

Excerpt from *The Midwife Problem: A Necessary Evil*

Helmina Jeidell and Willa May Fricke could have almost been mistaken for the same person. They had both shortened their given German name Wilhemina. They both had oval faces with dark buns of hair piled atop their head. They both had graduated from Barnard College.¹ They both roamed the halls of the Johns Hopkins Hospital in white shirts and dark skirts, the unofficial uniform of the female medical students. A closer inspection revealed their differences. Jeidell's hair was straight, her bun high and neat; Fricke's hair was curly, giving her bun a messy look. Jeidell's chin was more square, her eyes softer, her eyebrows thicker, her lips plumper. Fricke's chin was round, her eyes large and bright, her eyebrows thin and manicured, her lips thinner, drooping down at the edges.

Their personalities were different too. Jeidell was widowed, claimed her profession in 1900 was an actress, and had been president of the Barnard theater club. Fricke lived with her father and brother, and being seven years younger than Jeidell, had always been a student.² Yet the one detail — that they were both female medical students — trumped any differences their colleagues might have seen. They didn't even have to look as much alike as they did to be lumped into the same category: hen medics. They were disparaged by their male counterparts, who had been known to say women had no business going into medicine³; by their teachers, who made off-color, chauvinistic comments during lectures⁴; and even their by administrators, who had only agreed to allow female students into the

¹ Barnard College Yearbook.

² 1910 Census, Polk's City Directory for Baltimore 1912

³ Bliss, Michael. *William Osler: A Life in Medicine*. New York: Oxford University, 1999. p. 231

⁴ Ibid. p. 232

school when five wealthy, well-connected Baltimore women made that a stipulation of a generous donation.

The fact that Jeidell and Fricke were female and medical students, however, made them perfect for the special inquiry into rural midwives that Dr. Mary Sherwood had planned for the summer of 1911.

Jeidell and Fricke were strong, independent women — if for no other reason than that they had chose to become doctors during a time when most women got married and joined ladies' auxiliaries to make a difference in the world. Jeidell, with her theatrical background, might have been the more outgoing of the two women, ready to get the real answers from the midwives. Fricke was perhaps kinder; she had taken care of her father and brother after her mother's death. Now, during their break from classes at the most prestigious medical school in the country, they were doing research. They didn't get to go to Europe or the New England coast like their professors. Their summer would be spent wandering Anne Arundel County.

The county is just south of Baltimore city. One border follows the Baltimore and Ohio Railroad track south and then cuts down along the Patuxent River. The other side of the county is the Chesapeake Bay. The only reasonable way for Jeidell and Fricke to get to the county was by rail. From Camden Yards, close to where the Evening Dispensary was, the women could take the Annapolis short line for just 75 cents. If they didn't want to go that far downtown, they could also take Washington, Baltimore and Annapolis Electric Railroad trains from ten blocks north, close to the University. The WB&A Electric Railway car looked very similar to the streetcars that rattled by their homes in Baltimore. It was long and sleek, with a boom that stuck out from the top to connect the car to the electric lines overhead that powered it.

They made their way to Annapolis, the state capital and largest city in the county. The economic center of Maryland had moved to Baltimore in the early 1800s when larger commercial shipping vessels could no longer navigate the Annapolis harbor. But Annapolis still had the state capitol building, lawyers, politicians, and the Naval Academy. There wasn't much else commercial in the county, besides a couple of packing plants. Outside of the city, it immediately became farmland and forests.

There was no point for the women to stay in Annapolis and travel daily to the midwives they needed to speak with. In fact, it would have been impossible. There were twenty midwives that they could visit within the city, but the other ninety-nine were dispersed in the 430.4 square miles in the county. The railroads were mainly in the northern part of the county, and were primarily there to serve people traveling to Annapolis from Baltimore and D.C. To get to the midwives, Jeidell and Fricke would have to travel on horseback. Just like in many rural areas, roads were too underdeveloped to have anything except a horse be the best method of transportation.

The women hoisted themselves onto horses, their legs and skirts draped to the left side of the horse's body in a side saddle. They may not have worn formal riding clothes — these were city women, after all — but formal dress would have announced the official nature of their visit. Their horses trotted along through the flat tobacco fields, the sprawling fruit and vegetable farms, the hardwood forests.⁵ Their eyes began to tell the story of what they were up to. Jeidell's soft, kind eyes showed that they were here on a public health errand, interested in making a difference. Fricke's open gaze reflected their curiosity about investigating a rural area, both women having lived in cities for over ten years.

