

Gender Ideology in the Rise of Obstetrics

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INTRODUCTION

At present, obstetrics is a major specialty in the field of medicine in the United States. However, until the early twentieth century, there was no agreement on what constituted an obstetrical specialist, and different types of medical practitioners were involved in the practice of obstetrics. In 1910, approximately half of all the births were attended by midwives, and most of the physicians who attended the births were general practitioners and not obstetrical specialists.¹

Obstetrics struggled to achieve respect and recognition as a specialty during the time when the field of medicine in the United States was rebuilding its professional status and striving to achieve legal protection for its services. However, as Charlotte G. Borst states, “the professionalization process for obstetrics differed from that of other medical specialties.”² General practitioners argued that obstetrics was a part of their overall practice and thus obstetrics lacked recognition and respect as a specialty. John Whitridge Williams, Professor of Obstetrics at Johns Hopkins University, expressed regret at the lack of appreciation by his medical colleagues with regard to the importance of obstetrics. He stated that “even in such an institution as the Johns Hopkins University, several members of the medical faculty still believe that the obstetrician need

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only be a man-midwife, who is content to eat the crumbs that fall from the rich man's table."³ Similarly, Joseph Bolivar DeLee of Chicago deplored the lack of professional recognition and respect for obstetrics. "The public has no respect for the obstetrician. He is looked down upon, not alone by the people, but by the doctors themselves."⁴ Therefore, obstetricians in the early twentieth century strove to make obstetrics a prestigious branch of medicine, similar to surgery.

Pamela S. Summey and Marsha Hurst review the rise of obstetrics and gynecology as a specialty from 1920 to 1980.⁵ They argue that from the early 1920s through the late 1930s, obstetrics and gynecology organized itself as a profession. The primary goal of obstetrics and gynecology "has been to enhance its public image and professional prestige, to become firmly enough established in medicine so that its boundaries would be secure, to expand its sphere of expertise befitting a major specialty, to establish and enforce its own entry and exit criteria, to train only the best qualified and be competitive with other fields in recruiting the most talented, and, in the process, to have a firm hold on its paying clientele."⁶

However, these goals were complicated by two major contradictions, which were the basis of obstetrics and gynecology. The first contradiction was related to its two parents, surgery and midwifery. Obstetrics and gynecology inherited techniques, knowledge, and skills from the surgeons and received the human touch from the midwives. Summey and Hurst argue that obstetrics and gynecology has been engaged in a state of continual conflict with regard to the philosophies of conservative and active obstetrics. The matter was collectively resolved in favor of active obstetrics because its controlling role was consistent with professional growth and development and with the expansion of its market. The second contradiction was related to the relationship between the field and its women clients. As Summey and Hurst argue, the field of obstetrics and gynecology requires women for its existence; however, it must minimize its dependence on the "second sex" in order to acquire status and power in the medical world. "In other words, ob/gyn's relation to women both defines and degrades it as a medical specialty."⁷

The field of obstetrics and gynecology has focused on the physical conditions peculiar to women and their reproductive systems. The identification of obstetrics and gynecology as a specialty catering to women was a degradation compounded by the fact that a considerable amount of the obstetrician's work was formerly performed by female midwives. This paper aims to explore the gender ideology in the specialty of ob-

stetrics during the period of professional establishment and traces the process of resolving the contradictions mentioned above, namely, the philosophical conflict between conservative midwifery and active surgery and the relationship between the field and its women clients. The gender ideology in obstetrics is examined from the following four viewpoints: self-definition of the medical profession, therapeutic differences and similarities between male and female physicians, professional view with regard to women and childbirth, and maternal and infant mortality. This paper explains that obstetricians increased recognition and prestige of the profession by moving toward increased specialization and by emphasizing the important role of obstetricians in the birth process and in society at large.

