89 percent of the population who filed tax returns in 1918 and who earned between $2,000 and $5,000 annually.[2]

In 1914, hospitals in New York City provided ward space (the resort of the poor, yet repugnant to moderate income people), and private rooms ranging in price from $20.00 to $50.00 weekly before the physician's fee. One public health activist estimated that in 1914, the middle class could afford to pay no more than $10.00 to $15.00 per week for hospitalization.[3]

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[1]George W. Kosmak (in response to paper by Edward P. Davis, "The Need of Hospitals for Maternity Surgical Cases"), American Association for the Study and Prevention of Infant Mortality, Transactions of the Fifth Annual Meeting, November 12-14, 1914, p. 202.

[2]Lewinski Corwin, The Hospital Situation in Greater New York, pp. 91-92. Dr. Ralph Lobenstine of the Maternity Center Association voiced the same concern. See U.S., Department of Labor, Children's Bureau, Standards of Child Welfare. A Report of the Children's Bureau Conference May and June, 1919, Publication No. 60 (Washington, D.C.: Government Printing Office, 1919), p. 182.

[3]Edward P. Davis, "The Need of Hospitals for Maternity Surgical Cases," American Association for the

In 1920, the Babies' Welfare Association published a price listing of private and semi-private maternity beds in New York City. The survey reported that public hospitals required payment when possible. Bellevue Hospital with sixty beds reserved for confinement care, charged from $1.00 to $2.25 daily. Bellevue School of Midwives, with eighteen beds, charged $1.50 a day or $7.00 a week. Patients were "admitted in advance and required to work in return for board."[1] City Hospital, with capacity for seventy-six maternity patients, admitted the city's indigent without charge. Like City, Gouverneur and Greenpoint Hospitals, with sixteen and thirty maternity beds respectively, provided free services to the poor. Other municipal hospitals charged between $1.00 and $1.50 a day when patients could pay. These included Coney Island, Fordham, Harlem, and Metropolitan Hospitals.[2]

The middle class avoided these institutions and patronized voluntary hospitals, where the costs of confinement varied. The New York Infirmary for Women and

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Study and Prevention of Infant Mortality, Transactions of the Fifth Annual Meeting, November 12-14, 1914, p. 196.

[1] Information Concerning the Private and Semi-Private Beds in Maternity Hospitals in New York City, compiled by the Babies' Welfare Association (New York City: Babies' Welfare Association, 1920), p. 5.

[2] Ibid., pp. 6-11.

Children, with forty maternity beds, issued rates only upon application for admission. Other hospitals, however, published rate schedules. Booth Memorial Hospital, at 314 East 15th Street (now in Flushing, Queens), had sixteen beds for maternity care, and charged $1.50 a day for ward care and $3.00 daily for private rooms. The hospital imposed an additional delivery room charge of $5.00 for ward patients and $10.00 for private patrons. Booth's fees presumably fell within range of the middle-class pocketbook, but the cost of $40.00 for a ten-day stay excluded the physician's fee. Moreover, with a capacity of sixteen beds, the hospital had limited use. Similarly, Beth Israel Hospital charged $40.00 for the delivery room and two weeks of care, but offered space for only six maternity patients.

Flower Hospital charged $3.00 a day in the ward, $4.00 daily in semi-private rooms, and $5.00 to $9.00 for fully private accommodations, with an extra charge to all patients for the delivery room and physicians' services. Hahnemann Hospital charged $63.00 for two weeks' delivery care in the wards, all costs and fees included, with the rates at $87.00 plus the doctor's fee in semi-private rooms, and $119.00 to $133.00 and the physician's bill for private patients. At the Jewish Maternity at 270 East Broadway in Manhattan, ward confinement cost $35.00

and semi-private patients paid $95.00. Private rooms with two beds cost $135.00, with a fee of $175.00 in a single private room. The New York Lying-In Hospital charged $2.00 per day in the wards and from $5.00 to $12.00 in private rooms; physicians' services and operative deliveries added additional fees. Charges at the New York Nursery and Child's Hospital resembled those at the Lying-In Hospital.[1]

While voluntary hospitals usually admitted poor women for confinement and charged the city $25.00 for a two-week hospital stay, in 1920 an order of the Commissioner of Public Welfare restricted the city's reimbursement to emergency cases. The policy not only limited the amount of free work done in private hospitals, but also severely impeded free prenatal clinics in voluntary institutions, since the city considered patients receiving prenatal care to be non-emergencies, thus ineligible for public delivery cost reimbursement.[2] Hence the

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[1] Ibid., pp. 6-13.

[2] See Thirty Years in Community Service, Work of the Committee on Public Health Relations, pp. 38-39; see also John Duffy, A History of Public Health in New York City, 1866-1966 (New York: Russell Sage Foundation, 1974), p. 460. Perhaps as a result of the study of maternal mortality of the New York Academy of Medicine, at the onset of the depression New York City revised its reimbursement policy for public maternity cases in voluntary hospitals, and paid a flat fee to the hospitals of $35.00 per case for a ten- to fifteen-day stay.

policy worked in two directions. For women hoping for confinement in the more intimate and less intimidating voluntary facilities, it meant their avoidance of the hospitals' prenatal services. The hospitals, in turn, had to be scrupulous in their investigations of each patient's financial and medical background before admittance for fear of non-reimbursement.

In the first three decades of the twentieth century, organized medicine had matured. The elevation of medicine through scientific advance gave merit and status to a recently degraded profession. Concurrent with scientific discovery, the trend in medical education diminished the number of licensed physicians. Practitioners assumed a new professional confidence, often bordering on the arrogant. While parents' aspirations for their children's careers once shunned medicine and saw medical students as a rowdy bunch,[1] by 1930 the

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[1]For instance, J. Marion Sims, perhaps the most well-known and competent gynecologist in mid-nineteenth-century America, entered medical school at the expense of his father's deep disappointment. His father had hoped his son would become a lawyer, and regarded physicians as a scandalous lot, men without science, selling their wares like businessmen. See John Duffy, The Healers: The Rise of the Medical Establishment (New York: McGraw-Hill Book Co., 1976), pp. 136-37, 260-61. Martin Kaufman shows that among the major professions of theology, law, and medicine in the mid-nineteenth century, students with the least amount of academic preparation found their way into medicine. For example, in 1850-1851, graduate students with bachelor's degrees made up 80 percent of theological

profession stood in the highest esteem. Earlier, in 1903, the Journal of the American Medical Association sensed medicine's new power and urged more vigor from physicians:

> It has been said, and with some truth, that medical men are not business men. It is certainly true that in the past our medical societies and medical organizations have not been business bodies in any sense. . . . While this, as far as it goes, is noble and idealistic, nevertheless it is recognized that a little more medical statemanship, and a little more attention to the materialistic side would not be out of place, and ought not to detract from the scientific and educational, but rather add thereto.[1]

In 1924, the American Medical Association rested triumphantly after defeating the movement for health insurance, in the midst of what would become a successful battle against the modestly irritating Sheppard-Towner Act. Notwithstanding the public health movement's demonstration of life-saving pilot work produced by centralization of health activities, the experiments remained as local enclaves. Although the projects showed that coordination was axiomatic to good health, without federal assistance and encouragement, they could not and did not survive.

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students and 65 percent of law students, but only 26 percent of medical students. In American Medical Education. The Formative Years, 1765-1910 (Westport, Connecticut: Greenwood Press, 1976), p. 51.

[1]Editorial, "What One Country is Doing," JAMA 40 (January 31, 1903):314.

In New York City, the public health movement fostered local health centers, which sought to coordinate all the health activities of a given neighborhood in one facility. The centers aimed to eliminate the waste resulting from a voluminous voluntary health effort; agencies had been working separately, often conducting the same kinds of work among the same populations. The New York Milk Committee initiated the first such experiment in 1913.

The Committee selected a district in lower Manhattan (bounded by Broadway, Liberty Street, and the North River) containing 1,576 families representing 27 nationalities, with Syrians and Irish-Americans the major population groups. Mortality and morbidity rates for both children and adults reflected the area's poverty and dilapidation. In December 1916, the Committee ceased its work in the health center and turned over the activities to the Bowling Green Association, a community group which it organized to represent local sentiment. Impetus for the Committee to relinquish control of the center came in January 1915, when the City Department of Health established its own health centers, tailored to the needs of local residents. In 1917, although the city had extended its initial health center work into Queens, a new administration ended the work and the city returned to the old

pattern, not to resume leadership of health center projects until 1930.

