Editorial

Obstetrics And The Family Physician: A Medical Historian's Perspective

On 15 May 1915 Anna Rosina Zoladkiewicz, a Polish-American woman living in Milwaukee, Wisconsin, called Dr. Frank Wasielewski to deliver her 10th child. Mrs. Zoladkiewicz, like Dr. Wasielewski, lived in Milwaukee's southside, a predominantly working-class and ethnically Polish neighborhood. Though her economic and social circumstances were typical of her community, the particular details surrounding Mrs. Zoladkiewicz's confinement are of historic interest because they illustrate a profound shift in America's birthing practices in the early decades of the 20th century. Rosina Zoladkiewicz* was a school-educated midwife with an active midwifery practice in her community.[1] But her own childbearing history pointed to why many women in this period called upon a physician attendant. Though this delivery would be her tenth, it would also be only her fourth living child. Thus, even though she would continue to practice her own occupation for many years, perhaps her desire to ensure a safe outcome led her to decide upon a physician attendant for this particular birth.

Frank Wasielewski was a general practitioner in Milwaukee and an obvious choice for her and many other women in the early 20th century. The son of Polish immigrant parents, he received his medical training at the University of Michigan. After graduating in 1899, he settled in Milwaukee's southside Polish community, and in 1904 he married the daughter of a prominent Milwaukee Polish immigrant family.*[2,3] Though he remained a general practitioner until his death in 1937, from the beginning of his practice, he was interested particularly in obstetrics. First helping to train several Polish midwives,† he then turned toward attending births himself. Indeed in 3 months in 1910 he attended 108 births, but by 1920 the 3-month total was 55.‡[4]

Dr. Wasielewski's maternity practice,[5] the volume of which at times exceeded even late 20th century standards for obstetric specialists, represented the far end of a spectrum for general practitioners in this period. But like many general practice physicians and midwives, the demographic characteristics of his patients reflected a community orientation that was completely unlike the academic, hospital orientation of those physicians who claimed a specialization in obstetrics. For example, in 1910 and 1915 less than 25 percent of Wasielewski's patients were American-born, and all of them were the wives of either artisans or laborers. Moreover, unlike some of the new academic physicians whose patients came from Milwaukee's elite families and were all hospitalized, all of Wasielewski's patients came from the southside

*Thirty-five years old and a new graduate of the Wisconsin College of Midwifery, Zoladkiewicz registered with the State Board of Medical Examiners in 1912. She was listed in the Midwives section of Wright's *Milwaukee City Directory* from 1920 through 1945.

*Dr. Wasielewski and his wife were leaders in Milwaukee's Polish-American community. In 1911 Wasielewski was one of the southside physicians recruited by the reform-minded Child Welfare Commission to staff a demonstration baby clinic for poor families. He also helped to organize the Polish Physicians' and Dentists' Association in 1913. A Milwaukee-based group, despite its national description, the society acted as a Polish-American clinicians' group, with regular sessions complete with the presentation of scientific papers. In 1932 the wives of the Association members, under the direction of Mrs. Wasielewski, formed an auxiliary. The auxiliary members promoted the Association, but they also reached out to the community, aiding veterans and raising money for a local orphanage.

†At least two Polish-surnamed midwives, Jadwiga Kuzminska and Frances Jahnz, claimed that Dr. Wasielewski had provided some of their training. Wasielewski also signed nine midwife licenses as either the first or second physician.

‡The numbers of patients and their demographic characteristics are taken from my longer study of the change from midwife to physician-assisted childbirth in the late 19th and early 20th century. For this study, I collected data on approximately 1100 physicians and 900 midwives who practiced in four counties in Wisconsin between 1870 and 1920.

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wards near his own fifth ward, and almost all of them were delivered at home.*[3,5-8]

With his home delivery practice based in his own neighborhood, Wasielewski and the other physicians in this community represented pivotal figures in the adaptation of social childbirth and the process of change from midwife to physician-assisted childbirth. As late as 1900, one-half of all the children born in a given year in the United States were delivered with the help of a midwife attendant. Yet, by 1930 midwife-attended births had dropped precipitously to less than 15 percent of all births in the United States.†[9,10] The story of this dramatic change in the early 20th century lies with an understanding of the crucial role that general practitioners such as Dr. Wasielewski played in translating the new ideas about science and professionalism to their communities.

Though native-born white women had begun to hire physicians for their confinements as early as the beginning of the 19th century, the final transition from midwife to physician-assisted childbirth began in the late 19th and early 20th century as the practice of medicine was revolutionized by the onslaught of discoveries from the bacteriological and physiological laboratories of Western Europe and the United States. Among some physicians a new laboratory model for medicine emerged that downplayed the traditional role of bedside medicine. Indeed, as a Harvard University Medical School professor explained to his students, "I would have to dispossess your minds of the too common belief that everything can be learned at the bedside; it is a fatal barrier to individual and national progress in medicine."[11] Yet even as the laboratory promised new benefits, someone had to translate this progress into a language that ordinary people could understand.

