THE PROBLEM OF MATERNAL MORTALITY, 1919-1940

'SAVING THE NATION'S MOTHERS':
THE PROBLEM OF MATERNAL MORTALITY, 1919-1940

by

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ABSTRACT

The high number of maternal deaths in the 1920s and 1930s, and the attempts to alleviate this problem, represents an important segment in the history of childbirth. Although the issue of maternal health care has been examined in relation to other countries, such as England and the United States, it has received little scholarly attention in Canada.

This thesis is an examination of this one segment in the history of childbirth. Maternal mortality was the second leading cause of death for women of childbearing age during the 1920s and 1930s in Canada. In 1928 alone, over 1500 women died in childbirth. The central concern in this thesis is how the problem of maternal mortality was defined and resolved in Canada, with an empirical focus on Ontario. The activities and involvement of the medical profession and state officials provide the major focus of attention.

State officials were primarily responsible for the medicalization of the problem of maternal deaths, and concomitantly, played a crucial role in the medicalization of pregnancy and childbirth.

The findings in this work contrast with previous analyses of the history of childbirth, in that the majority of practitioners were apathetic to the problem of maternal mortality, and were reluctant to extend their control over

obstetrical care to include all classes of women. The profession did not seriously address the issue of maternal health care until they anticipated a crisis in their legitimation.

The findings are congruent with previous analyses in that it was found that physicians were responsible for a number of maternal deaths because of their excessive and unsanitary interference with labour and delivery.

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CHAPTER ONE

INTRODUCTION: THEORETICAL THEMES

Histories of Childbirth

It has been primarily feminist analyses which have offered an alternative to iatrocentric examinations of obstetrical practices and services, and changes in these practices and services. Most of the iatrocentric accounts have emphasized the positive benefits of the medical model of pregnancy, the benevolence of the medical profession, and tend to centre on prominent obstetricians responsible for obstetrical 'breakthroughs'. This type of analysis is usually done at the expense of excluding a discussion of the historical and social context of obstetrical developments.[1]

The renewed feminist movement of the 1970's included a feminist health movement, which focussed on not only documenting the oppressive relationship between women and the 'experts', but also proposed changes in health care provision.[2] Feminist provide a well-documented analysis and critique of contemporary childbirth practices and obstetrical services. It is argued that these practices and services not only degrade women, but also endanger the health and life of the woman and her baby. Women are no longer active participants in the birth process because the experience of childbirth has

been appropriated and transformed into a physician-centred operation. Childbirth is defined and treated as a medical event, and the medical benefits of the 'active management of labour' are questionable. There is extensive documentation of the prevalence of iatrogenesis in obstetrics, so that it is often concluded that "childbirth today is a hazardously overdrugged and overtreated event".[3] This conclusion is made on the basis of empirical examinations of the consequences of the application of routine interventionist techniques such as: episiotomies, enemas, shaving of pubic hair, analgesia, anesthesia, use of forceps, induction of labour and high incidences of cesarian births.[4] In commenting on the wealth of data and analyses which unmasked contemporary medical care, Ehrenreich and English state:

> Perhaps most shocking was the feminist dissection of professional obstetrical care: the routine use of anesthesia, and common resort to forceps, chemical induction of labour and Caesarian sections turned out to be hazardous for mother and child, though convenient and probably gratifying to the physician. "Scientific" childbirth, for the sake of which the midwives had been outlawed, was revealed by the feminist critics as a drama of misogyny and greed.[5]

Feminist historians, critical of contemporary obstetrical practices and services, set out to examine the historical development of modern practices. In studying that history, they have concentrated on the relationship between female midwives and male physicians. It is argued that the class,

race and sex privilege of male professionals enabled them to suppress and/or eliminate midwives as primary accoucheurs.[6] Ehrenreich and English argue that scientific medicine was on the rise as the predominant mode of health care in the nineteenth century, and further argue that the advancement of obstetrics/gynecology as a specialty was needed to complete the triumph of male scientific medicine.[7] The male-dominated medical profession then, under a guise of benevolence for their clients, condemned the midwives as incompetent, dirty and ignorant, and campaigned vehemently against midwives as accoucheurs. In Ehrenreich and English's words, "Obstetrics/gynecology was America's most rapidly developing specialty, and midwives would just have to get out of the way".[8]

What is particularly striking was the successful elimination of midwives as primary attendants at birth when the studies at the time revealed that midwives had a consistently lower maternal death rate than physicians.[9] This suggests that the transition from midwives to physicians in control over childbirth was essentially political. An understanding of the transition in control over maternal health care from midwives to the medical profession cannot be seen in terms of the demonstrable ability of the profession to improve maternal health care, or make the process of childbirth a safer event.

It should be noted that the transfer of control from females to males, and the monopoly established by the medical

profession over obstetrical care, is usually in terms of the extension of control to include lower-class women.[10] Most histories of childbirth begin with the fact that middle and upper-class women were already under the care and supervision of a physician by the early 1900s:

> Middle and upper-class women had long since accepted the medical idea of childbirth as a pathological event requiring the intervention and supervision of a (preferably regular) physician. It was the "lower" half of society which clung to the midwife and her services.[11]

The "lower" half of society consisted of poor and immigrant women. The fact that middle and upper-class women shared the professional bias of upper-class male professionals is used to partially explain the success of the takeover, because these women provided no support for midwives. This factor, combined with the lack of a feminist constituency to resist the trend, the privileged sex, race and class composition of the medical profession, and the use of instruments, techniques and medication unavailable to the midwives, meant that:

> ...the medical profession had arrived at a method of faith-healing potent enough to compare with woman's traditional healing-but one which was decisively masculine. It did not require a nurturant attitude, nor long hours by the patient's bedside. In fact, with the new style of healing, the less time a doctor spends with a patient, and the fewer questions he permits, the greater his powers would seem to be.[12]

The elimination of female midwifery, and the concomitant total susceptibility of women to the "biological hegemony of the medical profession" was accompanied by an increase in the use of medical and technical intervention.[13] Oakley states: "Along with the transfer of control from women to men has gone an increasing emphasis on techniques of intervention in the natural processes of pregnancy and delivery and in the postnatal relationship of mother and baby".[14] She argued that new dangers were introduced into the process of childbirth by the medical profession:

> Unlike a midwife, a doctor was not about to sit around for hours, as one doctor put it, "watching a hole"; if the labour was going too slow for his schedule he intervened with knife or forceps, often to the detriment of the mother or child. Teaching hospitals had an additional bias toward surgical intervention since the students did have to practice something more challenging than normal deliveries. The day of totally medicalized childbirth-hazardously overdrugged and over-treated-was on its way.[15]

This transfer of control from females to males as primary accoucheurs is seen as a deliberate and aggressive attempt to appropriate the experience of childbirth not only from midwives as accoucheurs, but from the parturient woman herself. Rich (1976) refers to the history of childbirth as the "theft of childbirth", and on a psychoanalytical level, this theft has been explained in terms of need for men to control women's generative powers. Arms in her instructively

entitled book, Immaculate Deception, concludes:

> There is no doubt that the history of childbirth can be viewed as a gradual attempt by man to extricate the process of birth from woman and call it his own. Indeed, some anthropologists and radical feminists believe that man has always been threatened by women's exclusive power in childbirth, and that by placing his strength and intelligence against her docility and instinct he "won" an authoritarian role in society.[16]

Critique

The examination of the development of obstetrical care and services by feminist historians reveals that the transfer of control from females to males was essentially a political struggle. However, these analyses may be criticized for their omission of factors which would place the analysis in a broader social and political context.[17] There is little discussion of how the issue of maternal health care, and the struggles for control surrounding this issue, arose in the first place. This criticism is made in reference to the extension of control established by the medical profession to include all classes of women. There are assertions made that the medical profession campaigned against midwives-who cared for poor and immigrant women-in order to complete the triumph of male scientific medicine. However, this struggle between midwives and physicians did not take place in a vacuum. The concentration on the relationship between midwives and physicians has been developed at the exclusion of two important

factors: the social and economic conditions in which women were giving birth in the early twentieth century; and the involvement of other agencies-particularly the state-with the issue of maternal health care.