The New York Association for Improving the Condition of the Poor began an intensive health demonstration in the Mulberry District on May 1918. But the Mulberry Health Center did not offer a coordinated effort to centralize all services; instead it sought primarily to fill gaps in an area which had some public health services available already. These needs fell in the areas of prenatal and preschool care, with the AICP's five-year experiment confined to these services. This meant that neighborhood residents still had to jump from one center to another for complete health coverage. The demonstration, however, illustrated clearly that with a minimum (three months) of prenatal care for expectant mothers, the neonatal infant mortality rate could be reduced markedly. With prenatal care of less than three months, the neonatal mortality rate was 35.6; with more than the three-month base, it fell to 19.7.

The most formidable public health merger began in 1921. The East Harlem Health Center resulted from cooperation among the New York City Department of Health and twenty-one voluntary agencies led by the New York Chapter of the American Red Cross. With the addition of the East Harlem Nursing and Health Service in December

1922, the Center combined, under one administrative board, all nursing and health work formerly conducted through voluntary organizations, with headquarters on 116th Street near First Avenue. The demonstration district covered an eighty-seven-block area. The accomplishments of the massive coordination in the United States during World War I stimulated the project. Although the Center offered no therapeutic services, only preventive health care, the participants believed confidently that the absence of duplication would result in better health.

The East Harlem Nursing and Health Demonstration provided home care and prenatal and postnatal supervision, as well as supervision of preschool children; it also ran classes and conferences. Health workers entered the predominantly Italian community (which, with its poverty and congestion, practically matched the Lower East Side and Central Harlem), and dramatically lowered mortality rates. General mortality in 1925 fell to 11.6, while Manhattan maintained a mortality of 15.2 deaths per 1,000 population. Infant death rates dropped as well. Until the center opened, between 1916 and 1920 an annual average of 412 babies died before reaching age 1; between 1921 and 1925, the annual average dropped to 262 and between 1926 and 1930 it fell to 158. In 1931, there were ninety-eight infant deaths. That year, the maternal

mortality rate in the East Harlem District was 5.0, against New York City's level of 6.0 and the state's rate of 5.9. This demonstration, along with the Bellevue-Yorkville Health Demonstration (a similar project, begun in 1926) provided the impetus behind the City Department of Health decision in 1929 to create a grid of districts with neighborhood health centers. A group of city-run centers opened in 1930. In the fall of 1931, the city took over the operation of the East Harlem Health Center as a permanent unit of the city health program.

Although the district health program flourished in the 1930s and still exists today, its strength peaked in that decade; today, services vacillate with the city's financial ups and downs. The health centers have always suffered from the competition inherent in dual authority (between district health administrators and the heads of the Health Department bureaus) and the struggle has never been resolved. Also, the facilities never became true neighborhood centers, but divided communities by subjecting patients to means tests to qualify for treatment, a concession to doctors' complaints of public abuse of free care.[1]

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[1]See George Rosen, A History of Public Health (New York: Medical Publications, Inc., 1958), pp. 475-76; George Rosen, From Medical Police to Social Medicine. Essays on the History of Health Care, "The First Neighborhood Health Center Movement. Its Rise and Fall," (New

Nationally, the United States government did not tackle the problem of health as did such countries as France, Germany or Great Britain. The country simply lacked a nation-wide scheme to ensure even distribution of the fruits of the health revolution. Americans could point only to isolated units. Even local efforts were often pedestrian. Although in 1923 at least 164 cities with populations over 40,000 had infant welfare programs, in 76 of these cities the work lay entirely in the hands

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York: Science History Publications, 1974), pp. 304-27; Lillian D. Wald, Windows on Henry Street (Boston: Little Brown and Co., 1934), p. 96; The Maternity Service Report of the East Harlem Nursing and Health Demonstration, Final Report, Section I (New York: The East Harlem Nursing and Health Demonstration, 1928); The Infant Service Report of the East Harlem Nursing and Health Demonstration, Final Report, Section III (New York: The East Harlem Nursing and Health Demonstration, 1928); The Preschool Service Report of the East Harlem Nursing and Health Demonstration, Final Report, Section IV (New York: The East Harlem Nursing and Health Demonstration, 1928); A Decade of District Health Center Pioneering. Ten-Year Report of the East Harlem Health Center (New York: The East Harlem Nursing and Health Demonstration, 1932); The East Harlem Health Workers' Handbook on Infant Development, Care and Training (New York: The East Harlem Nursing and Health Service, Inc., 1931); East Harlem Health Center. Casting the Life Lines for East Harlem. A Study of the Vital Statistics of the East Harlem District, 1916-1925 (New York: The East Harlem Nursing and Health Center, 1927); New York Association for Improving the Condition of the Poor, Protecting the Mother and Child. A Five-Year Report of the Mulberry Health Center. A Prenatal and Nursing Service for Mothers and Children, Publication No. 133 (New York: AICP, 1924); Seventh Annual Report of the New York Milk Committee for the Year Ending December 31, 1913, pp. 48; New York Milk Committee, Ten Years of Work, 1907-1916, pp. 15-16.

of voluntary agencies. Even when cities administered primary health care, the failure of the federal government to support these endeavors actively lent a precariousness to the municipal efforts. When health demonstrations enjoyed relatively long life spans, if depression or fiscal crisis struck they were often the first programs to be narrowed or even eliminated. Stability of services has never become a characteristic of American public health facilities.[1]

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[1]Today it has become increasingly clear that cities cannot survive without active and ample federal help, thereby demanding a revision of national priorities. The history of New York City's fiscal crisis, although unusually severe, is an example of the fate of programs earmarked for the poor--again, they are expendable. The city fiscal crisis has forced the closing of fifty health care clinics in hospitals, through budgetary cuts of $85 million on the Health and Hospital Corporation, the public agency which now operates New York City hospitals, generally under affiliation contracts with voluntary hospitals or medical schools for professional staffing. The clinics, which include well-baby services, podiatry, family planning, dental prophylaxis and venereal disease treatment, formerly accommodated 400,000 visits annually. The Corporation's justification for closing these clinics attests to the ultimate failure of the driving force of the public health movement. The decision was made because these clinics served a preventive, not "life-saving," function. In addition to this termination of free hospital service, the Health Department closed a number of child health stations, three district health centers, and eight eye, three dental, two cardiac, a venereal disease, and a chest clinic. With their backs to the wall, health officials nonetheless understood that "to a great extent, if we eliminate the clinics, we will be eliminating the services that they provide." But did city officials understand this? Community activists for the poor, including Dr. John L. S. Holloman, Jr., former President of the Health and Hospitals Corporation, claimed that the cuts

The American Medical Association had defined health as an individual matter and the definition won acceptance. In his presidential address before the 75th annual meeting of the AMA in Chicago in June, 1924, William Allen Pusey restated the position of organized medicine:

> There is an evident tendency now to appropriate medicine in the social movement; to make the treatment of the sick a function of society as a whole; to take it away from the individual's responsibilities and to transfer it to the state; to turn it over to organized movements. If this movement should prevail to its logical limits, medicine would cease to be a liberal profession and would degenerate into a guild of dependent employees.[1]

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were disproportionately large and unnecessary, and that they could have been imposed in other agencies. They were not, according to these spokesmen, because politicians and decision-makers saw the poor as politically insignificant. Moreover, health facilities which did not close are becoming run down because of underfunding. Are not the shoddy and unsupervised free-care units responsible for the privateering and profiteering of Medicaid mills? Dr. Holloman, who resisted cuts, was forced out of office. Despite his fight, the staff in municipal hospitals has dropped from 43,000 to 37,000. Holloman maintained: "They're trying to balance the budget on the backs of the poor." See "City Hospital Clinics Will Close," New York Times, 6 November 1975, p. 45; "Coalition Decries Cutbacks Made in Health-Care Services for the Poor in New York City," New York Times, 20 December 1976, p. A17; Editorial, "Health Care Crisis," New York Times, 19 October 1976, p. 38; "Defender of Health Care for the Poor: Dr. John Lawrence Sullivan Holloman, Jr.," New York Times, 21 October 1976, p. 36.

[1]William Allen Pusey, "Some of the Social Problems of Medicine," JAMA 82 (June 14, 1924):1906.

The adoption of an individualistic approach to medicine affected the government's attitude toward interfering with private practitioners and hospitals. Hence Michael Davis' fears that hospitals' take-over of maternity clinic facilities might lead to the termination of public control found support. Voluntary and proprietary hospitals evolved without coherent standards. Their bottom line showed heterogeneous performance, as well as varying record-keeping and rate policies. Rarely did cities impose enforceable standards of public good. Hospitals demonstrated a lack of planning which resulted in duplicated efforts and fragmented, if not anarchistic, care.