⁵ Maps of Anne Arundel County agriculture.

Jeidell and Fricke had to contact the sub-registrar for the Board of Health in each election district. The registrars gave them the names of midwives and where they might be found. Without that assistance, it would have been nearly impossible to find these women. A year earlier, the legislation for midwife registration had gone into effect. While urban midwives like Rosa Fineberg could have gone to the Board of Health in Baltimore directly, the rural midwives just had to report to their district seat to register. Only thirty-four had registered with the Board of Health. Only three of them had signs declaring their practice. To get to the homes of these midwives, they couldn't simply trot down the road on their horses and see a sign that said, "Midwife Here." The sub-registrars and physicians in the area knew which women practiced as midwives but weren't licensed, and where those women lived.

In the northern part of Anne Arundel County, farms hummed with activity during the summer of 1911. In May, a whole row of horse-drawn wagons had lined up on a Baltimore street almost like a parade. The wagons stretched for a city block, each packed with immigrants from the city who were ready for summer work. The half-day journey took them to the flat farmland of the fingers that stuck out into the Chesapeake Bay. They picked whatever was in season — strawberries, beans, tomatoes, melons — or worked in the local canning operations.⁶

Helmina Jeidell and Willa Fricke left Annapolis and followed the roads along the lower-lying land that had been cleared for those fruit and vegetable farms. Depending on the week of the summer, the pickers moved from crop to crop. First came the strawberries and

⁶ Lewis Hine Photo Collection, University of Maryland, Baltimore County.

spinach, then blueberries and beets, then tomatoes and tart cherries. They picked and canned until the season was over.

Any able-bodied member of a family could work. A girl as young as six with a dirty little face that matched a dirty dress would pull her hair back in braids so it wouldn't get in her face when she was picking. A boy of ten tied two corners of a square piece of fabric to each of his suspenders to create a little pouch to collect the bounty in. His pants had patched holes on the knees, his shirt was a little too short in the sleeves, but at least he had shoes. Their mother would work alongside them, in a light colored blouse and gingham skirt for summer, her skin darkened from the blazing sun. Everyone knew to pick only the ripe fruit; picking something that wasn't ready was basically like throwing it away. They'd get two cents a box⁷ for strawberries.

Pickers' shanties stood on the edges of the fields. They looked more like barns and outhouses than homes. The shanties were barely taller than one story, with an entrance on the first floor and a stairway going up the side to a loft that was not much more than a crawl space. The wooden planks that made the outside walls had been whitewashed. There was no chimney sticking out from the wooden-shingle roof. In the hot, humid summers of central Maryland, there was no need for heat and any cooking could be done outdoors. Three or four families crammed into each shack.

Inside, it ended up looking just as much like a tenement as any over-crowded building in the city. There were no mattresses, just wooden frames filled with loose straw and a thin sheet on top. Clothing hung from the rafters. The whole room felt like a cave; there was barely enough room to walk from one end to the other between the "beds." Still, there must

⁷ Ware, Donna. *Anne Arundel's Legacy: The Historic Properties of Anne Arundel County*. Annapolis: Anne Arundel County, 1990.

have been something nice about being able to feel an ocean breeze close by, to step out from the crowded dwelling into the fresh air.

Helmina Jeidell and Willa Fricke probably didn't find any midwives living in those shanties, but that's where the midwives worked. A pregnant woman couldn't ride into Annapolis to hope that the only hospital in town — the Annapolis Emergency Hospital — had a bed. She couldn't wait until the end of the summer and hope to get free treatment at Hopkins.

She had to call a midwife.

Jeidell and Fricke followed one of the midwives to an ill-kept structure on a house call. The room was a vision of poor, rural America. There was a broken chair. The two beds were dilapidated. Hopefully they were better than the loose-straw beds that were typical for the summer workers. Either way, the conditions were hardly fit for a woman to be in, much less a woman who had given birth that morning.