I SELF-DEFINITION OF THE MEDICAL PROFESSION

At the beginning of the twentieth century, there was no clear demarcation between obstetrical specialists and general practitioners who delivered babies as a part of their wider practice. Most physicians, whether male or female, identified themselves as general practitioners; in 1928, they comprised three-fourths of the profession.⁸ William Ray Arney argues that, with a weak boundary, it was almost inevitable that debates about the ultimate form of the profession occurred. One group specializing in obstetrics, led by DeLee, desired that obstetrics would become a super profession. The other group, led by Williams, desired a more egalitarian profession, which would be responsive to the needs of general practitioners.⁹ Generalists were vulnerable to a concerted campaign against "unqualified" practitioners, who were defined as those lacking either specialty training or membership in a specialty society. As a result, by 1942, less than half of all practicing physicians described themselves as generalists; this declining trend accelerated in the succeeding decades.¹⁰

In 1920, a new journal for specialists, the *American Journal of Obstetrics and Gynecology*, was founded to replace the fifty-one-year-old *American Journal of Obstetrics and the Diseases of Women*. This marked the formal beginning of the alliance of obstetrics and gynecology, with the promise of expansion into all aspects of womanhood.¹¹ The first volume of the *American Journal of Obstetrics and Gynecology* included information on the struggle for self-definition. In his presidential address at the American Gynecological Society, Robert L. Dickinson

suggested a four-year program to professionalize the field and delineated its role in medicine. He emphasized the establishment of a technical journal, publication of an adequate textbook, certification of specialists, training of leaders by developing training facilities, and even encouragement for women to pursue training in obstetrics and gynecology. "Think of tight lipped surgery with a tender heart," he stated, imagining female physicians performing operations.¹²

The female physicians largely confined themselves to what were termed as "feminine" specialties, such as the fields of obstetrics, gynecology, and pediatrics. Factors other than resistance from male professionals were responsible for female physicians being confined to these specialties, although they occasionally blamed it on sexual discrimination.¹³ Regina Markell Morantz-Sanchez argues that female practitioners also gravitated to these specialties because they were conscious of their "special" abilities. They were concerned about the health problems of women and children because they desired to raise the moral tone of the society through the improvement of family life.¹⁴

While female physicians could be viewed as taking advantage of their reputed expertise in obstetrics and gynecology, most of the national specialty societies refused to admit women as members until well after the creation of the specialty boards during the 1930s.¹⁵ For example, the Council of the American Gynecological Society discussed whether women could be elected to fellowship and unanimously recommended that women were eligible for membership. Lilian K. P. Farrar of Woman's Hospital in New York was elected as the first woman member of the Society in 1921, but it was only fifty years later in 1971 that the second woman, Georgeanna Seegar Jones of Baltimore, was elected to fellowship.¹⁶

The first thirty years of the twentieth century were crucial for female physicians; they struggled for self-definition within a field that was rapidly restructuring itself and its social role. Despite the achievements of female physicians in the late nineteenth century, the first few decades of the twentieth century constituted a difficult period for the progress of women in medicine. Due to a male backlash and institutional discrimination, fewer women were admitted to medical schools and female physicians had fewer opportunities for advanced training or scientific research. As a result, female physicians lost ground relative to their male colleagues and possessed neither power nor authority in the professional community.¹⁷

While professionalization in general created new career choices in “feminine” professions such as nursing and social work, professionalization in medicine constricted women’s activity as physicians and confined their participation to particular specialties that were already implicitly agreed upon in the nineteenth century. In the early twentieth century, when male physicians strove to define themselves as specialists in obstetrics, female physicians were excluded from the professional community, despite their “special” abilities and reputed expertise in the field.