The augmentation of hospitals in the first decades of the twentieth century was primarily an expansion of voluntary institutions, as doctors hoped to break the public's association of hospitalization with charity. Yet the mounting costs of new equipment which had given hospitals better reputations caused hospital administrators and trustees to seek public aid for the hospitals' survival. In 1909, thirty-five states assisted private hospitals with public funds.[1] Cities and states assumed this financial role principally because it was cheaper to

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[1]Joann Ashley, Hospitals, Paternalism, and the Role of the Nurse (New York: Teacher's College Press, 1976), p. 6.

subsidize pre-existing institutions than to construct and maintain their own. Yet this policy often became a betrayal of public trust, as governments abdicated their supervisory functions. Agencies gave public funds to private bodies which remained as free to abuse the contribution as to improve and democratize services. (As noted above, in 1916 New York City distributed over $5.5 million to private organizations for the destitute sick; in that year, the city provided 86.5 percent of the support of twenty charitable institutions for the sick. The city, through the Department of Public Charities, also paid for the delivery care of 6,549 women in private hospitals.)[1] Public subsidization of hospital confinement, whether on a per capita or yearly grant basis, did not depend upon any required municipal overview of physical facilities, treatment, admissions policy, or cooperation with city-wide planning.[2]

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[1] Humanizing the Greater City's Charity, pp. 20-24.

[2] Medicaid has continued the tradition of giving public funds to private individuals and groups without adequate supervision. Moreover, contemporary programs for the poor and the aged (i.e., Medicare) retain the divided nature of medicine. These programs sidetrack and postpone the inevitable necessity: an all-inclusive, comprehensive system of national health insurance. While Medicaid and Medicare have increased the aged and poor's use of physicians and health facilities, it is unclear whether the quality of care has been commensurate with the heightened quantity. At the same time, the programs have substantially inflated the costs of medical care and

The quality of medical care has depended largely upon individual ability to pay. When approximately two-thirds of American families earned less each day than the daily cost of hospitalization for one person, intensive medical treatment which required additional expenses for doctors or surgeons would, and indeed still does, threaten many--if not most--families' financial foundation.[1]

The unavoidable message of American medicine became one level of knowledge and skills, applied unequally. Attempts to carry the triumphs of science to those who could not afford private care bore the taint of charity. Except in extraordinary cases, physicians necessarily viewed their free or poorly compensated work with annoyance. If the wealth of an individual physician or hospital depended upon private endowments, subscriptions, and admissions, medicine rationally adopted a class preference. Without centralized control, market place philosophy determined medical choice. Lacking

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the individual profits of private practitioners. Recent investigations and exposures of Medicaid mills demonstrate that physicians have been the principal beneficiaries. See Editorial, Harry Schwartz, "Medicare/Medicaid: Tenth Birthday," New York Times, 29 June 1976, p. 31; also Editorial, "Medicaid Mess, Cont'd.," New York Times, 30 November 1976, p. 38.

[1]Davis, Medical Care for Tomorrow, p. 123; see also Reed, Health Insurance, pp. 33, 136, 242.

government intervention in health, the individual doctors and hospitals' perceived needs and preferences governed available care.

The population of the United States more than doubled between 1900 and 1950, while the number of licensed physicians rose but 35 percent from 149,000 in 1900 to 201,000 in 1950. Logically, the physician was preponderantly an urban practitioner. (In 1950, 70 percent of the 3,500 pediatricians practiced in cities; of the 3,073 counties in the United States, 90 percent had not one pediatrician.)[1] Doctors located themselves by the curve of the market, rather than its needs. Again despite the early twentieth-century preventive health movement, which saw social condition as an accountable contributory factor, medical education "has been oriented to the growing subject matter of a vocation rather than to the changing needs of a society."[2]

While both medical and non-medical professionals have sought to break the tiered system of care, without federal reinforcement these sponsors of one-quality care have merely been voices in the wilderness. Charity, as these proponents have noted, is not only intimidating but

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[1]Davis, Medical Care for Tomorrow, pp. 44, 46-47, 112.

[2]Ibid., p. 62.

also uneconomical. "Just as the cost of manufacturing and selling any single commodity by any single concern is very great, so the cost of manufacturing any single charity is out of proportion to the benefits bestowed by it."[1] More than that, charity could never sustain the needs of an economically unbalanced population. Taken out of context, American philanthropic donations for medical service seem generous; in 1950, they totaled between $400 and $500 million. This represented, however, less than 4 percent of the total annual outlay for medical care.[2] In 1916, J. Whitridge Williams saw compulsory health insurance as socialistic, but called it unavoidable and believed that it could easily be grafted onto the prevailing system of free enterprise. Arthur Newsholme was more emphatic and less apologetic for the implications of insurance:

> No section of the community--whether it be medical, non-medical, or concerned in public administration--can justify itself before the court of humanity in the possession of means for enhancing the public health, unless it adopts every available measure for securing the practice of these means.[3]

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[1]Wilbur C. Phillips, "Community Planning for Infant Welfare Work," Proceedings of the National Conference of Charities and Correction at the 39th Annual Session held in Cleveland, Ohio, June 12-19, 1914, p. 46.

[2]Davis, Medical Care for Tomorrow, p. 26.

[3]Williams, "Dispensary Abuse and Certain Problems of Medical Practice," pp. 1905-06; Arthur Newsholme,

Some proponents of state medicine asked how medical care differed from the state system of public education. Why should exorbitant fees be allowed to discourage people from obtaining care at all, or impoverish them if they did? Inez Philbrick, a physician who called for socialized medicine with salaried doctors, reminded her readers that private charity invariably proved unreliable and could never carry the costs of future medical expansion.[1] In another article she noted the advantages to the physician in state medical practice. The doctor, less pressured, would be relieved of "the embitterment of spirit under a competitive system with its attendant personal greed, envy, disloyalty and dishonesty."[2] Ultimately, only salaried practitioners could avoid discrimination between free and paying patients. Only then could medicine become a right, not a privilege.

In 1932, a self-created committee of fifty members published the first nationally inclusive survey of medical

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Values in Public Health, Vol. 1 of American Health Congress, Proceedings of the General Sessions, Atlantic City, New Jersey, May 17-22, 1926, p. 16.

[1]Inez C. Philbrick, "Significant Steps in Auguries Toward and of State Medicine," Medical Woman's Journal 35 (May 1928):123; see her earlier article, Inez C. Philbrick, "A Municipally Salaried Obstetrical Staff," Medical Woman's Journal 26 (August 1916):192.

[3]Ibid., p. 192.

care in the United States. The project, sustained by voluntary contributions, followed five years of investigation. "The quality of medical care is an index of a civilization," and the final published volume, Medical Care for the American People, reflected the level of American humanization in 1932.[1]

In essence, the report captured a self-serving medical system, guided by profits rather than public welfare. While human historical progression moves toward greater organization, medicine has not traveled from disorder to order. The anarchy of medicine permitted the profits of the few (the physicians themselves) at the expense of the public. In spite of the medical achievements of the preceding generation, the improvements in anesthesia, aseptic techniques, bacteriology, and radiology, "the predominant economic institution in medical practice today--private individual practice--dates back to ancient times."[2]

The committee focused upon the poor distribution of medical services and their inequitable costs as a chief problem. The United States presented an essential

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[1]Medical Care for the American People. The Final Report of the Committee on the Costs of Medical Care, Adopted October 31, 1932 (Chicago: University of Chicago Press, 1932, reprint ed., Washington, D.C.: U.S. Department of Health, Education and Welfare, 1970), p. xix.

[2]Ibid., p. 3.

inconsistency; the nation was financially and technologically able to provide quality medical care for all. Yet the bottom line of any social audit of American medical care in 1932, with 121,000 licensed physicians and 47,000 midwives, revealed bankruptcy. Gross maldistribution marked the seven thousand hospitals in the United States. Like doctors, hospitals located themselves where patients' ability to pay seemed most reliable. Hence rural and poor sections of the nation lacked medical services (in 1928, only 1,765 of the 3,072 counties in the country had community hospitals), while wealthier sections enjoyed oversupply. The situation played readily into the physician's ill-use of power; it was "an economic incentive to create unnecessary medical service or prolong illness." Medical care lacked certainty and logic. In 1929, there was 1 doctor to every 621 of population in New York; in California, the ratio of 1 to 571 was lower, but in South Carolina, the proportion stood at 1 to every 1,431 persons.[1]

Even family affluence did not correspond exactly to the quality of care received. The committee found that high income groups received inadequate treatment, when measured by standards of good medical care. To the extent that it purchased additional services, wealth

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[1]Ibid., p. 24; see also pp. 2, 4-5, 22.

primarily bought private nursing and hospital space for surgery. These families often received less than top quality maternity care, especially pre- and postnatal services.