But that was who lay in the bed: a postpartum Lithuanian woman, most likely in the area to do summer work. Thankfully, the midwife had supplied a clean pad to put down on the bed for delivery. Jeidell and Fricke feared that if she had not, the woman would have had to use anything she had on hand, a greased rag or burlap. The last conference on infant mortality had set up a fake city tenement room to showcase the abhorrent conditions children were being born in. This wasn't that fake tenement room. It was worse. It was real.

Outside, the medical students noticed another woman washing in a tub. The midwife told them that just yesterday that woman had been in the other bed after having given birth. Two beds in the house for two pregnant women. Maybe a bed was some comfort.

The midwife confided that she had provided clean pads for the women and had received no payment. Earning only pennies a day from farm work, who could afford to pay the three or five or ten dollars a midwife wanted for her services?

The southern part of the county was still predominately tobacco farms and more rural than the northern part, which almost didn't seem possible. Sometimes Jeidell and Fricke took private roads off the main road for a mile or more to get to a house. Most of the women they visited were African Americans.

More than three-fourths of the county's midwives were black, even though blacks made up less than half of the county's population. The majority of these midwives were old enough to have been born enslaved in Maryland, and many of the African Americans in the community remained share-croppers where they had once been enslaved. Although some African Americans worked shucking oysters or in canneries, most of them lived far from a town, far from a doctor.

Jeidell and Fricke found the African American midwives and their practices fascinating. When they published their findings, they felt a need to remark that two of the black midwives had gone into practice because they had "responded to the call of the good spirit."

Don't all doctors in some way respond to a higher power to help others heal? Jeidell and Fricke certainly had. The Hippocratic Oath traditionally sworn by doctors is not made to their colleagues or the Board of Health, but to the god Apollo, the healer. For those midwives who had not felt compelled to respond to a higher call, Jeidell and Fricke believed that the women were too old for any other type of work, and had become midwives. The "granny midwife" had become a term associated with older, African American midwives and was meant to be disparaging. Carolyn Conant Van Blarcom often commented in her writings

about the midwife problem that such old women couldn't be expected to do the hard work of helping deliver a baby or learn new scientific advancements.

Jeidell and Fricke, on the other hand, "marveled at the intelligence of several of these colored midwives who had their training on plantations before the war and who to most of our questions gave replies which would have been a credit to the present generation." Jeidell and Fricke also wrote that the African American midwife was, "more easily guided by the physician." This should have pleased doctors, since they believed the role of a nurse or midwife was to assist the physician and not the patient.

But in rural areas, Jeidell and Fricke learned listening to a doctor wasn't always a good thing.

Although black midwives would attend black women, Jeidell and Fricke found that they almost always served as assistants to doctors in cases of white women. One doctor had told an African American midwife that under no circumstances should she ever introduce anything into the birth canal. In fact, this went along with the statute that had been passed the previous year by the state legislature. Midwives were not to make vaginal examinations, attempt to deliver a retained placenta, use forceps, attempt to turn the fetus before delivery, or force delivery. The doctor was the trained professional and he should be called in to treat cases where any of these things might be needed. Not calling a "licensed practitioner" — meaning a doctor — in the case of an abnormal delivery was criminal. This midwife took that declaration seriously and now it haunted her.

The midwife had delivered a normal healthy baby to a woman in her neighborhood. Everything had gone well, and there had been no reason to call for a doctor or ask for assistance. After a child leaves the womb, contractions continue to expel the placenta, the

organ that grew and fed the baby for nine months through the umbilical cord. As the placenta begins to separate from the wall of the uterus, blood vessels are broken and bleeding starts. After the placenta is delivered, the uterus continues to contract, closing off the blood vessels and the bleeding stops. The midwife didn't have the training to know this physiology.

She had delivered the baby. She hadn't applied silver nitrate to the baby's eyes to prevent blindness, but that was about to become the least of anyone's worries. Something else, something not normal came over the mother. Her lips lost their rosy color. Her heart contracted faster and faster. Her forehead was wet, and beads of sweat trickled down her face. She acted restless, confused, and lightheaded. The sheet on the bed revealed the discomfort bearing down on her. A pool of thick, red liquid was spreading between her legs. Postpartum hemorrhage.

The body hadn't stopped the bleeding from the uterus and now the woman was losing blood — too much blood.

