An Historical Overview of Midwifery in the United States

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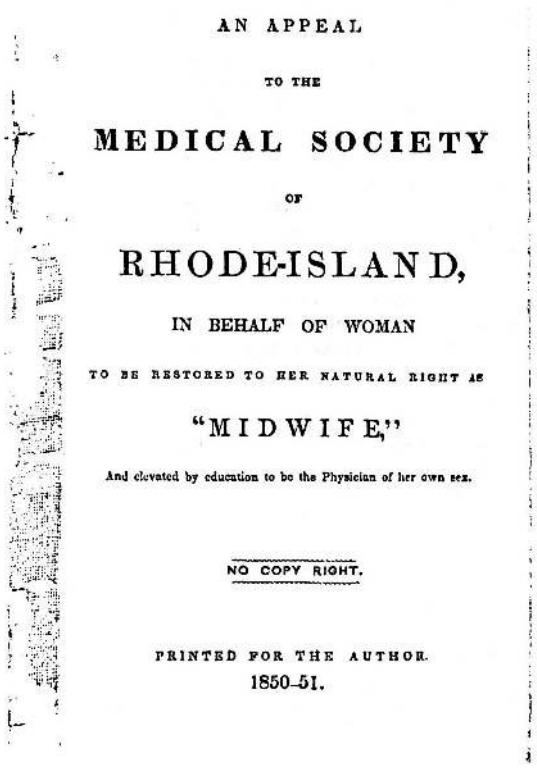
Full Text: Headnote ABSTRACT: This article provides an historical overview of the history of midwives in the United States from the seventeenth century to the present. Brief background information on the period prior to 1600 is included. The article shows how a profession that was traditionally considered to be "women's business" came to be dominated by a predominately male medical establishment. Special attention is given to the early twentieth-century "midwife debate." The origins of nurse-midwifery and the major factors which have contributed to the recent midwidfery renaissance are also considered. For centuries, the practice of midwifery was considered to be the almost exclusive province of women. The definition of midwife, "a woman who assists other women in childbirth," implies the existence of this female monopoly (Oxford English Dictionary, 1971). References to the work of midwives can be found in the Bible (Genesis 35:17, 38:28; Exodus 1:15-22). The writings of classical Greek and Roman physicians, such as Hippocrates, Galen, and Celsus, provide further information about the regularity with which midwives served as birth attendants (Goodell 1876, p. 381). Throughout the Middle Ages, midwives continued to officiate at births for both the rich and poor alike. Most midwives were empirically trained and learned their skills through personal experience and training with older, more established midwives. The monopoly which women held over midwifery was reinforced by the fact that it was generally deemed inappropriate for men, be they husbands, physicians, or surgeons, to be present in the lying-in chamber. Europeans who settled in North America in the seventeenth and eighteenth centuries brought the profession of midwifery with them. Colonial American midwives, like their European counterparts, dominated the practice of midwifery and were considered to be the recognized experts in the conduct of childbirth. Indeed, most colonial midwives were held in high esteem by their communities. The colonial American midwife usually subscribed to a noninterventionist approach of letting nature take its course. She may have offered herbal teas, wine, or perhaps hard liquor to help ease the birthing pains. Her chief duty was to comfort the pregnant women during the often long and arduous hours of labor (Wertz and Wertz, 1977; Donegan, 1978; Scholten, 1977, 1985; Ulrich, 1988). Although the vast majority of midwives in colonial America, as well as in Europe, were empirically trained, the invention of the printing press around 1440 paved the way for the publication of instructional materials for midwifery. By the early seventeenth century, when the first European settlers arrived in America, several midwifery manuals had appeared in print. Among the most significant of these were Thomas Raynolde's Byrth of Mankynde (1540), Jane Sharp's The Midwives Book (1671), and Elizabeth Nihell's A Treatise on the Art of Midwifery (1760). It is difficult to determine how widely these and other midwifery manuals were circulated or how carefully midwives followed their instructions. However, it is quite likely that midwives in colonial America found the works by Sharp and Nihell of special interest. Both of these authors expressed disdain for the emergence of man midwifery and forcefully argued that midwifery was rightfully "women's business." The idea of man midwifery did not begin to take root until the early 1600s. Prior to this time, the presence of men in the lying-in chamber was so rare that there was little cause for debate or discussion of this subject. No record is even known to exist of a man attending a normal birth until 1663. It was in that year that Louis XD7 of France engaged Julien Clement to attend the labor of his mistress (Goodell 1876, p. 382). The first men midwives were usually surgeons who were called upon to deal with especially complicated or difficult labors. Over the next two centuries, as the taboo against men in the lying-in chamber was gradually relaxed, men midwives were increasingly called upon to attend normal, uncomplicated births. The emergence of man midwifery can be traced to a number of complex factors. Of especial importance, however, was the evolution of