Families of moderate income brackets suffered because of the difficulty of planning for medical expenses. The lack of coordination among hospitals, private doctors, and indeed the different states meant that families of the same income status could not account or predict rationally for possible illness.[1]

The poor paid the highest price for an individualistic and privately-supported medical system.

> In spite of the large volume of free work done by hospitals, health departments, and individual practitioners, and in spite of the sliding scale of charges, it appears that each year nearly half of the individuals in the lowest income receive no professional medical or dental attention of any kind, curative or preventive.[2]

Blacks, the poorest national ethnic group, suffered the greatest. Black mortality rates stood at least twice those of whites for practically every major disease (nephritis, tuberculosis, malaria, pellegra, influenza, and puerperal, cardiac, and vascular conditions). Although the committee did not investigate health care separately by race, it reviewed the situation of five

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[1]Ibid., pp. 7, 15-19.

[2]Ibid., p. 9.

hundred syphilitic blacks in Tipton County, Tennessee. Only 14 percent enjoyed any medical consultation or treatment, and only 3 percent received neoarsphenamine and mercury, the contemporary antidote.[1]

The public health movement resulted more in verbal enthusiasm than financial commitment. In 1932, only 51 percent of urban preschoolers between one and six and 37 percent of rural children the same age had undergone one or more health examinations. Collectively, no more than 13 percent of rural and urban children under age six received dental examinations. The extent of actual vaccination and immunization against diphtheria did not match the rhetoric of public health fervor.

The bottom line of public health and of good health was money, and money was scarce at best:

> Of the entire $30.00 per capital spent for the prevention and care of disease, only $1.00 has been used for public health service, Federal, state or local. The gross inadequacy of present expenditures is illustrated by two examples. First, the current expenditure is 65 to 80 cents per capita in American cities with populations of approximately 100,000 whereas satisfactory service calls for $1.79 to $2.13. Second, in contrast with current expenditures of less than 35 cents per capita for county and rural health work, certain studies indicate that a comprehensive public health program in such areas calls for approximately $2.50 per capita.[2]

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[1]Ibid., p. 10.

[2]Ibid., pp. 12-13. See also White House Conference

Without active state involvement in health care, medicine necessarily retained a class-distinctive quality. Effective involvement required more than classroom analysis of priorities, since without substantially more money, physicians had little incentive for public health work.

American medicine's lack of planning led to enormous waste and underutilization of facilities. The committee recommended greater expenditures in public health. It urged strongly the establishment of voluntary (not compulsory) health insurance, so that "the cost of care for those who cannot pay should be distributed according to ability to pay, over the rest of the community." The committee asserted that wages lost due to illness should be compensated with cash benefits. Finally, it advocated private formation of group practices to prevent duplicated effort.[1]

Committee dissenters charged that voluntary insurance would never suffice, since it would not cover the unorganized and lowest paid workers who did not qualify for indigent status. For this group, voluntary insurance was a sham which did not move medicine away from its current reality: that quality varied with the

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on Child Health and Protection, 1930. Addresses and Abstracts of Committee Reports (New York: The Century Co., 1931), pp. 99-108.

[1]Medical Care for the American People, p. 26.

individual's wealth.

The minority report, however, opposed any insurance whatsoever, on the grounds that it was contradictory to quality care and a device for laymen to usurp physicians' legitimate role. Government should not compete with medicine, but instead limits its involvement to the indigent, armed services, veterans, and the realm of public health. In fact, the dissenters declared that the government should assume the care of the indigent completely, relieving private doctors of the "burden."[1] Predictably, the AMA favored the minority statement, calling the majority report vague and lacking in evidence.[2]

Americans have borne the cost of a graded medical system, and women and children pay for it regularly. Since pregnancy and childbirth (and today, the possibility of abortion) are a normal part of almost every woman's adult experience, her confrontation with the medical apparatus implies a predictability which is not necessarily common with men. Children, susceptible to childhood infirmities which threaten death or physical handicap, needing routine immunization and periodic examinations, are also more vulnerable to the quality of medical care.

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[1]Ibid., pp. 44, 48-49, 127-28, 131, 150.

[2]"Final Report of Committee on the Costs of Medical Care," JAMA 99 (December 3, 1932):1959.

Women and children thus require periodic medical assistance as part of their maturation processes, divorced from illness and even the normal health hazards of an urban and industrial society. Therefore, they feel the strengths and deficiencies of the medical system to a greater degree than do men. In 1926, as the ardor of the public health movement ebbed, childbirth remained "a dangerous occupation; . . . in fact, it causes as many deaths among women at childbearing ages as do all the industrial accidents of men at the same period of time."[1]

In 1927, New York City listed 128,000 live births. For every 1,000, there were 5.4 maternal deaths, 46 stillbirths, and 56 deaths of infants under 1 year.[2] These figures can mislead, since taken alone they imply that infants represented the medical problem. Yet broken

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[1]Newsholme, Values in Public Health, p. 15.

[2]Davis and Jarrett, A Health Inventory, pp. 87-88. Between 1915 and 1924, infant mortality in New York City declined 29 percent while maternal mortality increased 14 percent from 6.4 to 7.3 per 1,000. The chief factor causing the higher rate appears to have been poor obstetrical care, which coincided with greater hospitalization for confinement. The death factors of sepsis and eclampsia had stabilized at one-third and one-fourth respectively. Among major cities in the United States, New York City's maternal mortality was respectable. Chicago did better with a rate of 5.3 in 1925, but Boston and Philadelphia, with rates of 7.3 and 7.0, did worse. In 1925, the maternal mortality rate for the United States' birth registration area was 6.5, in Australia it was 5.6, and in England and Wales it was 4.1. The rates in Japan, the Netherlands, New Zealand and Scotland were 3.0, 2.6, 2.7, and 6.2 respectively.

down, more than half of the infant deaths occurred with the child less than one month old and over a third with the baby under a week.[1] The data signify that women have been medically ignored and maltreated. Babies were born dead or prematurely, without the strength to live independently, because the system overworked, underfed, and undersupervised women during pregnancy, or poorly delivered them at childbirth.

Two systems of medical care, one private and the other public, necessarily make charity a "welfare gift." Insofar as free medicine connotes beneficence, it will never gain the status of an absolute right. Conversely, funds for education may rise and fall, but always within defined limits, since Americans have accepted and indeed demand the notion of universal public education. That imperative has not been injected into medical care. By the 1950s, public health tradition established a minimal level of free services, but had not fixed a quality nor demanded an even distribution of care.

By 1952, the New York City Department of Health published a broad survey of maternity facilities in the city. The study's roots dated back to 1947, when Dr. Leona Baumgartner, then chief of the Bureau of Child Hygiene (and later the City Health Commissioner), drew

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[1]Ibid., p. 86.

attention to the city's infant mortality rate. Between 1935 and 1946, infant mortality had declined by a remarkable 40 percent (in 1946, infant mortality was thirty-four per thousand live births), but neonatal mortality (i.e., infant deaths under one month) shrank only 24 percent. Again, this depended upon conditions affecting women. Not surprisingly, the neonatal mortality rate fluctuated geographically. Its height lay in central Harlem, where women were most likely to be physically undernourished and medically ignored.

The Health Department appointed a committee which visited and analyzed practically every hospital in the city with a maternity service. (Of the 107 maternity services in the city, the committee studied 104, as only 3 small proprietary facilities refused to cooperate.) Probing the personnel, policies, and facilities of maternity hospitals provided the surest index of women's obstetrical care, since by 1951 only one percent of the city's births occurred outside hospitals.[1]

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[1]A collection of twelve municipal, sixty-two voluntary and thirty proprietary hospitals held the city's maternity services. The majority (two-thirds) provided a medium-sized facility, with somewhere between twenty and fifty beds. Voluntary hospitals delivered 62 percent of the city's total births with another 23 percent delivered in proprietary hospitals, leaving municipal hospitals with approximately 15 percent of the deliveries. Infant and Maternal Care in New York City. A Study of Hospital Facilities. Sponsored by the Committee on Public Health Relations, The New York Academy of Medicine,

The committee announced its "most striking finding": the discovery of an inordinate amount of services failing to meet basic standards of competent care. Insufficient staffs, the absence of qualified obstetricians, pediatricians, and nurses, and the lack of necessary equipment plagued maternity facilities. Except for the proprietary hospitals, which only accepted private patients, all were overcrowded. The committee encountered basic deficiencies:

> In several institutions supervision is nominally in the hands of qualified personnel, but closer scrutiny reveals instances in which appointments are only "on paper" and the actual work is done by persons lacking proper qualifications. Particularly inadequate is the extent of pediatric supervision in the nursery. With the exception of a few outstanding institutions, pediatric care is provided only in cases of illness.