In relation to the first factor, feminist analyses include adamant claims that childbirth is, and always has been, a safe and uncomplicated event:

> Perhaps the most useful way of viewing the history of childbirth is to see it as a chronicle of interferences in the natural process...but the process of normal birth remained as uncomplicated and inherently safe as it has been since the beginning of humankind.[18]

What becomes problematic is that to argue that childbirth is and always has been safe and uncomplicated ignores the fact that thousands of women were dying in this supposed safe and uncomplicated event in the 1920s and 1930s. Indeed, it can be argued that, under favourable conditions, childbirth can be (and could have been) a natural physiological event.[19] However, women in the 1920s and 1930s were giving birth under severe economic hardships which led to unsanitary home conditions and the greater likelihood of infection, as well as general poor health, which also impeded the likelihood of a safe and uncomplicated birth. Furthermore, the living conditions of urban areas were often unsanitary, as the public health movement had achieved limited success.[20] Therefore, many previous analyses have been developed without discussions

of the social and economic conditions in which women were giving birth. Lewis states:

> "There has been a tendency among some present-day sociologists and feminists to stress that pregnancy is a natural physiological function and to dismiss all aspects of hospitalised childbirth as bad. Looking at the inter-war period when the trend towards hospitalisation accelerated so rapidly, it is not so easy to reach such a clear-cut conclusion...the clinical causes of maternal deaths did need investigation and sepsis in particular did require more stringent aseptic and antiseptic procedures.[21]

The fact that some medical attention was warranted, given the high number of maternal deaths, is largely ignored, and therefore leads many to conclude that childbirth is and always has been a safe and uncomplicated event. Because this tenet is often accepted, the changes which took place in both the type of care provided to women before and during childbirth, and the transfer of control from female empirical midwives to male scientific professionals is seen as mysogynist Related to this, most of the histories preclude a discussion of why the issue of maternal health care arose in the first place. State health officials played an important role in raising the issue of maternal health care, because of a concern about high maternal death rates. Furthermore, the state, through its representatives and departments, was responsible for an intense educational campaign designed to convince women of the need for physician supervision and attendance at

birth. As well, this campaign was carried out by state health officials, despite the fact that studies at the time revealed that the maternal death rate was higher for births attended by physicians than midwives.[22] It is necessary to examine this contradiction more closely, in order to fully understand why the medical profession was able to consolidate control over obstetrical care.

The state was intimately involved in defining and resolving the problem of maternal mortality in medical terms, and in directing women to the medical profession. As well, the state played an important role in the 'problematization' of maternal mortality, which gave rise to the whole issue of maternal health care, and the issues of control surrounding it. The debates surrounding the definition and resolution of maternal mortality, however, were not restricted to the issue of who would have control over obstetrical care. The problem of maternal mortality also raised other issues, which influenced the direction of how the problem was defined and resolved: the role and definition of women, in terms of designated tasks and perceived responsibilities; state responsibility for the health of the population, and within this, responsibility at different levels of the state, and finally, the role of medical science as a mode of health care delivery. Therefore, it is useful to draw together themes from different bodies of literature because only then can we begin to understand the complex issues involved in the

definition and resolution of maternal mortality. As well, only then will we be able to place the history of childbirth, and the consolidation of control established by the medical profession, into a broader social/economic and political framework, that extends beyond a concentration on the relationship between midwives and physicians.

Theoretical Themes

The Political Economy of the State[23]

There has been marked and significant developments in Marxist analyses of the state since Marx's dictum that the state was "but a committee for managing the common affairs of the whole bourgeosie".[24] From this rather crude economistic interpretation, Marxists have developed a theory of the state which includes its fundamental nature-what distinguishes the state as capitalist-to its specific roles and functions. A dynamic model of the state has been advanced, which allows for an examination of the functions fulfilled by the state at historically specific periods, and allows for an inclusion of the issue of class conflict, and concessions made to the working-class.

At its broadest level, the role of the state in capitalist societies is the reproduction of capitalist relations of production.[25] A logical facet of this role is, in Miliband's terms "... to defend the predominance in society

of a particular class-that is, the capitalist class".[26] Three distinct factors have been advanced to explain why the state acts in the interests of the capitalist class.[27] First, the people in the positions of power within the state apparatus share the same class position and thus the same ideological perspectives and values as those who are in positions of economic power. Secondly, because the capitalist class owns and controls the economic resources of the country, they possess power as a pressure group to the state. Finally, there are structural constraints imbedded in the capitalist mode of production, in that the capitalist economic system has a momentum of its own, which must eventually be submitted to.[28]

To ensure the predominance of the capitalist class, it is argued that the state acts in the long-term interests of the capitalist class as a whole.[29] There is conflict and competition between different segments of the capitalist class itself, and capitalists-as individuals and as a class-have a proclivity to promote their short-term interests over their long-term interests. Through acting to protect the long-term interests of the capitalist class, the state can protect the capitalist class as a whole, rather than just certain segments within this class. Finally, in order to fulfill this broadly defined role, the state is 'relatively autonomous' from the capitalist class. This is necessary in order to protect the long-term interests of the capitalist

class.[30] It is useful at this point to outline the composition of the state, so we can understand how it fulfills its specific functions.

Miliband (1969) asserts that the 'state system' is a collective composite of a number of institutions: bureaucracy and administration; military; judiciary; and units of sub-central government-provincial and municipal bureaucracies, executive, legislatures and institutions.[31] Miliband argues that local power (sub-central units of government) diminishes as there is a general trend towards centralization in advanced capitalist societies. Panitch (1977) and Stevenson (1977) however, point out that sub-central governments in Canada have retained an importance power base independent of (but obviously influenced by and interacting with) the federal government. Furthermore, they assert that the relationship between the various levels of the state may be either harmonious or conflicting, depending on the particular issue under discussion.[32] Therefore, an empirical examination of state activities in Canada should include an analysis of this relationship, and how it affects the central problematic.

From the composition of the state and its broadly defined role, we now turn to a discussion of the specific functions of the state. According to O'Connor (1973), the two basic functions fulfilled by the state are: accumulation and legitimation-although at times these functions may be contradictory.[33] The state maintains and creates the

conditions which make profitable accumulation possible, by means of subsidies and expenditures for building an economic infrastructure. At the same time however, the state must maintain and create conditions for social harmony. Therefore, the state provides such services as welfare and health care, which serve to legitimate the capitalist economic system. The state is 'relatively autonomous' from the capitalist class, as the legitimation function sometimes requires making some concessions to the working-class.[34] As well, it enables the state to transcend the factitional interests within the capitalist class. Finally, although the capital accumulation process does not usually rely on the use of coercion or force, the state does have control over coercive apparatus, which can be used in response to the 'radicalisation' of labour.[35] It is through the legitimation function performed by the state, that we can better understand the emergence of social welfare legislation and provisions-an emergence which initially provoked ambivalent reactions on the part of Marxists:

> For a long period Marxist scholars were relatively silent on the expansion of social welfare legislation in capitalist society. Given their emphasis on the state as a representative of the interests of the capitalist class, the emergence of the so-called 'welfare state' was an anomalous development.36

Gough (1977) addresses this apparent contradiction, by arguing that the provision of services and policies is both supportive and coercive. It cannot be denied, argues Gough,

that certain policies and services do provide concrete benefits to the population or labour. However, these same services and policies also foster capital accumulation, as they repress and control the population by adapting them to the requirements of the capitalist economy.