scientific obstetrics, probably best symbolized by the invention and popularization of the obstetrical forceps. First developed by the British surgeon, Peter Chamberlen, the Elder, in the early seventeenth century, the forceps not only revolutionized obstetrics but they also provided surgeons and men midwives with an instrument not generally available to women midwives. With the forceps in hand, men midwives could argue that they possessed the means to deliver women in tedious and difficult labors without endangering the health of the mother or the baby (Donegan 1978, chapter 2). During the eighteenth and nineteenth centuries, as lying-in hospitals were founded in England and a number of important medical schools were established in the United States, the position of midwives was further undermined. Denied access to medical schools and formal clinical training, midwives found it difficult to meet the challenges presented by the male dominated medical profession. Increasingly after 1800, upper-class women living in urban areas of the United States regularly called on male physicians to attend their births (Donegan 1978, chapter 4). The growth of man midwifery after 1800 resulted in a vociferous midwife debate. Numerous books and pamphlets on this topic were published in both the Unites States and England. Significantly, nineteenth-century physicians were divided over the question of whether or not men should become birth attendants. Critics of man midwifery argued that it was dangerous, immoral, and offended the sense of modesty and delicacy of the pregnant woman. For example, one widely-circulated pamphlet, An Appeal to the Medical Society of Rhode-Island (1851), vehemently deplored the "indecencies and outrages of man-midwifery." According to the author, man midwifery exposed wives "to the shame and pollution of examinations, which are INVARIABLE, and manipulations, such as a pure-minded and sensitive woman must blush to think of-such as must excite the indignation of every man who regards the person of his wife as sacred." Critics also chastised men midwives for resorting too frequently to "iron instruments" capable of mutilating babies and mothers. An Appeal to the Medical Society of Rhode-Island reported that "twenty women now die in childbed, and a hundred are tortured with instruments, where there would not be one, if women, only, officiated as midwives; . . . the very instruments were never invented or required until the assumption of man as midwife."

FIGURE 1



AN APPEAL

TO THE

MEDICAL SOCIETY

OF

RHODE-ISLAND,

IN BEHALF OF WOMAN

TO BE RESTORED TO HER NATURAL RIGHT AS

"MIDWIFE,"

And elevated by education to be the Physician of her own sex.

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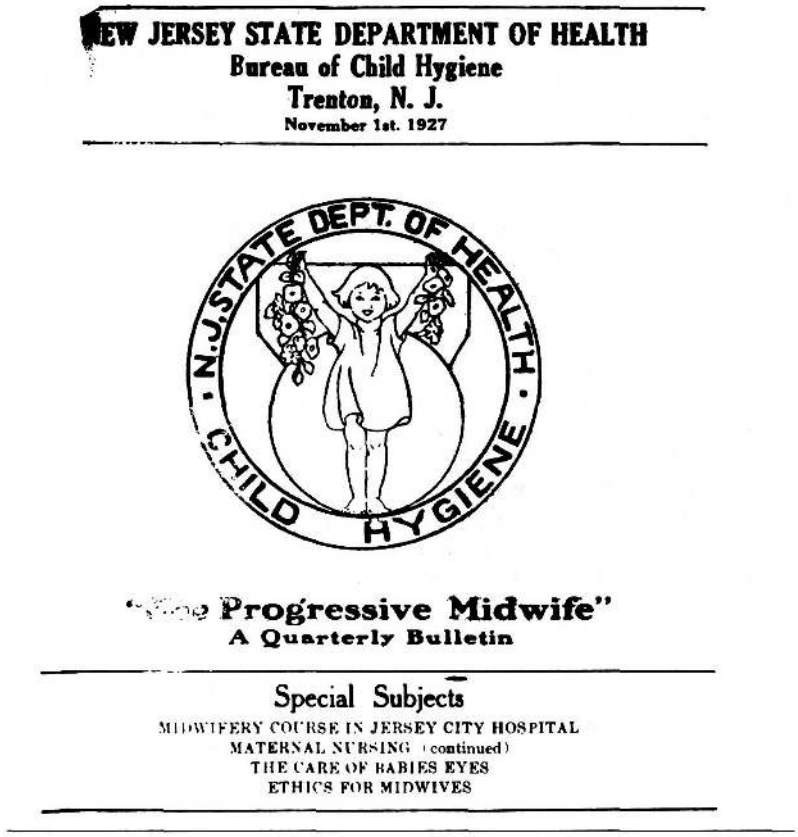
1850-51.