II THE THERAPEUTIC DIFFERENCES AND SIMILARITIES BETWEEN MALE AND FEMALE PHYSICIANS

Historians have wondered about the therapeutic differences and similarities between male and female physicians. Studies have revealed that gender played a small, but not necessarily insignificant, part in the treatment approach of male and female physicians. In order to determine whether male and female physicians differed in their treatment toward women during childbirth, Morantz-Sanchez compared maternity cases between the female-run New England Hospital from 1873 to 1899 and the male-run Boston Lying-In from 1887 to 1899.¹⁸

According to Morantz-Sanchez, the records and annual reports indicate that the patients of both hospitals were poor; however, the patients at Boston Lying-In were poorer. Both Boston Lying-In and New England Hospital normally refused obstetric service to unwed mothers who were bearing their second illegitimate child. However, unlike Boston Lying-In, the ratio of single mothers to married mothers at New England Hospital declined throughout the time period studied. The female physicians at New England Hospital showed a greater interest in patients who were amenable to moral reform and in creating a Christian atmosphere for erring women, whereas the male physicians viewed their role in the hospital from a narrower perspective. Morantz-Sanchez suspects that the traditionalism of the female physicians in this instance could be largely due to their investment in the Victorian culture that identified women as the moral guardians of society.¹⁹

Another noticeable difference between the two hospitals was the sheer amount of information listed on the hospital’s patient charts. According to Morantz-Sanchez, the records of New England Hospital were consistently more complete. In addition to an account of the actual treatment,

they provided a greater amount of information with regard to the patient's medical background and a more detailed indication of her social status. As Morantz-Sanchez argues, this meticulous record-keeping revealed not only the self-conscious professionalism typical of female physicians but also the "leveling" process at work at Boston Lying-In. The female physicians at New England Hospital attempted to find information about their patients and distinguished, at least in their records, between various levels of poverty. The lack of similar distinctions at Boston Lying-In implied that poor women treated in an often overcrowded teaching facility might have represented a single category to the male physicians.²⁰

The standard maternal recuperative period at Boston Lying-In was two weeks with very slight variation, whereas the New England Hospital patients remained under care for a period ranging from four days to three months and were, on an average, under medical supervision for one week longer than their Boston Lying-In counterparts. This variation could be attributed not only to individual physical considerations coupled with the availability of space but also to social considerations. Single mothers normally remained under medical care for a longer period of time; this could probably be due to the fact that they had nowhere else to go or because the female physicians at New England Hospital felt that such patients required more of the hospital's meliorative moral influence. With regard to female physicians, Morantz-Sanchez points out that when determining the duration of stay, the patients' social situations were considered to have the same weight as their medical variables.²¹

Statistics revealed no significant divergence between the two hospitals with regard to infant mortality or maternal outcome. However, methods of care offered to patients after delivery, particularly with regard to prescriptions for relief, differed between the two hospitals. At Boston Lying-In, drug prescription was dependent on the physical symptoms. The female physicians dispensed medication or supportive therapy for less codifiable and nonphysical reasons. Everyone received at least "beef tea" and on several occasions, a mild pharmaceutical. While it is possible that most of the Boston Lying-In patients were protected from unnecessary medication, it is also possible that they were virtually ignored after delivery. The medication policy by New England Hospital implied more patient-doctor interaction and an alternative ethos concerning the post-delivery needs of women. Morantz-Sanchez argues that if this specula-

tion is correct, then the female physicians were exhibiting a concept of professionalism that deemed the supportive therapy to be as important as the pure technical concern for the patients.²²

Another factor under consideration in her study was the relative use of intervention techniques, particularly forceps. According to Morantz-Sanchez, the data revealed no dramatic difference with regard to the relative willingness of physicians at either hospital to resort to intervention techniques. In addition, the medical criteria for the use of forceps were similar at both hospitals. The labor of women who underwent forceps deliveries was significantly longer than the average; this was probably because most women were bearing their first child. The use of forceps increased gradually at both hospitals during the last decade of the nineteenth century.²³

On the issue of childbed fever, Boston Lying-In had more difficulty controlling puerperal infection than New England Hospital. Prior to the introduction of successful antiseptic techniques in the Hospital in 1885, Boston Lying-In had been forced to shut down three times due to epidemics, in contrast to just one case of shutting down for New England Hospital. More deaths occurred at Boston Lying-In. It is possible that Boston Lying-In's comparatively poor record in preventing sepsis stemmed from the staff's stubborn reluctance to accept that nurses and physicians could be the possible sources of infection, whereas female physicians at New England Hospital were more willing to view themselves as fallible. However, Morantz-Sanchez argues that their divergent records with regard to the fever might not be related to the sex of the physicians in charge, but rather to complex and idiosyncratic difficulties relevant to the hospital architecture and finances, the personalities and experience of the physicians, and blind luck.²⁴