Gough further argues that our understanding of the 'welfare state' is advanced, if we consider another function of the state to be reproduction-defined by Gough as the daily and generational reproduction of labour power. Gough's work represents an important development in theoretical understandings of the state because previous theorists' analyses of the state's role and functions centred on political/economic factors, and hence on the production process. This focus may partially explain why the emergence of the 'welfare state' was initally an anomalous development. These previous theoriests paid scant attention to either the need for labour power to be maintained and reproduced, or to the social relations of reproduction. Marx acknowledged the need for the care and maintenance of the labour force, but further stated that the fulfillment of this is left to the workers' "instincts":

> The maintenance and reproduction of the working-class is, and must ever be a necessary condition to the reproduction of capital. But the capitalist may safely leave its fulfillment to the labourer's instincts of self-preservation and propogation.[37]

The provision of services and policies by the state can be understood as a component of the state fulfilling the function of reproduction. It is also a recognition that the maintenance and reproduction of labour power could not be, and was not, left to the labourers' "instincts". To not include a discussion of reproduction leaves us with not only an insufficient understanding of the role and functions of the state, but also reflects the 'sex-blind' categories of Marxist theory and analyses. The "instincts" for the care and maintenance of the labour force have been socially constructed to place women at the heart of the fulfillment of these tasks, and the state has played an important role in this construction.

Women, the State and Reproduction[38]

Gough (1977) was the first theorist on the 'welfare state' to expand beyond the narrow emphasis on production and the public sphere. Gough not only included the concept of reproduction, but made this concept central to his analysis. This is evidenced by his definition of the 'welfare state' as: "the use of state power to modify the reproduction of labour power, and to maintain the non-working population in capitalist societies".[39] It should be noted here that Gough uses the concept of reproduction in a limited sense-that is, exclusively in terms of the daily and generational reproduction of labour power. However, his inclusion of the concept broadens

the scope of analysis to include the 'family' and women's role as defined and directed by the state.[40]

According to Gough, the 'family' was fundamentally altered with the emergence of capitalist social relations-the wage labour system. In pre-industrialist society, the activities of production, reproduction and consumption were combined. With the emergence of the wage labour system, argues Gough, a split occurred between production and reproduction-between the male breadwinner and the housewife. It should be noted here that Gough assumes a sexual division of labour, whereby the man entered wage work-production, and the woman remained in the home-reproduction.[41] Because of this new 'family' form, the state has intervened to support the 'family' because it could no longer meet its reproductive needs. The state presumably has an interest in supporting this form of the 'family' because of the daily and generational reproductive activities which take place within this sphere, and particularly, because the wageless labour of women lowers the cost of reproduction.[43] Therefore, Gough concludes that:

> ...the welfare state denotes state intervention in the process of reproducing labour power and maintaining the non-working population. It represents a new relationship between the state and the family in this process. The dynamic of capital accumulation continually alters both the requirements of capital, particularly with regard to the first, and the capacity of the family to meet these requirements.[43]

It is the concept of reproduction, and the definition of women as wives and mothers, responsible for the daily and generational reproduction of labour power, that is expanded upon by feminists, in the development of theoretical formulations of women's oppression in capitalist societies.[44]

One of the most important tenets which links women's oppression with the capitalist system of production has emerged from the 'domestic labour debate'. It is agreed by all proponents within this debate that domestic labour is a hidden source of women's wageless contribution to capital. In other words, women's wageless domestic labour contributes, or is crucial to capital, in its function of maintaining and reproducing labour power.[45] Although one of the issues within this debate is whether women's labour produces use-value or surplus-value, capital maintains an interest in this wageless labour performed by women, whether or not it is of use or surplus-value:

> Capital has an interest in the production and reproduction of labour-power independently of whether or not this can be directly translated into the production and reproduction of surplus-value, and presumably therefore has some interest in the efficiency of this sector.[46]

The interests of capital in the production and reproduction of the labour force is understood in terms of the capitalist class as a whole, and in the long-term interests of this

class. The state intervenes to protect these interests because the reproduction of the labour force is not in the immediate interest of any individual capitalist.[47] The state plays a role in the exploitation and oppression of women, by supporting a type of household in the form of a male wage-earner and female domestic labourer, which in turn instills women's economic dependence upon men, and accordingly, an unequal marriage relationship.[48]

McIntosh points out that even when the state has undertaken some of the tasks of reproduction (for example, social services such as mother's allowances), the financial support and services provided are accompanied by an ideology that the state is reluctantly "...taking over functions properly belonging to the family or as 'substituting' for work that 'should' be done by a housewife".[49] Therefore, the ideology of women's responsibility remains, and serves to keep women in the home, and the state can rationalize the absortion of some, but not all of the costs of reproduction.

Land and Parker also point out that policies relating to the 'family' cannot upset the particular type of household supported-a patriarchal household:

> At the same time as preserving an unequal marriage relationship, social policies which impinge on the family have not been allowed to interfere with work incentives for men. Indeed, we would argue that by assuming an unequal economic relationship between men and women, the man's duty to participate in the

> labour market is reinforced and although the wife may take employment too, her first duty is in caring for her husband, children and sick or elderly relatives.[50]

Although the state does support this type of household whereby the woman is dependent upon the male wage earner, some currents within the working-class itself fought for the 'family wage', where the male would supposedly be paid enough to support his wife and children.[51]

The state also intervenes to support the household in its particular form because of the dynamics of social reproduction which take place in the home. Because children represent the next generation of workers, the state presumably has an interest in the efficiency of this task. The home is crucial in raising children who are trained for certain kinds of work necessary and available under capitalism, and "... trained to a belief in the naturalness and inevitability of this process".[52] This of course involves a legitimation or justification of the existing social and economic organization-which includes a justification and legitimation of the sexual division of labour. Therefore, the 'welfare state' provisions and services are also "... a set of ideas about society, about the family, and not least important-about women, who have centrally important role within the family, as its linchpin".[53]

What is largely ignored in analyses of the state's role and functions is a discussion of the third component

of reproduction-biological/human reproduction. The major emphasis is on daily and generational reproduction and social reproduction. There is little analysis of how the state controls the biological/human activities of women, and how this control is related to women's specific oppression under capitalism. These links are underdeveloped on both a theoretical and empirical level. We will now turn to a discussion of the links that have been suggested by some theorists.

Edholm, Harris and Young assert that physical capacities, or biological reproduction does not exist independently of power structures or the production process. Furthermore, procreation itself is socially constructed:

> Physical capacities do not exist outside-autonomously from-power structures and productive processed. Nor are they beyond human control and manipulation. Procreation is itself to a large extent socially constructed. It has a history. Its process, its consequences, and its meaning also vary from class to class.[54]

How women view the process of childbirth and pregnancy arises in part from their material conditions, and the material conditions are primarily determined by the production process.[55] As well, the controls placed upon women are greatly influenced by the economic system, in that women are expected to produce more or fewer children, depending on the perceived number of workers required for the next generation.[56]

> It seems clear that the growth of human populations is both uneven and fluctuating and is subject to considerable social manipulation and control...a certain interest of any social group-whether in times of expansion, when presumably increased female fertility is encouraged/enjoined or in times of stability when some proportion of the female population is withdrawn from reproduction-may well be the social appropriation of women and the regulation of their generative powers.[57]

It is important to note that attempts to control women's fertility-one of the basic characteristics of patriarchy-[58] are made in all systems of production. That is, attempts to control the biological/human reproductive activities of women are not restricted to capitalist societies. What is of primary concern in this thesis, however, is the form of women's oppression under capitalism.