As the story of Anna Zoladkiewicz and Dr. Wasielewski illustrates, the translator was not a elite medical specialist who represented the model of a disembodied, objective ideal science. Instead, general practitioners, whose practices were based on ties of class, ethnicity, and geography, helped to build a model of science within a social context that was adopted at the bedside. Physicians such as Dr. Wasielewski combined an understanding of the cultural values of their community with their knowledge of the possibilities of scientific medicine. Thus, as birthing women on Milwaukee's southside began to demand a professional birth attendant, they called on the physician professionals who were recognized in their community. Though these physicians represented a change in sex for the birthing-room attendant, their ethnic ties undoubtedly provided them with a strong link with tradition.

The ability of physicians to translate science for their patients was based on a concept of patient care that had deep historic roots. As a number of historians have shown, therapeutic efficacy traditionally had depended on a world view shared by physicians and their patients.[11,12] Thus, medical practice had always been built on close, personal relationships between physicians and their patients, and experience and judgment were important qualities for the physician who wished to build a flourishing practice. The successful physician, therefore, had to be an integral part of the community.

But the laboratory model for medicine at the end of the 19th century promoted a different orientation for physicians, one that would have a grave impact on the general practitioner. Based in the hospital, physicians who considered themselves at the cutting edge of science emphasized the need to specialize in one aspect of medical care,*[13,14] but obstetrics presented enormous problems. As obstetrician Dr. Henry P. Newman[15] pointed out in a 1919 article, the other

*Of the 1149 physicians in my sample, almost all were general practitioners. Using the criteria of 10 births per month as a cutoff point for a physician specializing in obstetrics, all but 21 physicians in my sample (1.8 percent) were general practitioners. Not surprisingly, all of the specialists were urban practitioners. The average number of deliveries for all physicians in my sample was 1.33 deliveries per month.

Of the 55 births Wasielewski attended in 3 months in 1920, all were home births. Like most of the physicians in my sample, he never received any postgraduate instruction. Wasielewski was not a marginalized ethnic physician, however. Unlike some other American cities, where Italian and Slavic physicians were almost unrepresented in hospitals, Wasielewski and other Milwaukee physicians of Polish backgrounds did gain some acceptance into the city's medical establishment. In 1914, for example, Wasielewski served as the President of the Board of the Johnston Emergency Hospital, and he was listed as member of the obstetric staff of Misericordia Hospital.

†By 1930 at least 80 percent of all midwives were reported to be living in the south.

*The hospital was literally the place of cutting edge of science. By the end of the 19th century, many physicians who wished to perform surgery found that the bulky nature of surgical equipment and the need for assistants made the hospital an easier place to perform operations. Thus, surgical patients were the first respectable persons to go to the hospital.

specialties have "grown out of the advancement of the science of medicine," but "with obstetrics one is not concerned with finding a new disease." Furthermore, he argued, "Everyone is doing, has always done, obstetrics, and this continuity of common participation is one of the hardest things to break. . . . One dislikes to be disputing the ground with midwives or poaching upon the broad preserves of the general practitioner."†[15,16]

For those who wished to make obstetrics a truly scientific discipline, the answer seemed to lie with a new understanding of pregnancy, labor, and delivery that would exclude the community-based understanding of the family physician. As early as 1894, Dr. Edward P. Davis[17] scolded the general practitioner who believed that "the condition of pregnancy . . . [is] naturally normal" and that "labor is a natural process." Dr. Davis, a professor of obstetrics at several Philadelphia medical schools, argued that the "scientific element" of modern obstetrics was "shown in the accurate knowledge that it requires concerning matters formerly thought to prosper inevitably through the kind cooperation of nature." In the interest of saving mothers and babies, the "private practitioner" was commanded to practice "scientific obstetrics."†

The question of whether the private practitioner as opposed to the elite hospital physician could learn and practice scientific obstetrics became a lively issue in the early 20th century.‡ The majority of physicians in this period were general practitioners, and as I found in a study of Wisconsin's physicians, most general practitioners by the early 20th century delivered babies.*[4] Indeed, many physicians recognized obstetrics as an integral part of their family practice. As Dr. W.T. Sarles[20] of Sparta, Wisconsin, wrote in 1894, "If a country doctor should be a specialist in one branch of the science of medicine more than another it should be in that of obstetrics."