Rarely did prenatal, parturient, and postnatal personnel review ward patients' cases before discharge. In spite of the presence of social service departments, hospitals offered little liaison between doctor, social worker and nurse.[1]

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under the direction of the Subcommittee on Neonatal Mortality. E. H. Lewinski Corwin, General Director (New York: Columbia University Press, 1952), pp. vii, 3, 9, 13, 132. In the United States in 1952, 13 percent of births occurred outside hospitals.

[1]Care in larger services came closer to meeting recognized quality standards. Hospitals with less than twenty beds (usually proprietary) lacked essential equipment, especially for premature infants. Voluntary

Two-thirds of all infant deaths under a year occurred in the first week of life; they "take place in maternity services before the newborn is brought home by its mother." The outstanding causes of these deaths, leading to 70 percent of all infant fatalities, were prematurity, congenital malformation, and birth injury, produced by insufficient care of mothers and bad obstetrics. Researchers saw the great variations within the city as the most disturbing element of the mortality statistics. Just as maternal mortality, at eleven per ten thousand live births for the city as a whole, ranged from forty per ten thousand in eight maternity services to none in six large facilities, so did the neonatal mortality rate. The rate varied between ten and thirty in the different institutions, with twenty per thousand live births the city-wide average.[1]

Mortality demarcations appeared distinctly between patients delivered by private practitioners against those delivered by staff (ward) physicians, and between white and non-white patients. In 1946, black infant mortality

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hospitals provided the best care, proprietary the worst. Care at municipal hospitals, which offered reasonable therapeutics and safeguards, suffered because heavy patient demand and tight city financing strained atrophied staffs. Ibid., p. 134, see also pp. 15, 133.

[1]Ibid., pp. 12-13, 24, 134.

stood at fifty per thousand births, against a white rate of thirty-two. The neonatal mortality rate among infants of ward patients, either at municipal or voluntary hospitals was twice the rate for infants delivered privately. Notably, the cleavage between death rates for black infants delivered by private and staff doctors appeared less marked than for whites. Presumably, this followed because black women's poor physical condition before and their lack of supervision during pregnancy made the issue of who delivered them insignificant.[1]

For the most part, the city hospitals provided appalling care for the newborn. Hospitals regularly violated recommended standards for the prevention of infection and cross-infection. Almost a third of the hospitals ignored the city's sanitary requirement for spacing bassinets six inches apart. Overcrowded facilities meant that maternity administrators reused bassinets before they could properly be cleansed and disinfected. Antiseptic precautions appeared lax at best. Twenty-seven percent of the services provided no washing facilities in the nurseries. Hospitals seemed unresponsive to the mortality curve, as a fourth of the facilities lacked incubators or heated cribs for premature infants (i.e., those born alive, at any time during gestation, but

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[1]Ibid., pp. 3, 5.

weighing no more than five and a half pounds).[1]

For women, supposedly at the peak of their womanhood, delivery care in 1952 proceeded as a rote process among an overtaxed staff. Twenty-five percent of the city's hospitals did not even have a qualified obstetrician supervising the services. Ward patients entering voluntary or municipal hospitals through prenatal clinics were often no better off than "emergency" cases or patients entering the hospital as free patients without prenatal observation. Free clinics served little medical function. In over 40 percent, the woman received no doctor's examination on each visit; in some, she did not see a doctor on her first visit. In a third of the clinics, the staff did not analyze urine at each visit--a complete

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[1]Ibid., pp. 43, 48-50, 57-58, 94, 136. In most of the institutions hand washing was not an accepted practice after diapering of infants. Hospitals regularly violated Sanitary Code provisions requiring damp mopping of nurseries. Thermometers, ideal media of cross-infection, were not cleansed with soap after use in 37 percent of the facilities. The loose health guidelines did not result from efforts to generate warmth between patient and personnel, in attempts to bring mother and infant together in love and instruction. Only thirty-eight hospitals allowed mothers to feed their babies three times a day; twenty-seven hospitals refused to allow mothers to feed their infants at all, and twenty-eight institutions permitted the mother and child together at feeding time only once a day. Making matters worse, when not with their mothers the babies were fed mechanically with propped bottles in all proprietary hospitals, in 75 percent of the municipal facilities, and in 79 percent of the voluntary institutions. This practice threatened not only infants' emotional withdrawal (at the most crucial moments of their day, they had no human contact), but their very lives, by aspiration.

denial of the value of prenatal work. Seventy percent of the clinics did not bother to communicate with women who missed appointments.

Typical of the atmosphere of free medical work, women waited hours at the clinics before their examinations, which were hurried, performed in the midst of a bustling staff, and utterly antithetical to confidential discussion between patient and physician. Virtually all clinics kept sparse records, preserving and detailing few medical guidelines for the delivery attendant.[1]

In many hospitals, actual labor and delivery, instead of representing the summit in a woman's life, proved instead to be a disorganized and dehumanizing experience. Demand for maternity services exceeded accommodations, and municipal hospitals particularly lacked sufficient labor rooms. Many women underwent labor in hallways, and because of space shortages, many deliveries actually took place on stretchers in corridors. The labor rooms themselves often had no sinks or toilets. With all the knowledge of puerperal fever, hospitals maintained inadequate sterilization precautions.[2]

By the mid-1950s maternity care had assumed a new status quo. Even the concerns of unnecessary

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[1]Ibid., pp. 27-29, 62-63, 135.

[2]Ibid., pp. 31, 34, 135-36.

mortality which triggered the Department of Health study in 1947 have diminished. Just as two generations ago, an infant's survival today depends on where and to whom he is born and his color.[1] Many countries which lagged

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[1]Sam Shapiro, Edward R. Schlesinger and Robert E. L. Nesbitt, Infant, Perinatal, Maternal, and Childhood Mortality in the United States (Cambridge, Massachusetts: Harvard University Press, 1968), pp. 133-34, 136-37, 146. See this volume for discussion of the slowdown of the decline of maternal and infant mortality rates in the 1950s. "Infant mortality increased in many large cities. Nonwhite infants especially were affected by this increase, but in some cities white infants also had a higher rate in 1960-61 than ten years earlier." Ibid., p. 134. Today as at the beginning of the century, socioeconomic status determines mortality. Premature births are two times greater among low income groups; the stillbirth rate and infant death rate in the first month of life is twice as great in the nonwhite group than in the white population. The discrepancy between white and black maternal mortality is greater today than it was in 1915. In 1915, the white maternal mortality rate was 60.1 per 10,000 live births, with the nonwhite rate at 105.6. In 1963 the differential stood at 2.4 per 10,000 live births for white women and 9.7 for black women. In 1968 the difference between white and nonwhite infant mortality was as follows: In New York State, 18.3 compared to 33.5; in Westchester County, 14.8 against 34.6; and in Cook County, Illinois, 20.1 against 37.6. See National Foundation/March of Dimes, Annual Report, 1972, p. 5. See also Jean E. Bedger, Abraham Gilperin and Eveline E. Jacobs, "Socioeconomic Characteristics in Relation to Maternal and Child Health," Public Health Reports 81 (September 1966):829-33, in Medical and Health Research Association of New York City, Poverty and Health in the United States. A Bibliography with Abstracts (New York City: Medical and Health Research Association, 1967), pp. 147-48; Arthur J. Lesser, "Closing the Gaps in the Nation's Health Service for Mothers and Children," Bulletin of the New York Academy of Medicine 41 (December 1965):1248-54, in Poverty and Health, p. 152; Edith H. Anderson and Arthur J. Lesser, "Maternity Care in the United States; Gains and Gaps," American Journal of Nursing 66 (July, 1966):1539-44, in Poverty and Health,

behind American infant and maternal mortality rates in 1952 eclipsed the United States in 1967. Half the nations which had poorer infant mortality standings in 1953 outstripped America fourteen years later. In 1953, the United States boasted the second lowest maternal mortality rate. Ten years later, eleven nations had better rates.