The state in capitalist societies, on an ideological and material level, attempts to control women's fertility. On an ideological level, women may be encouraged to bear more children, for 'true' fulfillment or as a national duty. On a material level, the state controls women's fertility with the use of judiciary[59] and legal machinery, and by granting many contraceptive decisions and abortion decisions to the primarily male medical profession. The medical profession, argues Eisenstein, "shares the state's interest in monopolizing and concentrating medical knowledge in its own hands, which denies women reproductive freedom.[60]

Although it is technically possible for women to control their own fertility, either through contraception, abortion, or sterilization, the medical profession has taken control of reproductive technology such that the potential for women has not been realized:

> For women, the development therefore of reproductive technology has been a contradictory process. Technically, it has given women more control over their own bodies, but at the same time it has increased the capacity of others to exercise control over women's lives.[61]

To recapitulate: the state, on both a material and ideological level, attempts to control women's fertility/ biological reproductive activities. This may include either an encouragement or discouragement to bear children. The nature and content of these attempts fluctuates, and needs to be examined with historically specific analyses. As noted earlier, these efforts to control women's fertility also includes efforts to control the conditions under which biological reproduction take place. The state, in its function of fulfilling the role of repoduction of labour power, involves itself with all three components of reproduction, as outlined by Edholm, Harris and Young (1976): biological; daily and generational; and social reproduction.

The following section examines state intervention in the health sector as it relates to the reproduction of labour power. Because of the poor living and working conditions which accompanied rapid industrialization and urbanization (the

early development of the capitalist economic system), the State intervened in the health sector. The privatized household was no longer able to provide the healthy worker that industry required, so the State became involved in the rationalization of health services. Within this section, the organization of health care- monopoly of medical science - and physicians as the primary agents or administration of health care, will be discussed.

State Intervention in the Health Sector[62]

It has been postulated that the State, at its broadest level, has the role of reproducing the capitalist economic system. The specific functions include: accumulation, legitimation, and reproduction. State intervention in the health sector represents part of the general process of the state taking over responsibility for the collective reproduction of labour power (Doyal, 1979).

Doyal (1979) states that the most obvious connection between health care and the reproduction of labour power concerns the physical fitness of the worker. It is labour power which workers sell, and it is the basis through which the capitalist appropriates surplus-value and is able to accumulate profits. However, as Doyal points out, not all labour power is of the same quality, and the physical efficiency of the worker can affect the amount of surplus

value extracted in a working day: "It is therefore a matter of some concern both to individual capitalists and to capital as a whole, that the physical health of the labour force should be maintained at a 'satisfactory' level".[63] It is important to note that this 'satisfactory' level is determined historically, and will vary according to the existing supply of labour, the type of technology in use and workers' expectations in relation to desirable levels of health.[64]

The state, in the early stages of capitalist development, concentrated on fulfilling the function of capital accumulation, by providing, for example, railway subsidies to build an economic infrastructure. Services such as nursing, medicine and teaching were provided primarily by women in the home. (Coburn, 1974). In the late nineteenth century, however, the state expanded its activities to include issues surrounding reproduction. Services provided by women in the home were no longer adequate. In relation to Canada,

> As industrialization increased from the 1880s onward, their (women's) services were not longer adequate. Production shifted from family to factory, whereupon the working family lost its viability as an economic unit and was forced into the town to sell the only thing that was left-the labour power of men, women and children. In this new setting, the family could not provide the disciplined, literate, healthy worker that industry required, so the state stepped in.[65]

In relation to health, the state "stepped in" by providing expenditures for hospitals, and Boards of Health were established to implement and oversee public health regulations. These 'needs' were created by the intense industrialization and urbanization that accompanied nascent capitalism. In relation to Ontario:

> ... families from outlying areas joined the thousands of immigrants who crowded into industrial centres. The state was faced with growing slums, high disease and mortality rates, vagrant youth, large numbers of unemployed and destitute old and sick. As industry and industrial centres expanded without concern for the squalor they created, it became apparent that more schools and hospitals would be needed...[66]

The definition of health itself in capitalist societies can be conceptualized as the capacity to work. The concern to both capitalists and to the state, is the level of physical health required to maintain the maximum level of productivity.[67] This concern can contrast to the perspective of workers, where a major concern may be for eg. quality of life. This conception of an 'acceptable' level of physical health is also closely related to the level of health required for the military capacity of workers. Schatzkin (1978) states: "... since periodic wars and military ventures are necessary to preserve the capitalist system and the capital accumulation process, a working force healthy enough to fight efficently is important".[68]

The maintenance of the capitalist economic system, however, also depends on the physical existence of the capitalist class as well as the working-class. This in fact has been an important factor in determining the overall level of health and medical care services in a capitalist society (Schatzkin, 1979). In England, Sanitary and Factory Acts were prompted by a bourgeoisie concern with infectious disease epidemics that threatened their existence. As well, the Sanitary and Factory Acts were a result of a growing concern with the militancy of the workers, and not least important, a concern about the productivity of workers:

> But the English bourgeoisie and its representatives like Chadwick were also becoming concerned that the English workers were simply being worked to death, burned out to a point where overall productivity was being threatened.[69]

This displays the proclivity of the capitalists to promote their short-term interests over their long-term interests. In their zeal to accumulate capital, they threaten both the daily and generatioanl reproduction of labour power.[70]

It is clear that many public health reforms and measures implemented by the state in the nineteenth century, were instigated by a growing concern about the effects of ill health on the productivity of workers. Health, defined as the capacity to work, was a major concern, and it was found that:

> Healthy noninfected workers could produce sufficiently greater surplus-value per worker than infected workers so that maintaining healthy workers-even adding to the cost of the public health program- resulted in a lower proportion of total value created going toward the reproduction of labour-power.[71]

What cannot be unequivocally stated, however, is that, in modern capitalist societies, scientific medicine contributes to the the productivity of labour.

In fact, scientific medicine has yet been unable to eliminate or lower the number of debilitating and chronic diseases of the twentieth century.[72] The question which arises is why scientific medicine has become the dominant method of health care, and been able to establish a monopoloy, and following from this, why the medical profession has been granted a special status in most capitalist societies. Medical science has retained its monopoly, despite the fact that medicine has been largely ineffective in dealing with 'twentieth century' diseases.

On a broad level, Doyal argues that: "the scientific claims for medical practice mean that it must be seen in the light of the more general process by which capitalist societies are legitimated on the strength of their relationships with science and scientific achievements".[73] In the latter part of the nineteenth century, science was well on it way to becoming a "sacred national value". The development

and adoption of medical science coincided with scientific management (Taylorism), scientific public administration, scientific social work, and domestic science.[74] Also, as Doyal points out, the availability of high technology medicine and the publicising of individual medical breakthroughs come to represent support for the existing system, and both mask and legitimise the social and economic inequities within the capitalist society.