But this kind of solo practice could also be quite frightening. Describing a case of postpartum hemorrhage, Dr. M.V. DeWire[21] of Sharon, Wisconsin, wrote in 1908 that "We have been in places where we would gladly have given a year's practice to have some good physician at hand to share the responsibility." Urban general practitioners who delivered babies in the home faced similar, though not as life-threatening, difficulties. As Edward Davis[17] pointed out, these physicians missed "the intelligent cooperation of resident physicians; and [they] experience[d] the great disadvantage that the absence of order and discipline, so common in a private house entails upon him."†

Faced with the need for someone to share the responsibility and to provide order and discipline, it is not surprising that family physicians increasingly sent their parturient patients to the hospital. By 1940, 55.8 percent of births nationally were in hospitals, and 90.8 percent of all births were physician attended.‡ By 1960 almost 100 percent of white women and 85 percent of African-American women had their babies delivered at a hospital.[23]

Though family physicians had helped to engineer this movement to medical attendance in the hospital, they were increasingly unwelcome as birth attendants. Though family physicians adopted the specialists' idea of board certification, their belief in the patient as part of a family and a community directly conflicted with the belief that scientific obstetrics could only be based in the

*Obstetricians were disputing the ground with more than midwives and general practitioners. In 1911 the American Medical Association formed a section entitled "Obstetrics and Gynecology." Only a year later, however, the section was renamed "Obstetrics, Gynecology, and Abdominal Surgery" because of the surgical interests of many of its members and because these surgeons were fighting with general surgeons over who should operate in the abdomen. The name of the section reverted to "Obstetrics and Gynecology" in 1938.

†The criticism of general practitioners grew quite shrill. By 1924 Dr. Davis,[18] for example, was quoted as arguing that "the middle class medical man, or general practitioner, so-called, is the greatest danger in obstetrics. A midwife, under strict control, does comparatively little harm, but the doctor who does obstetric work to get the medical practice of the family, . . . is the one responsible for many obstetric disasters."

‡Dr. J.P. McMahon,[19] Professor of Obstetrics at Marquette Medical School in Milwaukee, denounced general practitioners in his comments on a 1914 paper of puerperal fever as "inefficient professional male[s]" who did not understand that "obstetric practice is surgical practice, requiring surgical technique and experience."

*Among the physicians in my study, I found that about one-third of 19th-century physicians had obstetric components to their general practice, but that this figure rose to nearly 100 percent by 1920.

†Many physicians in this period wrote of the problems of family members and friends who would question their judgment. For an analysis of the historic dynamics of this process, see Leavitt.[9]

‡Like Wisconsin, the figures nationwide for urban births were much different from those for rural ones: 76.0 percent of all urban women gave birth in hospitals in 1940, whereas 32.3 percent of rural women went to hospitals.[22]

surgical suite.* Beginning in the 1940s, however, parturient women came to the defense of a broader perspective for scientific obstetrics. Questioning the prevailing model of a fully drugged, physician-controlled delivery, followers of Dick-Read[25] and Lamaze[26] attempted to reform childbirth practices within the hospital.† By the late 1960s the feminist movement, together with women in the counterculture, kindled a full-scale reexamination of the American model of obstetrics. While some of these critics argued that the entire model needed to be discarded and that birth should return to the home where it could be monitored by a female midwife, others promoted more moderate reforms within the prevailing system. Changes were achieved as women used their clout as consumers to force physicians and hospitals to modify their obstetric practices.‡

The 1990s might bring even more changes for obstetric care. With health care reform and calls from both the political right and the political left for a return to "community values," family physicians might find that they are called to resume their historic place in America's birthing rooms.

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*I found in my study that physicians had in the early 20th century, as did midwives, maternity practices that could be distinguished by such community variables as geography, social class, and ethnicity. Thus, the ethnicity and geographic location of the physician, similar to that of the midwives (usually he) replaced, could predict the characteristics of his patients. Though this may sound intuitively obvious, sociological literature on the professions argues that physicians, like other professionals, will attract patients through their professional qualifications, regardless of the demographic or geographic ties. I found in my study that academic obstetric specialists did meet this criteria of the professional. (For another critique of the relationship of professionalization and the growth of medical specialties, see Halpern.[24])

†The Lamaze method was introduced into the United States in 1959 by Marjorie Karmel,[27] a woman who had gone to Paris to have her baby with Dr. Lamaze. Both Leavitt[9 p 214-5] and Rothman[28] have argued that Dick-Read and Lamaze-type preparation were developed in the American context as efforts to reform hospital birthing practices.

‡Arms[29] and Rich[30] are among the many writers of the 1970s who noted the influence of the sex of the birth practitioner and advocated a more egalitarian, same-sex birth attendant. Ina May Gaskin was one of the most influential of the counter-culture authors of the 1970s. Her book, *Spiritual Midwifery*,[31] became a best seller, and has sold more than 500,000 copies around the world. For a recent analysis, see Mitford, *The American Way of Birth*.[32] Interestingly, Gaskin's[31] description of the qualities needed by a midwife sounded very much like those required by early 20th century midwives: "a real midwife" should be spiritual, compassionate, able to consider someone else's viewpoint, and "in her daily life take care of those around her." Gaskin's spiritual midwife was to "be married and have a solid, loving, honest relationship with her husband." She was to "have had a child naturally, and have a solid, loving relationship with her children." She was also to be "an avid student of physiology and medicine."[pp. 338-9]

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