> Obviously it was not imperative that they [other nations] do so; it was a matter of national priorities, and the United States had never yet chosen to give the matter of health protection a number-one priority[1]

In 1973, seventeen developed nations logged better infant mortality data than the United States. What the Children's Bureau discovered in the early years of the century unfortunately remains true today: Most of the deaths in

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pp. 159-60. Shaprio, Schlesinger and Nesbitt write: "The 1964 [maternal mortality] rate among nonwhite mothers was at about the same level as the rate among white mothers 16 years earlier (1948)." In Infant, Perinatal, Maternal, and Childhood Mortality, p. 146. Similarly: "It was not until 1973 that non-whites achieved the [infant mortality] rate of 26.8 per thousand that had been achieved for whites in 1950." See Leon Eisenberg, "The Search for Care," in John Knowles, ed., Doing Better and Feeling Worse (New York: W. W. Norton, and Co., 1977), p. 247.

[1]Edwin P. Hoyt, Your Health Insurance: A Story of Failure (New York: The John Day Co., 1970), pp. 19-20. In 1953, New Zealand had the lowest rate, with forty-four maternal deaths to every ten thousand live births. The United States rate was fifty-three per ten thousand. Ten years later, New Zealand, with a maternal mortality rate of 31.3, had fallen to seventh place among developed nations.

infancy can be attributed to environmental adversities affecting mother and infant and the standard of medical and hospital care which both received.[1]

[1]See the National Foundation/March of Dimes, Facts: 1976, p. 6.

CONCLUSION

I want them to feel fear now
as I have felt suffering in the womb, and
I want them
to know
that there is always a time to make right
what is wrong,
there is always a time
for retribution
and that time
is beginning.

--Susan Griffin
I Like to Think of Harriet Tubman

Recent monographic attention to contemporary obstetrics expresses outrage at the outcome of the undue medical orientation of childbirth. For these authors, obstetrics today is the culmination of male usurpation of a traditional female role as birth attendant; male professional supremacy carries a concomitant corollary of female passivity.[1]

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[1]Suzanne Arms, Immaculate Deception. A New Look at Women and Childbirth in America (Boston: Houghton Mifflin Co., 1975), p. 21: "Victorian woman, even more ashamed of her body than her European sister, received chloroform with immense gratitude, as she could now give birth, the ultimate elemental experience, without having to deal with any of the elements--emotions, sensations, bodily secretions, smells, blood. Floating into euphoria as she reclined on her back on the doctor's table, woman released everything she had--her power, her work, her responsibility, and her baby--to the authority of the physician. . . . There is no doubt that the history of childbirth can be viewed as a gradual attempt by man to extricate the process of birth from woman and call it his own." Adrienne Rich, Of Woman Born. Motherhood as Experience and Institution (New York: W. W. Norton and Co., 1976), pp. 170-71: "No more devastating image could be invented for the bondage of woman: sheeted, supine, drugged,

Physicians' efforts to dislodge the midwife went beyond scatological attacks on her cleanliness, integrity, and record of ability, to a scare campaign intended to corrode woman's confidence in the naturalness of childbirth. Arguing their omnipotence, physicians exaggerated the pathology of pregnancy and delivery, the successful outcome of which required their technological expertise.

Hospitals' resulting preeminence for confinement heaped indignities upon women, victims of often irrational institutional procedures which threatened essential bonding between mother and newborn. It also depersonalized a key experience in women's lives, once rich in overtones of family ritual and closeness. More unpardonably, hospital confinement correlated graphically to the escalation of technical interference. Doctors subjected women to elective labor induction, the routine use of analgesics and anesthesia, and episiotomies. The use of forceps and resort to cesarean section rose precipitously through the expansion of vague and dubious indications. Indeed, the very obstetrical fatalities which obstetricians used to justify their ascendancy often resulted from such interventions, making childbirth a key arena of iatrogenic disease and death.[1] These

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her wrists strapped down and her legs in stirrups, at the very moment when she is bringing new life into the world."

[1]Arms, Immaculate Deception, pp. xii, 21, 23, 45, 135, 138-39, 142, 170-71, 182, 185, 220, 270. In Holland in

writers posit the plausibility of home birth by midwife, as long as prenatal care has been continuous.[1]

1965, where only 31.4 percent of the women gave birth in hospitals, infant mortality was 14.4 per 1,000 live births. In the United States that same year infant mortality was 24.7 per 1,000 even as 97.4 percent of the births took place in hospitals. Adrienne Rich, Of Woman Born, pp. 29, 170-73. See also Juliet Mitchell and Ann Oakley, eds., The Rights and Wrongs of Women (Middlesex, England: Pelican Books, 1976), pp. 18, 20, 22-23, 35-36, 47-48, 51-52; Gena Corea, The Hidden Malpractice. How American Medicine Treats Women as Patients and Professionals (New York: William Morrow and Co., Inc., 1977), pp. 185-86, 194-98, 200-02, 204-13, 220-22, 225-28; Sheila Kitzinger, The Experience of Childbirth (Middlesex, England: Pelican Books, 1977), pp. 22-23, 25, 86, 150-51, 181-217. These authors attribute the alienation of modern childbirth to a list of intrusions (largely unwarranted medically) upon the natural rhythm of birth. Women, afraid of their bodies, have abdicated the experience of childbirth to physicians. The procedures to which they object include the supine delivery position; the overuse of fetal monitors; elective labor induction, risking the delivery of premature or brain-damaged infants (faster, harder contractions give the fetus less time to recover from oxygen deprivation during a contraction), and causing resort to more pain relief and forceps; routine shaving and enemas; automatic willingness to administer pain relief; overuse of forceps and cesarean sections; automatic episiotomies; removal of the newborn from the mother at birth; and rigid hospital feeding schedules.

[1]While the authors contend that 90 percent of all births are normal and therefore within the realm of the midwife, they do not abide by the contemporary nurse-midwife. Instead they envision independent midwives, free from the authority of the physician. Today there are approximately 1,200 practicing nurse-midwives, of whom 600 are certified through the American College of Nurse Midwives in Washington, D.C. The nurse-midwife has defined herself--at least through the College--as an adjunct to the obstetrician. Her handling of normal pregnancies and deliveries enables the overcommitted physician to devote time to complicated cases. All nurse-midwife cases fall under the general direction of an obstetrician, who intervenes in the event of abnormalities. Nurse-midwives are restricted to hospital deliveries. To become a certified nurse-midwife, an applicant must be a

This contemporary assault appears to relate directly to the transitions in maternity health care of the late nineteenth and early twentieth centuries, when the resurgence of midwifery brought on the total elimination of the midwife and the hospital supplanted the home for childbirth. Were these changes avoidable? If so, was the status quo in obstetrical care tenable? Were public health leaders disingenuous front men and women for the medical establishment, seeking its hegemony? Were there not real risks in childbearing which demanded remedial redress?

In fact, problems existed. Women and infants died unnecessarily. Childbirth attendants, whether female midwives or medical practitioners, had to be trained to bring

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registered nurse and complete a one- to two-year program recognized by the American College of Nurse Midwives. Certification comes after successful completion of National Certification examinations. Since the training of nurse-midwives takes place in hospitals, contemporary critics of obstetrics claim that the nurse-midwife has also been educated to see childbirth as a risky and often abnormal medical event. Yet while nurse-midwives acknowledge the medical supremacy of the physician in complicated cases, they also see themselves as levelers in the humanization of childbirth. The nurse-midwife offers patients more human and continuous contact; she is constantly by the side of the laboring woman; she understands her potential effect in lowering the costs of maternity care. In some hospitals in which nurse-midwives practice, they have succeeded in permitting women to sit while delivering the fetus and have put infants of minimally-medicated mothers to the breast immediately upon delivery. See Dorothea M. Lang, "The Midwife Returns--Modern Style," reprinted from Parents' Magazine, October, 1972, pp. 1-3; Research Committee of the American College of Nurse-Midwives, Descriptive Data. Nurse-Midwives --U.S.A. (Washington, D.C.: American College of Nurse Midwives, 1971).

women and infants through childbirth safely and scientifically. The maturation of medicine at the turn of the century indeed made obstetrics a science, no longer an art or craft. Researchers developed life-saving procedures, requiring specialized study. Yet in the major shortcoming of this stage of obstetric history, the solutions settled upon betrayed the public health philosophy which generated them. The public health movement, which posited health as a human birthright, which elevated preventive health care over curative treatment, and which demanded that medicine bow to a higher public good, established and enforced by central authority, went unfulfilled.