Finally, the characteristics of medical practice are compatable with the capitalist economic system. According to Navarro, these characteristics are: reproduction of the class structure; reproduction of alienation; and reproduction of bourgeois ideology. The first characteristic- reproduction of class structure- occurs as the distribution of functions and responsibilities within the health labour force are replicated on class, sex and racial lines: physicians are primarily upper-middle class; nurses are primarily lower-middle or working class females; and auxiliary health workers are predominantly females of working-class backgrounds.[75]

The ideology of capitalism-individualism and liberalism- is the second characteristic which is replicated and subsumed in the ideology of medicine. The medical ideology takes two forms: the mechanistic conception of the human body as a machine, in which it is assumed that disease is the

imbalance of the components of the machine-like body; and the second form, which is derived from the first, the cause of disease is primarily individual and thus the response is individually oriented. In other words, the bio-medical model focuses on organic pathology in individual patients. Navarro sums up the consequences of this ideology of medicine:

> At a time when most disease was socially determined due to conditions of nascent capitalism... an ideology that saw the "fault" of disease as lying in the individual and that emphasized individual therapeutic response clearly absolved the economic and political environment from the responsibility for disease and channelled potential response and rebellion against that environment to an individual, and thus less threatening level. The ideology of medicine was the individualization of a collective causality that by its very nature would have required a collective answer.[76]

The final characteristic of state intervention in the health sector is the reproduction of alienation. This is achieved through a division of labour between experts and lay people. The lay person has no control over the definition and nature of health in the medical sector. In the doctor/patient relationship, there is a lack of patient autonomy and power in which the "...citizens are supposed to be the recipients of care and the experts are supposed to be the providers and administrators of therapy".[77] People come to believe that they have little power over their bodies, just as they have little power over other

areas of their life.

Scientific medicine has been adopted as the primary mode of health care, and the medical profession yields immense power over the administration of the health care system. However, the medical profession has not been granted control of the health care system itself. The health care system is increasing part of, and dependent upon the state, primarily through the state provision of funds for training, research and the delivery of service (Navarro, 1976). Friedson (1970a, 1970b) is in agreement with Navarro, as he argues that the medical profession has been granted autonomy from the state, but is ultimately dependent upon it: "The foundation on which the analysis of a profession must be based is its relationship to the ultimate source of power and authority in modern society- the state".[78] Also, related to the assertion that medical science has been largely ineffective, the effectiveness or lack of effectiveness of the medical profession's performance has not led to serious considerations of whether their special status is warranted:

> ... it is very important to separate demonstrable scientific achievements from the status of the occupation involved and the success it has had in establishing its jurisdiction. The jurisdiction that medicine has established extends far wider than its demonstrable capacity to "cure".[79]

To summarize, medical science has evolved as the predominant mode of health care, and a special status has been granted to

its agents the medical profession. This predominance can be understood in terms of the links between the theory and practice of medical science and the capitalist society within which it has evolved. The adoption of medical science is one way in which capitalist societies all legitimated. Both health and the provision of medical care are essential to all individuals, and the availability of what becomes viewed as the best type of care-medical science- serves to instill and maintain support for the existing system. An ideology which professes the superiority of medical science, and the 'proof' of this through, for example, the publicising of individual medical breakthroughs helps to present the society or system as essentially benevolent. As well, the question of whether medical science is largely effective is rarely addressed, at least in a collective sense.

The ideology of medical science itself, in terms of the theory of the causes of ill health and disease, also has the effect of masking and legitimising the social and economic inequities within a capitalist society. The cause of ill health and disease is viewed as primarily individual, and thus the solution is individually oriented. This serves to obfuscate the importance of other social economic or environmental factors as they relate to ill health and disease.

Summary of Theoretical Themes

It has been argued that the history of childbirth, and within this, the specific problem of maternal mortality, needs to be examined in light of broad social/economic and political factors. The broad role of the state is the reproduction of capitalist relations of production and a logical facet of this role is to defend the predominance of the capitalist class. To do this, the state protects the long-term interests of the capitalist class as a whole, by fulfilling the functions of accumulation, legitimation and reproduction. Reproduction is understood to include biological/human reproduction, daily and generational reproduction, and social reproduction. When the state intervenes, it may be to fulfill any one or all of the stated functions, including the various components of reproduction. The exploitation and oppression of women is partially explained by the definition of them as first and foremost, wives and mothers. As wives and mothers, women are held responsible for the daily and generational reproduction of labour power. The state support of the form of household with a male wage-earner and female domestic labourer instills women's economic dependence upon men, and accordingly, and unequal marriage relationship. The state also plays a role in the exploitation of women through the control of women's fertility, which denies them reproductive freedom.

Finally, state intervention in the health sector is partially explained by the trend towards the state taking over responsibility for the collective reproduction of labour power. Health is primarily defined as the capacity to work, and intervention in the health sector increased in the nineteenth century, as it became clear that the poor health of the population was restricting the amount of surplus-value to be extracted from labour. The capitalist system of production also determines the characteristics and organization of the medical care sector.

The various theoretical themes, and the refinements proposed for historical analyses of childbirth, are incorporated into the examination of the problem of maternal mortality. Previous histories of childbirth tend to pay scant attention to the fact that thousands of women were dying in childbirth during the 1920's and 1930's. The high number of maternal deaths, and the proposed and adopted solutions to this problem, represents an important segment in the history of childbirth. The issue of maternal health care arose out of the debates surrounding the problem of maternal mortality, and as a result, significant changes occurred in the definition and treatment of childbirth, and the control over obstetrical care.

As well, an examination of the problem of maternal mortality and maternal health care should not be reduced to

a focus on the involvement of the medical profession. The state played an important role in raising the issue of obstetrical care, and was influential in directing the course of future childbirth practices and services. In order to understand the state's intervention, and the nature of this intervention, in the health sector in general, and its specific involvement in the problem of maternal mortality, the theoretical discussions of its role and functions are incorporated. The eventual definition of childbirth as a medical event; the monopoly established by the medical profession over obstetrical care; and the transition from home to hospital births was not just a result of a successful campaign levelled by the medical profession. The adoption of medical science with the medical profession as its agents, as it applied to the resolution of maternal mortality, can be understood in terms of the compatability of its theory and practice with the capitalist economic system.

In the following section, the major focus and arguments developed in each subsequent chapter will be outlined. This should orient the reader to the general thrust of this thesis, and the relevance of the theoretical discussions within this chapter will become clearer with an outline of the empirical applications.

Chapter Outline

In the second chapter, the initial state interest and involvement in the health of the population in general, and the specific problem of maternal mortality is examined. It is argued that the state involvement can be understood in the context of a growing concern about the daily and generational reproduction of labour power. Both the quantity and quality of the present and next generation of workers was perceived as threatened. There was, therefore, an ideological attempt to entice women to bear more children as well as a recognized need, on a material level, to make the process of childbirth a safer event. The establishment of a central health agency, and within this, the efforts directed towards documenting and proposing solutions to alleviate the high number of maternal deaths, represent the state fulfillment of the function of reproduction. Maternal mortality was conceptualized as a problem in terms of the tasks left unfulfilled by women as wives and mothers.

The third chapter examines the strategies proposed and adopted by state health officials to alleviate the problem of high numbers of maternal deaths. Although the state at various levels had acknowledged a certain responsibility for

the reproduction of labour power, it is argued that there was a delineation between these levels in terms of the responsibility for the implementation of concrete policies and services. What is further revealed was the individualization and medicalization of the problem of maternal mortality. The problem and solution was eventually seen as the responsibility of individuals, and in particular, individual women. There were educational campaigns directed to women which stressed how they could help themselves, with for example, proper hygiene. The problem was medicalized (which is also a form of individualizing the problem), in that one of the primary solutions proposed was the medical supervision of parturient women and physician attendance at birth. State health officials, therefore, were not only responsible for the 'problematization' of maternal mortality, (as shown in Chapter Two) but they also played a decisive role in directing women to the medical profession for obstetrical care.

According to state health officials, however, the medical profession was not displaying enough interest in either the problem of high maternal deaths, or maternal health care in general. At the same time that officials argued that the solution was medical care, supervision, and attendance at birth, they also argued that practitioners themselves were responsible for a number of maternal deaths because of their poor obstetrical training, practices and services.