Morantz-Sanchez concludes that the gender of the physician was important in more subtle ways. Social assumptions influenced the medical practices of the male and female physicians, and their attitudes toward their roles were divergent. The male physicians embraced a more modern technocratic approach toward their patients, whereas the female physicians continued to cling to traditional holistic orientations. It is certain that the female physicians were always aware of their gender, and this influenced their interests within medicine as well as their affective behavior while caring for patients. It is possible that the female physicians exhibited a different orientation toward patient care. Morantz-Sanchez

argues that male and female physicians acted in a similar manner in most therapeutic situations; however, the reasons for the action taken were very different.²⁵

Ellen S. More also draws a comparison between Practitioners' Society, a women's medical group in Rochester, New York, and Pathological Society, the city's all-male counterpart, in order to provide some insight into the character and extent of the ideological and therapeutic differences and similarities between male and female physicians. A comparison between the therapeutic values of the two societies revealed an overall similarity in their clinical judgment. In the discussion held at the Pathological Society in 1888 with regard to the complex matter concerning the appropriate use of forceps in obstetrics, the majority was of the opinion that forceps should be used only as a last resort. With regard to the related question of whether to repair lacerations of the perineum, a discussion held several years later revealed that most members favored immediate repair. A similar discussion at the Practitioners' Society in 1900 also showed that the majority was in favor of immediate repair. With regard to the use of forceps, a survey of sixteen consecutive cases in 1901 indicated no disagreement among male and female physicians.²⁶

The therapeutic similarities convey that the female physicians viewed themselves as full-fledged medical professionals. Their medical opinions tended to reflect professional and scientific trends. The female physicians internalized many "male" values. The different orientation toward patient care and the therapeutic similarities suggest that the female physicians struggled to strike a balance between science, professionalism, and their womanhood in the male-dominated medical world.

III PROFESSIONAL VIEW WITH REGARD TO WOMEN AND CHILD BIRTH

Medical journals of the late nineteenth and early twentieth centuries reveal a debate among obstetricians with regard to whether childbirth was a natural event requiring the obstetrician to allow the natural course of events or a pathological crisis demanding active and vigorous intervention. The obstetricians openly identified with what they referred to as the "radical" or the "conservative" position. In the first volume of the *American Journal of Obstetrics and Gynecology*, DeLee argued that birth was "a decidedly pathologic process" and that "only a small minority of women escape damage during labor."²⁷ In his view, "the powers

of natural labor are dangerous and destructive in many instances to both mother and child” and “interference by a skilled accoucheur [male midwife] at the proper time can prevent a goodly portion of this danger and much of this destruction.”²⁸

The groundwork for intervening in labor was laid by the following view of radical obstetricians: modern women, at least those who could afford the services of obstetricians, were weakened by education and the changing environment and were thus unfit for childbirth. DeLee referred to women of his time as “the nervous inefficient product of modern civilization,” emphasizing the important role of obstetricians in the birth process, which modern women could no longer manage without the expert’s assistance.²⁹ In defense of the widespread use of anesthesia in childbirth, George Clark Mosher of Kansas City argued that women in the twentieth century had “by education and environment, developed into [sic] an extreme type of hypersensitiveness” and therefore felt pain more acutely.³⁰

Apart from their weakened state, women were portrayed as being quite demanding of their obstetricians, clamoring for shortened labors and relief from pain. At the meeting of the American Gynecological Society in 1921, Brooke M. Anspach of Philadelphia stated that the expectant mother “grasps quickly at any new plan that will bring on her labor at the appointed time, that will hurry it along and save her from pain, etc., little knowing or weighing the disadvantage to herself or to her baby.”³¹ DeLee argued that women had learned to seek the expert’s skills and were willing to pay for these to avoid labor pain.³²