The requisite for standardized obstetrical training did not foreclose the profession to midwives, but required intervention for their uniform education. In the United States, this never happened. In Europe, on the other hand, governments trained midwives, and they became linked inextricably to the obstetrical process. The debasement and elimination of the midwife in America combined components of historical luck and institutional and structural failure. In part, different traditions of medicine and midwifery in Europe and the United States allowed the integration of the midwife overseas and caused her abolition here. Yet the distinction in obstetrical care reflects an attitude and willingness of European governments to interfere with free

enterprising physicians to establish national medical boundaries.

In Europe, the long history of midwifery put midwives on surer footing when male accoucheurs encroached upon their domain; they fought back with the confidence of inherited tradition. In the United States, midwifery enjoyed but a short period of prestige: before the Revolution. In the late eighteenth century midwives continued to practice, but without formal education and licensing; a professional consciousness did not emerge from these conditions. At the same time, American physicians showed interest in obstetrics, as word of new methods and techniques filtered into America from Europe. Toward the end of the century, as the United States became more urban, widespread destitution surfaced. The resulting municipal welfare consciousness, which led often to the attachment of public hospitals to almshouses or independent hospitals, provided clinical material for physicians' burgeoning interest in childbirth. Once it became fashionable for middle- and upper-class women to seek male assistance in childbirth, uncontrollable forces doomed midwifery to play a tangential role. Male hostility to the midwife until the last two decades of the nineteenth century remained negligible, as midwives had ceased to play a predominant part in obstetrics.

When midwifery did reemerge as cultural baggage of immigration, beginning in the 1880s, it sparked fears and counterattacks from male and female practitioners. Alien midwives, poor and foreign-tongued, were ill-equipped to meet the attack. Their immigrant clientele could not lobby for them.

Moreover, the resurgence of midwifery at the turn of the century coincided with internal shifts in American medicine, which practically predetermined the failure of midwifery here. Medicine had been plagued with sectarian divisions from its beginning; at the end of the nineteenth century the alleopaths, or regular physicians, after making accommodations with homeopaths, became satisfied that practitioners had formed a united front, essential for professional status. Hence, American physicians found themselves particularly sensitive to any invasion. Concurrently, as obstetrics formed an independent branch of medicine, obstetricians sought to elevate their specialty to the level of surgery and medicine. To do this, they had to wrestle childbirth out of the hands of the general practitioner. Obstetricians obviously had little patience for incoming midwives who threatened to undermine whatever progress they made.

Yet even in this atmosphere, midwifery might have survived had municipal and state governments intervened with

educational and licensing requirements sufficient to legitimize the profession. Instead the midwife was left to fend for herself, amidst charges of her incompetence from the medical elite and among diverse and casual state requirements, none of which sought to make her a permanent entity in America. While many public health experiments demonstrated the midwife responsible and responsive, government officials succumbed to the pressure of organized medicine to phase out the midwife rather than control her. The abandonment of midwifery resulted less from male hostility than from physicians' fears of government-established regulations and where those controls might lead. This represents a structural flaw in this nation. European governments, often weathering vocally fierce opposition from physicians, incorporated the midwife, ensuring her safety for women who would continue to employ her. In the United States the midwife could have been trained; there was--and still is--need for her services, and she should have been trained. When government, however, exhibits a social laissez-faire policy, private needs, profit motives, or sectarian professional goals bury the public interest.

In spite of the unnecessary failure to create a place for the midwife, obstetrical care had to move forward. When history moves from lower to higher planes, reformers often discover inadequacies in the new and attribute the

flaws to the transition itself. Yet once change is defined at the new plateau, true progress means the necessity of involving some elements of the old, rather than rejecting it entirely. The pendulum, having swung too far, requires readjustment. Because many women today can safely give birth at home or in small, intimate maternity clinics does not mean that the movement from home to hospital for childbirth in the early twentieth century was incorrect. With life-saving procedures available, health leaders had to attempt to apply controls evenly and uniformly. Logically, a central institution, capable of combining the resources of equipment and personnel, became the distributor of maternity care.

The fact that hospitalization through 1930 often had no noticeable effect on maternity or infancy death rates--indeed fatalities from accidents at birth rose markedly as a result of physicians' haste, unnecessary interference with delivery, and their desire to experiment with new techniques --attests to the ubiquitcus tradition of laissez-faire and medicine. It does not mean ipso facto condemnation of hospitalization for childbirth. By 1915, the leaders of the public health movement had advanced philosophically beyond the palliative recommendation of education; the emphasis on education avoided the issue of poverty and skirted the fact that while poor health is inherited, good health must be

bought and cannot be learned. If individual health had less to do with intelligence and more with social and economic conditions, and if health were indeed among the government's priorities, then it would have to intervene with assistance and structural equalizers. The public health movement of the early twentieth century bore the concept of health as human birthright, but failed to reconstruct organized medicine to serve the public interest. Instead, two systems of medical service (one private, depending on one's ability to pay, and one charity, measured by the public budget, largess, and current politics) emerged, catering to different social groups. The public sphere, necessarily plagued with financial uncertainties and overworked and resentful staffs, could never offer its care generously. Bogged down with administrative requirements that recipients qualify financially, public health never became more than a welfare gift.[1]

Free medicine could hardly offer quality care when it could not attract physicians who would otherwise profit in the private sector. The public health movement came no closer to a structural redefinition of medicine than its

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[1]State officials in California recently reported that among the state's obstetricians only 37 percent are willing to deliver babies of the poor, because they would receive only the $300.00 permitted under Medi-Cal. See "Rebirth for Midwife." Time (August 29, 1977):44.

fight for health insurance, but the issue brought little support from the federal government and the A.M.A. proved stronger, having converted the government to an individualistic interpretation of medicine.

Through the 1920s, medicine remained a business in the United States. Hospitals served physicians' needs for clinical teaching and for technical services for their private patients. But hospitals failed to ensure quality of care by doctors. As public acceptance of hospitalization for childbirth grew, physicians, regardless of their level of training, sent their patients to the institutions. Yet because of the facilities' egalitarian approach, nothing prevented untrained doctors from performing procedures for which they were unqualified, and little pressure existed to control even the most obvious malpractice.

Hence women's tragedies lie more in the unregulated performance of doctors than with the application of science to childbirth. If physicians' whim or personal inclination were not supreme, women would no longer be victims of their attendants' fancy to anesthetize routinely or become a casualty of a capricious weekend vacation and hence the object of a non-indicated induced labor. With uniform and enforceable standards, cesarean sections, forceps, and episiotomies would only follow medically acceptable criteria. Were doctors servants of the public and not their

pocketbooks, then free or ambulatory prenatal care could become quality care, capable of eliminating many obstetrical abnormalities and the commensurate need for interference, emergency or otherwise, at birth. If public need dictated the form of medical practice, organized medicine would be forced to acknowledge and adapt to the lack of trained obstetricians and their uneven distribution.[1] Midwifery might then become possible in the United States.

Contemporary arguments abound with reproach of an over-technical delivery system which robs women of what some authors describe as the sensual experience of birth. Following this line, they attack the Lamaze method of natural childbirth as a distraction that does not permit women to feel the power of their bodies at birth, described as orgasmic by some.[2]

Whether this account of childbirth is valid or romanticized, it ignores the central reality of health care for women dating back to the early nineteenth century: the mortality of poor women and children. The demands that childbirth be at home where carnal or voluptuous sensations

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[1]In 1970, at least 15 percent of residency positions in obstetrics/gynecology were vacant. See Lang, "The Midwife Returns," p. 1. In the mid-1970s, obstetricians numbered 19,000 of the 335,000 practicing physicians in the United States. See Arms, Immaculate Deception, p. 45.

[2]Arms, Immaculate Deception, pp. 145-46; Rich, Of Woman Born, p. 26; Kitzinger, Experience of Childbirth, pp. 181-217.

can prevail must sound empty and even farcical to poor women. For low-income groups, childbirth still presents significant risks stemming from neglected physical conditions, undernourishment, and inadequate prenatal observation. While there has been major progress in the reduction of infant and maternal mortality rates, embarrassing variation remains as class and racial status still determines the cleavage between life and death. All abnormalities associated with pregnancy occur with greater frequency among low-income women and children. Home birth for New York City's poor population would often mean birth among rats and cockroaches.

Are we to return to the nineteenth-century division of two levels of medical care? Should the poor once again be relegated to hospitals, while upper-class women remain at home for childbirth? Or, instead, should the demand focus on high quality care for everyone? If so, the only conceivable method of achieving this aim is to eliminate all distinctions in care. To do this, the government must transform medicine into the service of the public. The costs of medical care must be distributed, and become predictable and affordable. Ultimately, there can be no demarcation of medical facility or personnel according to the recipient's wealth.