Men midwives were also accused of turning to "ergot, to stupefying chloroform, the crushing forceps, or the murderous perforator" in order to bring about more prompt deliveries (An Appeal to the Medical Society of Rhode-Island, 1851). In fact, the phrase "meddlesome midwifery" was commonly used when describing the practices of men midwives. Proponents of man midwifery emphasized the complexity and potential dangers of pregnancy. They related detailed accounts of women who had died in childbirth because the midwife had waited too long in summoning a doctor. Even man-midwifery critics conceded that physicians should be enlisted during complicated or abnormal labors. Consequently, courses in midwifery and the diseases of women and children were included in the curricula of the burgeoning numbers of medical schools established in the United States during the nineteenth century. Although not every medical school had a separate chair of midwifery, the inclusion of midwifery in the curricula of medical schools was an indication of the inroads physicians had made in a field that had once been dominated by women (Packard 1931, pp. 1125-1127). Man-midwifery proponents frequently portrayed women as frail and emotional beings who lacked the intellectual capacity to become competent birth attendants. They argued that women were not capable of withstanding the demanding regimen of a medical school education (Smith-Rosenberg and Rosenberg, 1973). Moreover, the nineteenth century was an era in which proper "ladies" were expected to devote their entire lives to domesticity and motherhood (Welter, 1966). Women who sought professions which took them away from their homes faced ridicule from large segments of the population. By the decade of the 1860s, the American debate over man midwifery had somewhat subsided. The moral issue of whether or not a man's presence in the lying-in chamber was offensive to women's sensibilities no longer elicited the vehement emotional response that it once had. Physicians had been successful in convincing many middle- and upper-class Americans that the well-being and safety of the parturient woman required that she rely on the services of the specially trained medical practitioner. During the second half of the nineteenth century, it looked as if American midwifery would soon become obsolete. The growth of medical professionalism and the advancement of obstetrics as a recognized medical specialty seemed to ensure that the midwife would eventually be displaced by the physician. Most late nineteenth-century doctors, as well as most middle- and upper-class Americans, complacently ignored the midwife. Yet just as it appeared that the midwife was quietly fading from the American setting, a new and vociferous debate over her present and future role began to take shape. The arrival of millions of immigrants from eastern and southern Europe on American shores between 1880 and 1920 brought forth new visibility to the midwife. Midwifery was a long-established and highly respected profession throughout most of Europe. When immigrant women arrived in America, they continued to employ midwives. By the early decades of the twentieth century, many cities and towns of the urban northeast and midwest, where the immigrants most often settled, had begun to experience an unexpected revival of midwifery (Declercq, 1985; Declercq and Lacroix, 1985; Litoff 1986, pp. 3-4). Black Americans also sought out the assistance of midwives. In the southern states, perhaps as many as 90 percent of all black births were attended by midwives during the early decades of the twentieth century (Holmes, 1984; Holmes 1985, 273-291; Logan, 1989). Throughout the rural areas of the United States, friends and relatives were often called upon to act as midwives, and it was sometimes difficult to distinguish between the woman who acted in the official capacity of a midwife once or twice a year and the neighbor who occasionally came to the aid of a friend in need (Dart 1921, p. 27; Paradise 1919, pp. 30-32; Moore 1917, pp. 22-23). All total, approximately 50 percent of births in the United States were attended by midwives at the turn of the twentieth century (Darlington 1911, p. 870; Abbott 1915, p. 684). But these statistics alone do not account for the renewed interest in the midwife. In their search for a safer birthing experience, increasing numbers of upper- and middle-class childbearing women had turned to physicians. Yet the maternal and infant mortality rates of the United States had remained alarmingly high-well above that of most European countries. In 1917, the federal Children's Bureau reported that "childbirth caused more deaths among women fifteen to forty-four years old than any disease except tuberculosis." In fact, only two of fifteen countries investigated by the Children's