In the fourth chapter, the response of the medical

profession is examined. It is argued that the state health officials' perception of the profession as complacent and the need for improved obstetrical care was essentially correct. Contrary to findings in previous examinations of the history of childbirth, the profession did not aggressively attempt to monopolize obstetrical care. In fact, it is argued that the profession was initially disinterested in both the problem of maternal mortality, and obstetrical care in general. In other words, the profession was relatively silent on issues surrounding childbirth practices and services, prior to state involvement and public awareness and interest in these issues. It was the public awareness and interest which precipitated the leaders of the profession to seriously address the problem of maternal mortality. Leaders of the profession argued that the complacency and poor obstetrical practices and services of practitioners could potentially threaten the legitimacy and credibility of the profession as a whole. Although the problem of maternal mortality and the need for improved obstetrical care was espoused, there were few changes made either in training or practice. As a result, it is argued that practitioners themselves were partially responsible for the high number of maternal deaths which showed no appreciable decline until the late 1930's.

In the fifth and concluding chapter, there is an attempt to understand why the general course of resolving the

problem of maternal mortality evolved as it did. There is a return to the role and functions of the state, which are explored in relation to why the problem of maternal mortality was medicalized and individualized. In conjunction with this, there is discussion of other possible routes or avenues which state health officials could have followed to alleviate the problem of maternal mortality. It is argued that state health officials were structurally constrained to define and propose solutions within a limited framework. The possible significance of social economic and environmental factors, as they related to the high number of women dying in child-birth, was consistently avoided. The adoption of a medical solution had the effect of diverting attention from these factors. Medical science at the time however, also held out the promise of being a mode of health care which could alleviate both ill health and disease. It is argued that there were few efforts made to eradicate the underlying causes of maternal deaths. Medical science, in the form of antibiotics, was eventually able to lower the number of maternal deaths without requiring significant social, economic or environmental changes.

Background

For years prior to federal state involvement (1919),

infant and maternal welfare had been a serious concern for various reformers, foremost among these being women's organizations.[80] The maternal death rate, however, was high, if not higher, in the period prior to both the involvement of reformers and state health officials.[81] In the 1890s, infant and maternal welfare was addressed by the National Council of Women, primarily in the context of unattainable or unavailable medical care for many people, who were either too poor or too isolated (particularly in the prairie provinces), to secure medical care. As a solution to this, the National Council of Women established the Victorian Order of Nurses, with the purpose of visiting homes to nurse the sick- especially women and infants- and give advice on diet and hygiene (Buckley, 1979). Both physicians and nurses initially opposed the establishment of the Victorian Order of Nurses. Physicians saw this organization as an economic threat, and nurses, who were in a crucial stage in their attempt to professionalize, did not threaten their precarious status by criticizing the physicians.[82] This organization was eventually supported by the physicians, however, with the assurance that the Victorian nurses "would attend only the poor people who could not well afford to pay a doctor".[83]

Specific efforts by women's organizations to reduce infant mortality consisted primarily of 'pure milk' campaigns and 'little Mother' classes designed to educate women on the care of their babies and infants.[84] It was not until

approximately 1915 that the efforts of these organizations centred on maternal welfare. The impetus for this came from the realization that healthy infants required healthy mothers. Once again, the emphasis of the National Council of Women was on the lack of medical care and assistance. It should be noted that middle and upper-class women were already at this time under the supervision of physicians during parturition (Mitchinson, 1975). Most women, however, were either unattended at birth, or used the services of lay midwives. Despite the fact that midwifery was illegal in most of the provinces, and had been in Ontario since 1865, it was difficult to stop because physicians were not only poorly distributed, particularly in rural areas, but the services of a midwife were also less costly than that of a physician (Buckley, 1979).

Despite the efforts to reduce infant, and later maternal mortality, the results are best described as "piece-meal and plodding" (Buckley, 1979). As early as 1905, and as late as 1919, women's organizations had lobbied and demanded greater federal state involvement, in the form of a central health agency to deal with the health of the population in general, and a specific division for infant and maternal welfare.[85] The Victorian Order of Nurses had a slow growth, and was hampered by inadequate finanacial resources. In a report compiled by the National Council of Women in 1917, it was concluded that the problem of

inadequate maternity care could not sufficiently be remedied by a private organization: "... to be successful a scheme required the authority of the Government as well as its financial aid".[86]

NOTES FOR CHAPTER ONE

1. For example of this type of presentation, see Findley (1939) and Graham (1950).

2. For example, see: Frankfort (1972); Seaman (1972); Our Bodies, Ourselves (1976); Corea (1977); Ruzek (1978); Scully (1978); Dreifus (1978); and the journals, Women and Health and Healthsharing.

3. Ehrenreich and English (1979), p. 97.

4. For a critique of contemporary obstetrical practices and services, see: Haire (1974); Arms (1975); Ostrum (1975); Rich (1976); Stewart and Stewart (eds. 1977, 1978). For contemporary analyses of women's experience of childbirth, see: Shaw (1974); Kitzinger (1973, 1975); and Danzinger (1979). Finally, for a history of the development of obstetrical practices and services, see: Ehrenreich and English (1973, 1979); Brack (1976); Donnison (1977); Wertz and Wertz (1977); Litoff (1978) and Lewis (1980).

5. Ehrenreich and English (1979), p. 316.

6. The situation in Canada is best compared with the United States, in that midwives have been virtually eliminated, whereas in England, midwives have been incorporated into the health care system, although subordinated to the medical profession. For a comparison of British and American midwifery, see Kobrin (1966) and Anisef and Basson (1979).

7. Ehrenreich and English (1979, p. 94.

8. Ibid., p. 92.

9. For references to specific studies, see: Kobrin (1966), Lewis (1980).

10. Middle and upper-class women shared the class and professional bias of physicians, and embraced the profession partly because they had no desire to be attended by midwives who were predominantly lower-class.

11. Ehrenreich and English (1979), p. 93.

12. Ibid, p. 123.

13. The use of instruments and medication was withheld from midwives by the medical profession (Oakley, 1975; Arms, 1975; Brack, 1976: Mitchinson, 1976; Ehrenreich and English, 1973, 1979).

14. Oakley, (1975), p. 641.

15. Ehrenreich and English (1979),p. 97.

16. Arms, (1975), p. 25.

17. Ehrenreich and English (1979)provide the broadest examination of this, as they place the success of the takeover to the rise of science in general, and relate it to the class struggle. However, in dealing with the specific issue of the elimination of midwives in the twentieth century, they do not place this takeover into a broader context. They also do not provide discussions of the problem of maternal mortality, and how this issue relates to the elimination of midwifery.

18. Arms, op. cit. p. 26.

19. The range of between approximately 90-97 percent has been quoted in the previously mentioned literature (see footnotes 2 and 4) as the percentage of women who could have an uncomplicated normal birth.

20. See for instance: Morrison (1976), Sutherland (1976), Copp (1979), Bator (1979) and Piva (1979). Bator argues that the public health movement, particularly in Toronto, was successful. Copp and Piva, however, argue that the movement was at best, partially successful, but primarily ameliorative.

21. On the other hand, Lewis shows with her data that the mortality rate in hospitals was higher than the mortality rate for home births. It is not necessarily true to state that aseptic and antiseptic procedures needed to take place in a hospital, or in other words, that hospital births was the solution to high maternal death rates.

22. The Canadian studies will be introduced in the course of the following chapters.

23. There are important analyses which contribute to our understanding of the 'welfare state'. As Gough states, the very term reveals its ideological character. For a critique of functionalist theories, economic theories and pluralist theories of the policies and services provided by the state, see: Mandell (1975); Gough (1978, 1979); and Finkel (1979).