A psychological unity joins all women, regardless of their place in the social strata. The commonality is the result of biology, as well as the peculiar forms of discrimination and exclusion to which women have been subjected. These links extend to motherhood and to issues of reconciling the many facts and pressures of women's lives--whether work or outside interests--with their rearing occupations. These are central concerns for women. Where and by whom a woman delivers a baby is essentially irrelevant, as long as her attendant is competent. While doctors' disdain, treating patients like children, is infuriating and untenable, form always influences content. Arrogance is an expression of individualism, more pervasive when groups do not have a sense of accountability.

Any reformation of medicine in this country demands the elimination of a two-tiered medical care system. The inclusion of midwives, paramedical assistants, and other social service representatives to make medicine personally more responsive requires a centralized base as the guarantor of quality standards. Comprehensive care must replace fragmented and disparate facilities which treat people as problems instead of full individuals. First-rate care is impossible without centralization.[1]

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[1]The poor either have been ignored medically or subject to the most superficial care from a farrago of

Significant anomalies remain in the childbirth process, requiring immediate redress. While such modern techniques as fetal heart monitoring and amniocentesis have evolved from the revolution in medical care, medical insurance infrequently covers any more than a small portion of the cost of maternity care.[2] At the same time, carriers

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unsupervised and uncoordinated agencies. Not infrequently they are the unknowing subjects of medical experimentation. In late 1976 the United States General Accounting Office revealed that the Indian Health Service in 12 centers located in Albuquerque, New Mexico; Phoenix, Arizona; Aberdeen, South Dakota; and Oklahoma City, Oklahoma had sterilized at least 3,400 Indian women without informing them that the procedure was not mandatory. See "Study Finds Many Indians Sterilized by United States Agency without Full Explanation," New York Times, 23 November 1976, p. 16. The costs of maternity care are so high that in many regions of highly concentrated low income groups, the quack practitioner can profit by using low prices to attract patients. An osteopathic physician has been charged with ten counts of murder in the neglect of newborn infants in a maternity clinic he operates. This doctor previously served a two-year prison term and lost his license for the deaths of women from illegal abortions. In 1974, the license was restored. Mexican-Americans were the chief clientele at the maternity clinic which he ran once he resumed practice; he charged between $200 and $300 for delivery attendance. The doctor, Dr. Joseph Emery, was the only professional with a medical license serving the clinic. See "Infant Dies after Being Taken from Doctor Held in Ten Deaths," New York Times, 10 June 1976, p. 20.

[2]To have a baby in a voluntary hospital in New York City costs up to and often beyond $2,000, with the physician's fee approximately $850.00 and the price of a five-day hospital stay at $1,200.00. The tariff for a private room in the hospital maternity division can reach $230.00 daily. In Manhattan in early 1976, the least expensive semi-private accommodation (with four patients to a room), at the New York Infirmary for Women and Children, costs $90.00 a day. "Staggering Expenses of Having a Baby," New York Times, 23 January 1976, p. 37.

almost routinely pay substantial amounts for appendectomies. The failure of maternity compensation in the United States has meant that working women who cannot afford to take leaves of absence risk postpartum complications for themselves and congenital debility and prematurity for their infants. Pregnant women are also subject to haphazard firing, refusals to re-hire, and unpaid leaves, and often find themselves stripped of their seniority rights in what many argue is the most highly developed "welfare state" in the history of the world. The Supreme Court decision of December 7, 1976, excluding pregnancy leave workers from disability payments not only discriminates against women on the basis of sex, but also makes childbirth an economic liability for millions of working women.

If private profits remain the driving force in medicine, achieving public health is impossible. The chain of poverty and inadequate health care cannot be broken. Today an estimated one-quarter of American children are excluded from ordinary health care, as have been their mothers while pregnant. The advancements of science benefit the few. Kenneth Keniston has written: "The mortality rates for nonwhite infants born in America's twenty largest cities approach the rates in urban areas of undeveloped countries. While surgeons perform an estimated 500,000 unnecessary tonsillectomies on children each year, we are among the

few modern nations that do not guarantee minimal health care to all mothers and children."[1]

As guilt and self-contempt invaded women's lives, when they accepted the notion of education for motherhood, today many child experts continue to posit the notion of intelligent parenting. This concept predicates itself on the assumption that families are autonomous and that they and their children can become immune from outside pressures. It condones social laissez-faire when family support requires social intrusion. Today, for instance, when a third of mothers of preschool children work and over half of mothers of school-aged children work outside the home, the system still lacks quality substitute child care. (Indeed, present programs which require mothers to work in lieu of welfare or to maintain their benefits are doubly anamolous,

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[1]Kenneth Keniston, "For Him, There Is No Exit from the Cellar," New York Times, 20 February 1976, p. 33. Approximately 248,000 infants born each year in the United States (or almost 8 percent) weigh five and a half pounds or less. Low-birth-weight infants are three times more prone to birth defects and seventeen times more liable to death in their first year than normal-weight infants. The prenatal coverage of pregnant women to detect complications and prevent maternal malnutrition make up the key elements--as five decades ago--in bettering American death statistics. Infant mortality remains a function of poverty. "[It] is inversely proportional to birthweight. And birthweight, in turn, depends heavily on the nutritional history of the mother throughout her childhood and adolescence." The National Foundation/March of Dimes, Annual Report, 1972, p. 6; see also National Foundation/March of Dimes, Facts: 1976, p. 7; The National Foundation/March of Dimes, Annual Report, 1975, pp. 9, 18.

since they cost more, when combined with public child care, than straight Aid to Families with Dependent Children, and also damage children by removing them from their mothers.)[1] Sixty years ago, social workers recognized that working mothers, overwhelmed and harassed, could not be nourishing rearers; they suggested mothers' monetary benefits as the remedy.

Today the solutions must go further. Work must promise at least minimum economic security, for enriching parenting cannot take place in an environment of starvation; new work schedules might be devised, offering part-time work to men and women, giving them time to raise children; at the very least paid maternity and paternity leaves of absence must be federally mandated.[2] In a purportedly child-centered society, housework and child-raising remain the only two unremunerated professions in the country. "The pity is that we define work only as paid participation in the labor force, ritually celebrating but leaving financially unrewarded the strenuous and indispensable work women and men also do at home rearing children."[3]

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[1]Selma Fraiberg, Every Child's Birthright: In Defense of Mothering (New York: Basic Books, Inc., 1977), 112-47.

[2]Kenneth Keniston, "The Emptying Family," New York Times, 18 February 1976, p. 35; Keniston, "For Him There Is No Exit," p. 33.

[3]Kenneth Keniston, "Should We Stop Blaming Parents?" New York Times, 19 October 1977, p. C9.

The denial of Medicaid benefits for abortion poses a central example, if perhaps reversible, of the intransigence of the class orientation of medicine and the federal government's unwillingness to challenge this bias. Hence the Supreme Court of the United States countenanced the status quo in American health service: that quality of care depends upon one's ability to pay.[1] For women, the Supreme Court ruling that neither the Constitution nor federal law requires states to fund elective abortions through Medicaid does not say simply that only those who can afford to will determine the time and the suitability of their motherhood. It means that many women will continue to terminate their pregnancies at their discretion but will now be forced back into the hands of cut-rate physicians of dubious skill and reputation, or else outright illegal abortionists. Only wealthy women will vindicate their legal right.

Medicaid avoids the issue of social health insurance. A tiered system will exist, however, unless there is one level of practice; welfare connotes beneficence and not right. President Carter's defense of the withdrawal of federal funds for abortion is a classic comment on the subordination of right to subjective caprice. The New York

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[1] "Recent Supreme Court Rulings Have Set Back Women's Rights," New York Times, 8 July 1977, p. A8. Until the decision, Medicaid funds paid for the abortions of 300,000 women a year.

Times reported that "President Carter conceded today that denial of Federal aid for abortions could discriminate against poor women, but he said that 'there are many things in life that are not fair, that wealthy people can afford and poor people can't. But I don't believe that the Federal Government should take action to try to make these opportunities exactly equal.'"[1] If not, who should? And if not the federal government, who can?

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[1]"President Defends Court's Action Curbing Federal Aid for Abortion," New York Times, 13 July 1977, pp. A10, B11; see also "Abortion Cut Off Causing Hardship for Poor Women around Country," New York Times, 25 December 1977, p. 20.

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