Bureau had maternal mortality rates higher than the United States for the 1900-1917 period (Meigs 1917, pp. 7, 17). The infant mortality statistics were just as disconcerting. In 1910, as an example, there were 124 infant deaths per 1,000 live births in the United States. When compared with the infant mortality statistics of the major countries of Europe, the United States again fared badly (Bradbury 1962, p. 6). Physician-directed obstetrics had not resulted in a safer maternity for American women. Instead, the evolution of "scientific' obstetrics had given rise to a fresh set of problems (Leavitt 1983, 1986, chapter 3). The forceps probably best symbolized the dilemma facing physicians schooled in the "new" obstetrics. When correctly used, the forceps could save lives, but when misused they could cause perineal lacerations to the woman and injuries to the fetus. Moreover, almost any type of intervention by the attending physician brought with it the possibility of harm due to the dangers associated with infection. Because doctors frequently treated patients with communicable diseases, they were more likely to introduce agents of infection to the laboring woman than were midwives. Unfortunately, outbreaks of life-threatening puerperal fever were far too common among the practices of physicians. The use of anesthesia in childbirth, first introduced in the 1850s, was another medical innovation that did not always benefit the parturient woman. While anesthesia usually brought about improved comfort for the laboring woman, its careless administration could result in the deceleration of labor and breathing disorders. The physician's lack of first-hand clinical experience could also hamper him in his work. Beginning around the middle of the nineteenth century, a few medical schools began to allow students to observe women in labor, but many others continued to rely upon the use of mannequins. As late as 1910, a large proportion of doctors were forced to begin the practice of medicine having witnessed few or no births (Williams 1912, pp. 1-2). Clearly, the maternal and infant mortality rates of physicians were much higher than desired. Several studies conducted during the early twentieth-century revealed that maternal mortality rates were lowest in those localities reporting the highest percentage of midwife-attended births (Levy 1913, p. 90-91; Baker 1927, p. 2017). Significantly, some physicians reluctantly conceded that they had contributed to this dilemma. A 1911 survey determined that medical professors at the nation's leading medical schools concurred in the opinion that "general practitioners lose as many and possibly more women from puerperal infection than do midwives" (Williams 1912, p. 5). More than two decades later, physicians were still being held accountable for the nation's persistently high maternal mortality rates. Nationwide studies conducted during the 1930s by the White House Conference on Child Health and Protection, the national Committee on the Costs of Medical Care, and the New York Academy of Medicine all concluded that the record of physicians was not equal to that of midwives (White House Conference on Child Health and Protection 1933 pp. 18, 217-218; Medical Care for the American People 1933, pp. 122-127; Hooker 1933, pp. 32-33, 186, 209, 214). For example, the Committee on the Costs of Medical Care reported that the midwife took better care of pregnant women because "she waits patiently and lets nature take its course" while physicians employ "procedures which are calculated to hasten delivery, but which sometimes result harmfully to mother and child" (Reed 1932, pp. 4, 13-16, 20, 22). Nevertheless, it was the midwife who was most often blamed for the nation's high maternal and infant death rates. Physicians, many of whom were obstetric specialists, spared few words in condemning her "ignorant" and "dirty" ways. They argued that only by eliminating the midwife, or, at least, by substantially reducing her numbers, would the health of pregnant women and infants be adequately safeguarded. All too easily the midwife became the scapegoat for the high death rates associated with childbirth (Kobrin, 1966; Litoff 1978, chapter 5; Litoff 1986, chapter 1). Anti-midwife physicians published scores of articles on the American "midwife problem" in medical journals and popular periodicals during the early decades of the twentieth century. Indeed, between 1910 and 1930, the medical community and, to a lesser extent, the general public became embroiled in a vehement debate over the present and future role of the midwife in American society (Kobrin, 1966; Litoff 1978, chapter 5; Devitt, 1979). Midwives found it extremely difficult to counter the charges of their critics. Beset by problems of poverty, language differences, and geographical separation, they remained isolated from each other. Unlike physicians, they had no national or regional professional organizations to lobby for their cause. Largely left to their own resources,