24. Marx (1964), p. 61.

25. Miliband, (1969); O'Connor (1973); Panitch (1977); Gough (1979).

26. Miliband (1969), p. 3.

27. This discussion is taken from Gough (1979).

28. Gough argues that structural constraints is the most important factor because the class background of state personnel can change, and the power of the capitalist class can be partially countered by the power of labour. However, the state is consistently dependent upon the successful functioning of the capitalist economy for its own revenue.

29. Miliband (1969); O'Connor (1973); Gough (1979).

30. The concept of the state as 'relatively autonomous', rather than just an instrument of the ruling class is extremely important because it moves beyond a static model of the state, and provides room for an analysis which can incorporate class conflict. As well, this conception of the state enables one to examine the historically specific activities of the state and avoid conspirational and mechanistic analyses.

31. The municipal level of the state is often seen as the closest representative of the interests of the entire local community. However, Cockburn (1978) shows that even at this level, policies and services are designed to benefit the ruling class.

32. Stephenson (1977) for a discussion of the history of the relationship between the various levels of the state in Canada, and why the power of sub-central governments has not decreased as was asserted by Miliband.

33. For example, when the state expansion of welfare services and provisions are needed to fulfill the legitimation function, the state may be unable to, at a fiscal level, provide these services. O'Connor (1973); Gough (1979)

33. and Navarro (1976) all discuss the fiscal crisis of the state resulting from increased state expenditures.

34. Which function is being fulfilled requires an examinations of the historically specific period, because there are a number of factors which may determine this- for example, the power of labour, labour force requirements, unemployment levels.

35. The capitalist mode of production is unique in that labour can be extracted from workers for the benefit of the ruling class without the use of overt control. However, coercion or force is at the ultimate disposal of the state, should the other functions of accumulation and legitimation fail.

36. Walters, (1981), p. 14.

37. Marx, p. 711.

38. The concept of reproduction used in this thesis is taken from Edholm, Harris and Young (1979). Reproduction is comprised of three components: social reproduction; daily and generational reproduction and finally, biological/human reproduction.

39. Gough (1977), p. 44.

40. Gough assumes the concept of 'family' is self-explanatory, and seems to be using it in a universalistic sense, and therefore does not address its historical specificity. See Barrett (1981) for a critique of the concept of 'family'.

41. Gough not only assumes a division of labour whereby the woman would 'naturally' stay in the home, and the man would enter wage work, but he also completely dichotomizes the process of production from reproduction. However, there are productive activities which take place in the home, and conversely, there are reproductive activities that take place in the sphere of wage work.

42. Gough gives no discussion of the historical determinants of 'needs', but instead relies on crude economistic determinants.

43. Gough (1977) p. 43.

44. Feminists are by no means homogeneous in their analyses. One of the major debates is whether patriarchy and capitalism are autonomous systems, or whether they are integrated. See the three anthologies which address the relationship between patriarchy and capitalism, in the development of Marxist-feminist theory: Kuhn and Wolpe, eds. (1979); Eisenstein, ed. (1979), and Sargent, ed. (1981). For an excellent summary of the key discussions and debates within the development of this theory, see Barrett (1980). This work is intended to be a contribution to the analyses of women's specific oppression under capitalism, from an integrationist perspective.

45. Some feminists argue that although women's wageless domestic labour functions for capital, they argue it also serves the interests of men, and in fact men fought for this form of household, where women perform personal services for them. The major exemplar of this approach is Hartmann (1979).

46. Humphries (1977), p. 27.

47. Sen (1980), p. 82.

48. The home has been identified as the primary site of women's oppression (Barrett, 1981).

49. McIntosh (1978), p. 264.

50. Quoted in McIntosh (1978), p. 267.

51. See the debate on the 'family wage' between Humphries (1977) and Barrett and McIntosh (1980).

52. Walsh (1977), p. 15.

53. Ibid, p. 9.

54. Edholm, Harris and Young (1976), p. 43.

55. Armstrong and Armstrong, 1983.

56. Doyal (1979). She argues that in advanced capitalist societies the emphasis is on the quality rather than quantity of the population.

57. Doyal, (1979), p. 41.

58. Eisenstein, (1981).

59. See Gordon (1976) for a thorough history of women's struggle for control over their fertility.

60, Eisenstein (1981), p. 221.

61. Doyal (1979), p. 229.

62. The state literature previously dealt with alludes only briefly to state intervention in the health sector. O'Connor (1973) sees it as fulfilling the function of legitimation, and Gough (1979) states that it partially fulfills the reproduction function. Navarro (1979 argues that the provision of health care was a concession made to the working-class for an alternate view on this, see Walters (1980); Rodberg and Stevenson (1977) are exemplars of the political/economic view, in that they emphasize the function of capital accumulation to explain state intervention in the health sector.

63. Doyal (1979, p. 39.

64. This definition adopted by Doyal (1979) and Schatzkin (1978) is taken from Kelman, as a "functional definition' in that health is defined as the capacity of workers to fulfill their primary role- the production of surplus-value.

65. For the changes as they occurred specifically for women in Ontario, with the transition from independent commodity production to a capitalist economic system, see Johnson (1974).

66. Coburn (1974), 133.

67. Doyal (1979), and Schatzkin (1978).

68. Schatzkin (1978), p. 215.

69. Ibid., p. 218.

70. See Engels (1958) for a vivid protrayal of the atrocious working and living conditions in the mid to late nineteenth century.

71. Schatzkin, p. 216. Schatzkin argues that capitalists will invest in medical care only to the extent that the investment increases the rate of exploitation.

72. Authors such as Illich (1976) and Navarro (1975) argue that modern medicine does not address the social and economic determinants of illness and disease, such as stress, heart disease, malnutrition, and occupational illnesses and hazards. These authors conclude that

72. scientific medicine is largely ineffective, and neither improves health or life expectancy. However, Doyal (1979) and Schatzkin (1978) argue that medical science has the capacity to alleviate symptoms of illness, or reduce recovery time from an illness or injury. Schatzkin further argues that this alleviation serves to increase worker productivity.

73. Doyal, p. 43.

74. See Strong-Boag (1983) for a discussion of the trend towards scientific housework and mothering.

75. Navarro (1976), p. 206.

76. Ibid, p. 207.

77. Ibid, p. 208.

78. Freidson (1970), p. 143. Although Freidson asserts the necessity of an analysis that examines the relationship of the profession to the state, he himself does not do it. McKinlay (1977) provides an excellent summary and critique of Freidson's work.

79. Ibid, p. 171. See Powles (1973) and McKinlay and McKinlay (1977) for statistical analyses which show that medical science should not be credited with the overall improvement in the health of the population, or the decline in mortality rates. In this thesis, it is argued that medical science- specifically antiobiotics- did in fact play a major role in the reduction of maternal mortality rates.

80. See MacMurchy's (1922) Handbook on Child Welfare for an exhaustive list of the women's organizations involved with the problem of infants, and less intensely, maternal mortality.

81. Copp (1979); Piva (1979).

82. Coburn (1974) and Buckley (1976) provide histories of nurses in Canada and Ontario.

83. Buckley (1979), p. 137.

84. Sutherland (1976) points out that the public health reformists centred on: the health of school children, infant mortality and 'feeble-mindedness'.

85. The contemporary term of 'maternal feminism' has been adopted to explain the activities of women's organizations in the late nineteenth and early twentieth century. These feminist accepted the prevailing attitude of submissiveness and domesticity in family life as the ideal but also used the attitudes of superior morals and religous values to expand their influence and participation in the public sphere. See Kealey, ed. (1979) for a series of articles on women and reform from the 1880s to the 1920s.