Obstetricians insisted that the fear of suffering caused many young women to escape pregnancy at all costs, even going to the extreme of having a “criminal abortion” to avoid childbirth. When Mosher studied “the statistics of the alarming decrease in the size of the families in this country in the last 40 years and the alarming increase in abortion,” he concluded that American women desired to escape maternity because they feared the suffering they had to endure during childbirth.³³

Most of the methods of intervention, including anesthesia during labor and cesarean sections, were developed with the stated purpose of relieving these women from the perils and pain. “Many women are ready to undergo the slightly increased risk of cesarean section in order to avoid the perils and pain of even ordinary labor,” argued DeLee. “I am confident that if the women were given only a little encouragement in this direction, the demand for cesarean section would be overwhelming.”³⁴

Such assertions created a market for the services of obstetricians among women who could afford to pay, and helped in establishing the dominance of obstetrical specialists over midwives and general practitioners.

The conservatives opposed this radical intervention in childbirth. At the annual meeting of the American Gynecological Society in 1921, Rudolph W. Holmes of Chicago warned that the basic error “that pregnancy and labor are pathologic entities, that childbearing is a disease, a surgical malady which must be terminated by some spectacular procedure” had crept into the obstetric field. He believed that “childbearing is not a disease, is a normal physiologic function.”³⁵ According to Charles P. Noble, since the ancient times, labor for the majority of women had been considered as a physiologic process accompanied by a minimum risk to the mother and the child; therefore, to transform it into a major surgical procedure was “contrary, not only to logic, but also to common sense.”³⁶

Some conservatives emphasized the danger of intervening, while others expressed the fear that the physicians readily intervened in order to serve their own interests by shortening the labors and thus saving time. Anspach argued that “the obstetrician, no matter how conscientious he may be, is almost tempted to induce labor at set date, administer stimulants for the pains, and adopt manipulative or operative measures to shorten the period of parturition.”³⁷ In his chairman’s address at the Section on Obstetrics, Gynecology and Abdominal Surgery at the Session of the American Medical Association in 1926, George Gray Ward of New York stated that “the fact that some expert obstetricians can more or less safely hasten labor by operative intervention, thus saving themselves time and shortening the patient’s immediate ordeal, together with our national tendency to hurry in the rush incident to competitive practice” had been the cause of dangerous shortcuts by the general practitioner and many so-called specialists, which too often led to disastrous results for both mother and child.³⁸

Despite such criticism of widespread intervention in labor, the activist ideology has persisted as the dominant ideology of the obstetricians. Its emergence and the displacement of the less interventionist conservative stance were influenced by not only the union of obstetrics with the surgical field of gynecology but also the expressed need of the new specialty to separate itself from the general practitioners. According to Summey and Hurst, obstetricians felt that “any medical person could assist in a delivery, but only the experienced specialist—the ob/gyn—could inter-

fered safely and successfully.”³⁹ Although some conservatives challenged this activism on both economic and safety grounds, Summey and Hurst argue that “the activist ideology developed during the 1920s served as a foundation during the late 1940s and 1950s for an expansionist view of the ob/gyn’s role of caring for women’s entire reproductive system in all its physical and psychological aspects.”⁴⁰ The supposed demands of women for shortened labors and painless childbirth were used to justify the constant search for and use of new methods of intervention in childbirth. The combination of the risks during childbirth and relief from pain ensured the importance of the obstetricians in the birth process.