The midwife didn't try some of the folk-remedies that Jeidell and Fricke learned about in the county. She didn't tell the mother to hold ice or a hot potato in her hand and she didn't tell her to lick alum. She didn't administer ergot, which would have been effective, but midwives were discouraged from using it. She didn't press down on the woman's belly to try to stimulate contractions. Maybe she didn't understand that physiology either.

The midwife didn't do what was natural: try to stop the bleeding.

The doctor had told her that she should not put anything into a woman's vagina, and in this case, that meant not packing rags to stop the bleeding.

Desperate, and wanting to do what was right, the midwife sent for the nearest doctor, who was five miles away. Even a horse galloping at fast speeds couldn't get there fast enough. When the messenger arrived at the doctor's, he was three miles away on another

house call. There was no telephone there, and the messenger had to go even farther to get the doctor.

Jeidell and Fricke didn't report whether or not the patient survived, but it's not likely. Most doctors in a hospital would have given a patient with postpartum hemorrhage a blood transfusion, a nearly impossible task in this rural place. After the incident, no one wanted to call that midwife. Her neighbors couldn't understand why she had refused to treat the complication on her own. Wouldn't that have been smarter than letting the woman writhe in agony, believing no one was going to help her? The midwives who were the most popular in their community were the ones that were the most dangerous in the eyes of doctors. They were the ones who would try anything to save a patient. They were the ones who thought they were just as good as professionals.

Helmina Jeidell and Willa Fricke had discovered something in Anne Arundel that summer that had only been speculated about: *midwives were needed*. While some doctors and public health workers, like Mary Sherwood and Carolyn Conant Van Blarcom, believed that the midwife could be educated and of use in the city, most doctors didn't think they were needed there. Hospitals and dispensaries could do the work better than a midwife. But half of the United States population didn't live in cities with access hospitals, dispensaries, and doctors. Anne Arundel County butted up against one of the largest cities in the United States, and yet there was no easy access to physicians. There was only one doctor for every twenty square miles.

What happened when a woman went into labor? The doctor could travel there, but what happened when another woman he delivered the day before needed his assistance? What happened when a pregnancy wasn't developing normally and the situation was acute? And

could he return everyday for ten or fourteen days after the birth to check on mother and baby? Jeidell and Fricke understood the lives of doctors. They reported that these areas were too big for a physician to cover properly and his potential earnings from these farmers weren't really worth his time. The midwife was a necessary evil, and even physicians in the area agreed. Jeidell and Fricke wrote, "Most of the physicians in the country agree that the midwife cannot be dispensed with."

Jeidell and Fricke had investigated a rural area between two metropolises. States like California and Colorado were even less dense, and surely the medical needs in other rural communities were just as dire. The midwives the women had seen were needed. They were also trying their best.

But their "best" was barely adequate in most cases.

The midwife needed more help. She could be provided with a medical bag and clean rags. She could learn antiseptic techniques and how to prevent infection. She could receive a supply of silver nitrate and prevent infant blindness. She could know the warning signs of delivery complications. She could attend normal labors and know when to call someone with more experience.

Medical professional associations claimed there were too many physicians already, and getting rid of the midwife would clearly strain those rural doctors even further. The condition of childbirth in these rural areas was deplorable. Jeidell and Fricke thought that as hard as the midwives tried, they needed adequate training, equipment, and supervision from doctors to do their jobs well.

Dr. Mary Sherwood had spent the summer in Europe with Lillian Welsh⁸, traveling and attending international conferences on infant mortality. This data was exactly what she needed to further the idea that the midwife must be trained and doctors alone could not solve the problem of unsafe childbirth. In the fall, she would lead the session on midwifery at the American Association for the Study and Prevention of Infant Mortality. Dr. John Whitridge Williams, didn't agree with Dr. Sherwood or with Carolyn Conant Van Blarcom. He had spent time researching, too, and his views were strong, and public. He didn't believe in training the midwife and had his own experiences as the chief of obstetrics at Johns Hopkins to prove his point. He intended to make that point at the session Sherwood would lead, and advocate forcefully for it.

⁸ "CLOSE CALL FOR DR. SHERWOOD: With Dr. Lillian Welsh, She Went Through Hurricane"
The Sun; Oct 5, 1911; pg. 14