midwives simply went about their work as unobtrusively as possible. At a time when medicine was becoming an important and powerful professional force within the United States, midwives were compelled to go their separate ways. The American midwife did not face this onslaught of criticism entirely alone. Most importantly, there were a number of prominent public health reformers who spoke out in her defense. Through statistical analysis, they showed how properly trained and regulated midwives could help bring about significant declines in the nation's infant and maternal mortality rates. Carolyn Conant Van Blarcom, a nurse and leading advocate of midwife training and regulation, published a book-length study, The Midwife in England, in 1913, which described how the training of English midwives had contributed to a substantial reduction in that country's infant mortality rate. Van Blarcom chastised the United States for being "the only civilized country in the world" that did not protect its mothers and infants by providing for the training and licensing of midwives (Van Blarcom 1913, p. 15). Public health officials in New Jersey and New York City were leading supporters of midwife reform, and they initiated midwifery training and regulatory programs which were remarkably successful. For example, under the guidance of Dr. Julius Levy, New Jersey instituted a comprehensive supervisory program for its midwives. Reports issued by Levy in the early 1920s indicated that maternal mortality rates were lowest in those New Jersey counties which had the highest percentage of midwife-attended births (Costill, 1926). New Jersey also promoted the welfare of its midwives by producing a magazine, The Progressive Midwife, published between 1927 and 1932, which included articles on pregnancy, parturition, and postpartum care as well as information about county and state midwife association meetings. The Progressive Midwife was one of only a handful of early twentieth-century journals published expressly for American midwives (Litoff 1978, p. 96). New York City demonstrated its support for midwifery by establishing the Bellevue School of midwives, the nation's first and only municipally sponsored midwifery school. Due largely to the diligent work of Dr. S. Josephine Baker, a midwife reformer who served in a leadership capacity with the New York City Department of Health for more than a quarter of a century, the infant mortality rate of New York City was cut in half. With the passage of the Sheppard-Towner Maternity and Infancy Protection Act in 1921, several southern states joined New Jersey and New York City in establishing training and regulatory programs for their midwives (Lemons, 1969). While midwife reformers in New Jersey, New York City, and several southern states instituted exemplary midwifery programs, the majority of public health officials saw little future for the American midwife. They supported training and regulatory programs as stopgap measures. Their ultimate goal was the replacement of midwives by physicians (Litoff 1978, chapter 6; Brickman, 1978). Even as the early twentieth-century midwife debate was raging, the ranks of the midwives were sharply and steadily decreasing. By 1930, only 15 percent of all births in the United States were attended by midwives. (Reed 1932, pp. 4, 13-16). There is no simple explanation for the dramatic decline in the number of midwife-attended births that occurred during the first three decades of the twentieth century. Certainly, the arguments of the anti-midwife physicians played a prominent role in bringing about the midwife's near demise. Because physicians were both well-organized and highly articulate, they found it relatively easy to convince a receptive public that childbirth was a complicated medical condition requiring the skills of the specially trained medical practitioner. Moreover, midwives were not in a position to respond effectively to these charges. Isolated from each other because of poverty and language differences, they lacked the resources to address the challenges presented by their critics. While some public health reformers spoke out in the midwife's behalf, this support paled in comparison to the onslaught of criticism initiated by the obstetric specialists.

FIGURE 2


NEW JERSEY STATE DEPARTMENT OF HEALTH
Bureau of Child Hygiene
Trenton, N. J.
November 1st. 1927

N.J. STATE DEPT. OF HEALTH · CHILD HYGIENE ·

"The Progressive Midwife"
A Quarterly Bulletin

Special Subjects

MIDWIFERY COURSE IN JERSEY CITY HOSPITAL
MATERNAL NURSING (continued)
THE CARE OF BABIES EYES
ETHICS FOR MIDWIVES

Lacking a strong mandate from the public, both state and federal health officials were reluctant to invest large sums of money in training and supervisory programs. The medley of regulatory legislation that was adopted by the states at this time further complicated and obfuscated the position of the midwives. No two states provided for their midwives in exactly the same way. However, only one state, Massachusetts, actually outlawed midwifery (Declercq and Lacroix, 1985). Social and cultural changes also served to undermine the midwife's position. The rapid growth of hospitals in the years after 1910 led to the creation of additional maternity wards. The halting of immigration from eastern and southern Europe during the early 1920s resulted in fewer women calling on midwives for their services. Moreover, the striking and sustained decline in the birth rate in the years after 1920 had an adverse effect on the midwife's role and status as young married couples increasingly came to regard childbirth as a special, rather than routine, event for which careful planning was required (Litoff 1978, pp. 113-114). Given this vast array of events and forces coming together during the early decades of the twentieth century, it is little wonder that the midwife nearly met her demise. But she was not defeated. In the midst of the early twentieth-century midwife debate, a few public health reformers and physicians began to endorse the concept of the trained and regulated nurse-midwife as a possible solution to the "midwife problem." Unlike the old-style midwife who was usually empirically trained, the nurse-midwife was a graduate nurse who had also received special training in midwifery. While the idea of nurse-midwifery had been discussed among public health reformers as early as 1911, it was not until the mid 1920s that a nurse-midwife service was actually established in the United States. Located in the poverty stricken mountains of eastern Kentucky, this first nurse-midwifery program, known as the Frontier Nursing Service, was the product of the tireless and undaunted efforts of Mary Breckinridge (Breckinridge, 1952; Dye, 1983). The Frontier Nursing Service was a very successful organization. Between 1925 and 1937, its maternal mortality rate stood at 0.68 per 1000 live births, while the national average during these same years ranged between 5.6 and 6.8 deaths per 1000 live