IV MATERNAL AND INFANT MORTALITY

The internal advancement of the profession along increasingly active clinical lines was complicated by intense societal pressure to lower the persistently high maternal mortality rate. The mortality associated with childbirth became a matter of public concern in the late nineteenth century, as health authorities began to systematically record births and deaths and compile vital statistics. In 1880, the Bureau of Census established a death registration area. The annual collection and publication of mortality statistics within the registration area was begun in 1900. The original death registration area included only two states (Massachusetts and New Jersey). The area had gradually expanded, and by 1933, it included all forty-eight states. Similarly, a birth registration area was established in 1915, and by 1933, it had gradually expanded to include all forty-eight states.⁴¹

Concern for maternal and infant health began in the late nineteenth century and led to the foundation of the federal Children’s Bureau in 1912. In 1917, Grace L. Meigs, Director of the Child Hygiene Division of the Children’s Bureau, published the first study to compare the maternal mortality rate in the United States with those of certain other countries. It was estimated that in 1913, at least 15,000 women died from complications during childbirth in the United States; approximately 7,000 of these women died from childbed fever, a disease that was proven to be almost entirely preventable, and the remaining 8,000 died from diseases known to be, to a large extent, preventable or curable. Among women in the age group of fifteen to forty-four years, childbirth caused more deaths than any diseases, with the exception of tuberculosis. From 1900 to 1913, deaths due to childbirth and childbed fever in

the United States showed no decrease, although deaths from other preventable diseases such as typhoid, diphtheria, and tuberculosis declined during this time. Of the fifteen foreign countries investigated, only two showed a higher number of deaths due to childbirth than the United States.⁴²

The high maternal mortality rate roused great interest among physicians in the United States. After this study was made public, physicians and health officials attempted to determine the cause of the high maternal mortality rate in the United States. The conservatives attributed the high maternal mortality rate to radical operative interference. In 1925, at the meeting of the Section of Obstetrics and Gynecology of New York Academy of Medicine, Austin Flint concluded that a less invasive, more conservative approach was “the outstanding remedy for the present high mortality.”⁴³ James E. Davis of Ann Arbor found that “where obstetricians are highly trained, elective operative interference has increased sufficiently to neutralize an otherwise descending maternal and infantile death rate.”⁴⁴ Admitting the abuse of cesarean section among physicians, H. J. Stander of the Department of Obstetrics and Gynecology at Cornell University Medical College and New York Hospital estimated that “close to 2,000 women are unnecessarily sacrificed each year due to this urge to operate.”⁴⁵

The radicals attributed the high morbidity and mortality rate to reasons such as “lack of aseptic practice and conscience in a large number of physicians,” “interference in the labor process by men that do not know how,” and “lack of prenatal care.”⁴⁶ As Summey and Hurst point out, there was a considerable amount of interest in prenatal care as a possible solution to the problem since it allowed the profession to continue to expand rather than to criticize itself and retreat.⁴⁷ The interest in prenatal care led to the formation of a committee in order to “draw up standards of prenatal care for the use of physicians at clinics and also those engaged in private work.”⁴⁸

Moreover, it was recognized that numerous unnecessary deaths of mothers took place, and this propelled federal, state, and municipal health agencies to initiate programs that were intended to reduce the mortality rate. In 1921, the federal government passed the Sheppard-Towner Maternity and Infancy Act for the promotion of the welfare and hygiene of maternity and infancy, providing financial help to the states for the promotion of good prenatal care for all mothers during childbirth. The American Medical Association and several state medical societies

opposed the Act since, as George W. Kosmak of New York City argued, it would “practically take out of the hands of the medical profession the care of pregnant women and children, and place their observation in the hands of lay persons, not to be solved as a medical but as a sociological problem.”⁴⁹

In 1925, the *American Journal of Obstetrics and Gynecology* established a special section called the “Department of Maternal Welfare.” In its initial announcement, the professional view with regard to government meddling was clearly stated: “Within recent years the specialty of lay activity and even the national government has attempted through the ministrations of the Shepard-Towner Act to control or supervise the problem of so-called ‘better maternity care.’ . . . It cannot be solved except by a combination of forces, and the direction of these forces should rest in the medical profession itself.”⁵⁰ The medical professionals were in fear of being deprived of their control on maternal care.

In contrast, the Children’s Bureau supported the Act on the ground that it would assist in the elimination of the high maternal and infant mortality rates in the United States. The Act was strongly supported by several women’s groups, including the American Medical Women’s Association.⁵¹ Some members of the obstetrical and gynecological societies recognized its inevitability. At the meeting of the Section on Obstetrics and Gynecology of the New York Academy of Medicine in 1922, Frederick W. Rice argued that when the act would be “carried out by co-operative action of the States,” it would “be responsible for the beginning of a decline in the present high mortality rate.”⁵²

However, maternal and infant health did not improve during the 1920s; the profession was under considerable public and specialist pressure to create the qualification criteria for the practice of obstetrics. The external pressure to lower the maternal mortality rate and the internal pressure to raise the status of the profession resulted in the establishment of the American Board of Obstetrics and Gynecology in 1930. The purpose of the board was to certify the specialists in the field of obstetrics and gynecology by virtue of their passing an examination and presenting reports on fifty obstetric or gynecologic cases. The American Board of Obstetrics and Gynecology was the fourth specialty board to establish itself.⁵³

The development of the prenatal care programs and the professionalization of the field could not prevent the maternal mortality problem from reappearing in the early 1930s. The Public Health Relations Committee

of the New York Academy of Medicine studied the maternal mortality in New York City from 1930 to 1932.⁵⁴ The study concluded that the death rate due to puerperal causes had not shown any tendency to decrease over the past twelve years, despite progressive improvement in the methods of treatment and the increased hospitalization of expectant mothers. It was estimated that two-thirds of all the deaths studied could have been prevented if the women had been provided with proper care in all aspects. Certain elements were reviewed as contributory causes of the production and maintenance of the persistently high death rate. These included inadequate and improper prenatal care, high incidence of operative interference during labor, incapacity of the attendants, inadequate hospital standards, and midwife practice.⁵⁵

According to Charles R. King, the female physicians were largely silent about maternal mortality. The female physicians did not voice any differences that they may have had with the official pronouncements of the leading obstetricians of the city. They neither had the position nor the authority to speak up on the expanding professional role of the elite obstetricians in the city.⁵⁶ The report by the White House Conference on Child Health and Protection published in 1933 also featured the fact that the maternal mortality rate had not declined between 1915 and 1930 despite the increase in the number of hospital deliveries, introduction of prenatal care, and increased use of aseptic techniques.⁵⁷ Since the statistics were obtained from a considerably wider area, approximately eleven states, the impact of this report was even greater than that of the New York study.⁵⁸

After the publication of these reports, the maternal mortality problem received little attention. One reason was the reduction of the maternal mortality rate. Between 1933 and 1940, the national maternal mortality rate decreased from 61.9 to 37.6 per 10,000 live births.⁵⁹ However, another reason was that infant mortality became the focus of attention for the medical community as A. J. Skeel of Cleveland stated that "in recent years attention has been focused on the baby and its welfare more than on that of the woman."⁶⁰ From a national point of view, the significance of high maternal mortality rate was "found not only in the loss which this means of the lives of women presumably in their prime, but also in the far-reaching effect of maternal mortality on the infant death rate."⁶¹ Instead of focusing on the expectant mothers or their reproductive systems, the obstetrical specialists now concentrated their efforts on the infants, ignoring several needs of the expectant mothers. In an environ-

ment where the obstetricians strove to minimize their dependence on women patients in order to acquire status and power in the medical world, it was not surprising that they emphasized saving the lives of the infants rather than those of the mothers.

CONCLUSION

By the end of the 1930s, the field of obstetrics was firmly established as a specialty in American medicine. As obstetrics achieved status as a specialty within the broader medical profession, the women patients did not have an important part in childbirth. Arthur H. Bill of Cleveland asserted that “the part which the patient takes in labor is largely a passive one, consisting chiefly of breathing the anesthetic as directed.”⁶² J. Wesley Bovee of Washington, DC held that “a patient should be treated as judgment dictates; that we should act as practitioners of medicine instead of those who cater to the wishes of their patients.”⁶³ It was not the women patients but the obstetricians who played an important role in childbirth.