births. In succeeding years, the maternal mortality rate of the Frontier Nursing Service was even further reduced (Dye 1983, pp. 500-501; Ernst and Gordon 1978, pp. 505-516). The noteworthy accomplishments of the Frontier Nursing Service were replicated by New York City's Maternity Center Association. Originally established in 1918 for the purpose of providing low-cost prenatal care and services to poor women living in Harlem, the Maternity Center Association expanded its activities in the early 1930s to include a nurse-midwifery clinic and school. Although located in an area of New York City widely recognized for its impoverishment and high maternal death rate, only one of the first 1,081 pregnant women who enrolled in the nurse-midwifery clinic died (Maternity Center Association [1955], pp. 39, 54-61). Despite the near flawless records of both the Frontier Nursing Service and the Maternity Center Association, nurse-midwifery failed to make significant headway over the next several decades. Physician opposition to nurse-midwifery and the medicalization of childbirth worked against the growth of nurse-midwifery. Not until 1955 did nurse-midwives establish their own professional organization: the American College of Nurse-Midwifery, renamed the American College of Nurse-Midwives in 1969 (Litoff 1978, p. 128). In the two decades following the establishment of the American College of Nurse-Midwives, the number of midwife-attended births in the United States steadily declined. By the early 1970s, the number of births attended by midwives reached an all-time low, with over 99 percent of births occurring in hospitals and attended by physicians. Women chose the hospital over the home because they believed that it offered them a safer and less painful birthing experience than a home birth attended by a midwife (Leavitt 1986, chapter 7). Hospital-managed births allowed for the systematic use of pain-relieving drugs, labor inducers, and other types of medical treatment not routinely available in the home. However, there is no definitive evidence which demonstrates that hospital-managed births afforded healthy mothers with normal pregnancies a safer maternity, and there is some evidence to suggest that women who went to hospitals faced greater perils than their neighbors who chose to give birth at home. While it is true that the maternal mortality rate of the United States dropped precipitously in the years after 1935, this decrease cannot be directly and solely attributable to the movement of birth to the hospital. The development and widespread adoption of antibiotics, sulfonamides, and blood and blood substitutes was probably most responsible for this decline (Devitt 1977, 57; Antler and Fox 1976, p. 592; Shapiro, Schlesinger, and Nesbitt 1968, p. 145). Despite the near unanimity with which pregnant women chose to give birth in hospitals, there were occasional rumblings of discontent. A small minority of American women expressed dissatisfaction with the impersonal, scientific approach to childbirth adopted by many hospitals. The emergence of the natural childbirth movement in the late 1940s and early 1950s was evidence that at least some women were concerned about the human dimension of childbirth. Popular works, such as Grantly Dick-Read's Childbirth Without Fear: The Principles and Practices of Natural Childbirth, first published in the United States in 1944, and Marjorie Karmel's Thank you, Dr. Lamaze: A Mother's Experiences in Painless Childbirth, which was published in 1959, helped to reinforce the view that the parturient woman had the right to a personally satisfying and safe birthing experience (Sandelowski, 1984). During the decade of the 1960s, the natural childbirth movement gathered momentum. However, its proponents continued to focus on the personal satisfactions and pleasures associated with natural childbirth and expressed only marginal interest in the feminist implications of the American way of birth. Not until the emergence of the "second wave" of feminism in the late 1960s and early 1970s would childbirth be defined as a distinctly feminist concern (Sandelowski 1984, pp. 136-137). The "new" feminism marked the debut of a movement concerned with a wide array of women's issues as diverse as equal pay for equal work, the expansion of child care facilities, lesbian rights, and the restructuring of traditional marriage and family patterns. Yet central to this "new" feminism was the commonly shared assumption that the ultimate goal was to create a society which would allow women to experience autonomy and personal fulfillment within their lives. One branch of the "new" feminism which exhibited considerable vitality and influence was the woman's health movement. Feminist health advocates firmly and forthrightly demanded the right of women to exert and maintain control over their bodies. The strength of the movement was underscored as women's health collectives were organized, gynecological clinics were