The obstetricians viewed the obstetrical “case” independently of the patient. Walter Edmond Levy of the Department of Obstetrics at Touro Infirmary and Tulane University in New Orleans admitted that “we are prone to accept each new patient as ‘just one more confinement case,’ and in the rush of our daily routine we seldom stop to individualize the woman, to classify her, as it were, not only medically but sociologically and psychically as well.”⁶⁴ The obstetricians regarded the women patients as mere carriers of the “case.” As Arney points out, the women patients were clinical specimens that the obstetricians and medical students could use for teaching, observing, and experimenting, a practice that continues even today.⁶⁵

Until the early twentieth century, there was no agreement on what constituted an obstetrical specialist. Obstetrics lacked recognition and respect as a specialty and therefore obstetricians struggled to establish obstetrics as a prestigious specialty, similar to other fields of medicine. When the male physicians defined themselves as specialists in obstetrics and strove to acquire status and power in the medical world, the female physicians were excluded from the professional community despite their “special” abilities and reputed expertise in the field. Although female physicians were aware of their gender and its influence on their interests within the field of medicine, they acted in a similar manner as their male

colleagues in most therapeutic situations. The female physicians regarded themselves as medical professionals and internalized many “male” values in the male-dominated medical world.

The radical obstetricians regarded birth as a pathological process and intervened during childbirth to prevent danger and destruction. They portrayed women as clamoring for shortened labor and relief from pain. The risk during childbirth and relief from pain ensured the importance of obstetrical specialists in the birth process. The advancement of the profession was accelerated by societal pressure to lower the high maternal mortality rate. The obstetricians attributed the high maternal mortality rate to reasons such as lack of prenatal care. Interest in prenatal care allowed the profession to continue to expand. Moreover, pressure to lower the maternal mortality rate resulted in the creation of qualification criteria for the practice of obstetrics. Through this process, obstetrics gained recognition and respect as a specialty in the medical world and in society at large.

NOTES

¹ Charlotte G. Borst, “The Professionalization of Obstetrics: Childbirth Becomes a Medical Specialty,” in *Women, Health, and Medicine in America: A Historical Handbook*, ed. Rima D. Apple (New Brunswick, N.J.: Rutgers University Press, 1992[1990]), 197.

² *Ibid.*, 198.

³ J. Whitridge Williams, “The Midwife Problem and Medical Education in the United States,” *Transactions of the American Association for Study and Prevention of Infant Mortality* 2 (1912), 188.

⁴ Joseph B. DeLee, in Discussion on J. Whitridge Williams, “The Midwife Problem and Medical Education in the United States,” *Transactions of the American Association for Study and Prevention of Infant Mortality* 2 (1912), 196.

⁵ Pamela S. Summey and Marsha Hurst, “Ob/Gyn on the Rise: The Evolution of Professional Ideology in the Twentieth Century,” *Women and Health*, part 1, 11–1 (1986): 133–45; part 2, 11–2 (1986): 102–22.

⁶ *Ibid.*, part 2, 117.

⁷ *Ibid.*, part 2, 117–18.

⁸ Ellen S. More, *Restoring the Balance: Women Physicians and the Profession of Medicine, 1850–1995* (Cambridge and London: Harvard University Press, 1999), 96.

⁹ William Ray Arney, *Power and Profession of Obstetrics* (Chicago: University of Chicago Press, 1982), 51–53. One historian has identified Joseph Bolivar DeLee and John Whitridge Williams as two “titans” of the twentieth century obstetrics. See D. N. Danforth, “Contemporary Titans: Joseph Bolivar DeLee and John Whitridge Williams,” *American Journal of Obstetrics and Gynecology* 120 (1975): 577–88. See also Judith Walzer Leavitt, “Joseph B. DeLee and the Practice of Preventive Obstetrics,” *American Journal of Public Health* 78–10 (1988): 1353–60; Harold Speert, “Memorable Medical Mentors: IV. John Whitridge Williams (1866–1931),” *Obstetrical and Gynecological Survey* 59–5 (2004): 311–18.

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