established, and a wide array of information about women's health issues and sexuality was published (Our Bodies, Ourselves, 1971). Not surprisingly, women's health advocates developed an exhaustive critique of the American way of birth. They pointed out that hospital-managed births routinely included a variety of dehumanizing and impersonal procedures such as the shaving of the pubic hair, fetal monitoring, chemical stimulation of labor, episiotomies, and the separation of the mother from the newborn infant. They also expressed concern about the growing rate of cesarean births in the United States. Perceiving birth to be a "vital feminist issue," they called upon women to exert ultimate control over childbirth (Arms, 1975; Rothman, 1982; Warshaw, 1984). At about the same time, several important alternative birthing organizations, including the American Association for Childbirth at Home International, the American College of Home Obstetrics, Home Oriented Maternity Experience, and the National Association of Parents and Professionals for Safe Alternatives in Childbirth, were established. Arguing that birth in the hospital was fraught with the potential for iatrogenic disease and death, these organizations promoted alternatives to traditional hospital childbirth, including the introduction of home-like birthing rooms in hospitals, the establishment of free-standing birthing centers, and, perhaps most importantly, the restoration of birth to the home (DeVries, 1980; Eakins, 1984; Stewart, 1976). The growth of the alternative birth movement has been accompanied by a renewed interest in the time-honored profession of midwifery. At the beginning of the 1970s, the number of midwife-attended births equaled a minuscule 0.5 percent. Around 1974, however, there was a small, but significant, shift away from physician-managed, hospital births. By the early 1980s, the number of midwife-attended births had more than quadrupled (National Center for Health Statistics, 1975, 1976, 1982, 1983, 1984). There are actually three distinct types of midwives in the United States today. Old-style lay midwives still practice throughout much of the south and southwest. Because most of these midwives are elderly women and many states no longer issue lay midwifery permits, it is not likely that this type of midwifery will survive for many more years. Certified nurse-midwives make up a second group. Although the medical profession's acceptance of nurse-midwifery is far from unanimous, physicians have increasingly supported the work of nurse-midwives. A third group represents a new brand of younger, largely empirically-trained women, usually referred to as lay or independent midwives, or simply midwives (Teasley 1986). Some independent midwives have also received training at special midwifery schools, such as the Seattle Midwifery School. In an effort to create a single profession of midwifery separate from nursing, a group of independent midwives and nurse-midwives joined together in 1982 to form a new midwifery organization, the Midwives' Alliance of North America (Litoff 1986, p. 18). Women who seek out midwives are not trying to turn back the clock on medical science. Rather, they are demanding that the human dimension of childbirth be recognized and that they be given a measure of control and opportunity for choice over an event which has traditionally been defined as "women's domain." SUMMARY For centuries, the practice of midwifery was considered to be the almost exclusive province of women. During the colonial period of American history, midwives were the recognized experts in childbirth. With the emergence of man midwifery in the 1600s, however, increasing numbers of male physicians began to make inroads into the lyingin chamber. Arguing that birth was a complicated medical condition requiring the services of the highly-trained medical practitioner, physicians were able to convince a receptive public that midwives did not have the requisite knowledge and skills required of birth attendants. Over the next three centuries, there was a precipitous drop in the number of midwife-attended births. By the early 1970s, approximately 99 percent of all births in the United States were attended by physicians in hospitals. In recent years, a small, but growing, minority of American women have begun to seek out midwives as birth attendants. They are demanding that the human dimension of childbirth be recognized and that they be given a measure of control and opportunity for choice over an event which has traditionally been defined as "woman's domain." References REFERENCES Over the last two decades, there has been an outpouring of published material on the history of midwives in the United States. The references cited in this article provide examples of the major works which have appeared. For a detailed discussion of the historiography of American midwifery see, Judy Barrett Litoff. (1990). "Midwives and History."

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