86. Buckley (1979) p. 143.

CHAPTER TWO

The Context of Federal State Involvement

Introduction

In this chapter, the initial federal state involvement in the health of the population in general, and the specific 'problematization' of maternal mortality is examined. For literally years, women's organizations had lobbied and demanded that the federal government address and deal with the health of the population and infant and maternal mortality. Therefore, it becomes necessary to suggest why the state at the federal level became involved when it did. The emphasis is on the state at the federal level because its involvement marked the centralization and concentration of efforts to alleviate the high number of maternal deaths. As well, the federal involvement instigated greater effort at the provincial levels of the state.

I argue that the federal involvement was instigated by national, imperialist and racist concern.[1] With the population losses suffered during the war, combined with the declining birth rates of the Anglo-Saxon population in Canada, and the high immigrant population, there was a perceived need to increase the 'native' Canadian population.

Therefore, there was a post-war ideological campaign to elevate the status of motherhood, which may be seen in part, as an attempt to entice women to bear more children.[2] This form of indirect population policy, however, required material or concrete efforts to make the process of childbirth itself a safer event. In other words, the problem of maternal mortality was inimical to the state concern about increasing the population, and hence the state became involved and addressed maternal mortality as a problem.

This state concern to increase the population was compounded by a growing concern with the quality of the population, or in theoretical terms, a concern with the daily and generational reproduction of labour power. Once again, the war served as the impetus for state involvement. It was revealed that the physical quality of many army recruits was poor and often resulted in rejection. After the war, the health of the men as fighters became transformed into a concern with the health of men as workers. Therefore the state became involved in the health sector generally because of a perceived need to improve the physical quality and efficiency of workers-both the present and next generation.[3] It was within this context that maternal mortality was conceptualized as a problem. It was the care and maintenance of husbands and children that was threatened by maternal deaths.

State Intervention in the Health Sector[3]

The federal government in 1919, established a Department of Health and the Dominion Council of Health, to coordinate and centralize public health efforts.[4] In 1920, a Child Welfare Division was formulated within the Department of Health, with Helen MacMurchy as the Chief of this Division.[5] All of these bodies directed attention to the problem of maternal mortality and public health work in general.[6]

The parliamentary speeches, discussions and addresses made by representatives of the above stated bodies reveal the imperialistic concerns, and the perceived need to improve the physical efficiency of the population. With the announcement of the establishment of a federal Department of Health, it was stated:

> This (Public Health Department) is in line with what I believe this Government, as all governments in Canada, will have to do in the next few years...the importance of our country is determined by our people, and unless we have a vigorous, virile, healthful people we cannot have a country of the first importance. Universal health conservation is... the duty of the nation. (emphasis added).[7]

This imperialist concern interacted with a perceived need to improve the physical efficiency of the present and future generation of workers:

> Without a healthy infancy and childhood, healthy adolescence and manhood are impossible. The character of the future adult

> population, its health, vigor, intelligence and working capacity are determined by the development and growth of the child of today. (emphasis added).[9]

This state concern with the health of workers was highlighted by the fact that over half of the army recruits had been rejected because of poor health. It was not only the health of men as workers which elicited concern, but also the closely related military capacity of workers was addressed. In order to preserve the capitalist system, and the capital accumulation process, it is necessary to be prepared for wars and military ventures. It is necessary to have men healthy enough to work as well as to fight:

> In regard to Canada, one may refer to the speech of Hon. R.W. Rowell, when he introduced the bill providing for a federal Department of Health in the House of Commons recently, to realize that work along the line of Child Welfare is urgently needed in the Dominion if the present "slaughter of the innocents" is to be reduced, and if a greater number of our coming men are to belong to a higher category of physical fitness than was the case in the medical examination of applicants for military service during the war.[10]

The concern for the "slaughter of the innocents" was accompanied by fears of "race suicide". The Anglo-Saxon birth rate in Canada was declining despite relatively stable marriage rates and greater fecundity (McLaren, 1981). Also, the foreign migration (primarily of the Irish), and

decreasing Anglo-Saxon fertility rates relative to the Irish and French-Canadian fertility rates, caused a great deal of concern, or better said, alarm (Buckley, 1979; McLaren, 1981). Volunteer organizers and reformers were the most explicit in expressing racist comments. For example, in response to the loss of infant and maternal life, it was stated by one reformer:

> In 1922... Canada saw a preventable loss of 13,454 Canadian lives. Our recorded loss was equal in numbers to one-fifth of the gain through immigration. The loss was a loss of Canadian life whereas the gain was merely one of outsiders.[11]

The reformers during this period attributed the declining birth rates of the Anglo-Saxon population to the "selfishness" of women. First of all, the increased number of women entering wage work led to, it was believed, "...the acquisition of tastes and habits of independence which would render them unfit to raise the traditionally large family".[12] There was less sympathy expressed for the middle and upper-class women, as their restriction of family size was seen as a result of luxury and indulgence, and a 'shirking of responsibility':

> ... the race suicide, flourishing among wives in our nation, who are in an economic position to raise children, most adequately equipped to take their places in the national life. The shifting of their maternal duty to the weary shoulders and the work-racked bodies of their less "well-placed"

> sisters; or to the too carelessly prolific immigrant, lays these women open to charges of national disregard from which they cannot be exonerated, even by an "interest" in ameliorating conditions among the children of the latter.[13]

In a letter from Charlotte Hanington, Director of the Victorian Order of Nurses in Canada, to a Superintendent of Nurses in England, Hanington stated:

> I can imagine no greater opportunity than is offered to the highly educated nurse to carry on what is her service to the pioneer mothers of Canada who are doing the greatest service of all- filling the cots with British born citizens - and in some measure, making good the wastage from this war.[14]

At the state level, ideological attempts to entice women to bear more children, and hence increase the Canadian population, brought forth suggestions that propaganda should begin prior to its inclusion in discussions of maternal welfare: "If the population of Canada is to increase, the propaganda will have to begin a little previous to the maternal care and baby welfare".[15]

Because of the population losses suffered during the war, the declining birth rates, and the poor physical efficiency of army recruits, there was an increased emphasis on the health and efficiency of the next generation of workers and fighters, and the need for an active Child Welfare Division was viewed as important for the future of Canada as a country. John McCullough, Chief Officer of Health for

Ontario, asserted: "By far the most valuable asset of any country, particularly of a young country like ours, is the conservation of its native-born children".[16] One of the factors which may have contributed to the sustained interest was an anticipation of the second World War. In a quote from the National Department of Health, the concerns of 1919 were the same concerns in the late 1930's:

> The fact of the declining birth rate enhances the value of child life and health, particularly since the population is so small in relation to the size of the country, and more especially in war time when the youth of the country is being depleted.[17]

In a more blatant expression of the concern for children as the next generation of workers, it was stated: "Speaking in the cold terms of metal and figures, the loss of the child is an economic loss - it is the loss of a future wage-earner, the loss of the parent of future wage-earners".[18]

The concern about increasing the 'native' Canadian population, and improving the health of children, as the next generation of workers, directed attention to those responsible for biological/human reproduction, and daily and generational reproduction-women. There was, in Strong-Boag's words, "a post-war celebration of maternalism which challenged declining birth rates... Press, pulpit, clinic, and school reaffirmed familiar efforts to direct girls to motherhood as the career par excellence".[19] A high maternal

death rate would, rather obviously, be inimical to state concerns for increasing the population. An ideological campaign to entice women to bear more children rings hollow, if on a material level, thousands of women were dying in the performance of their 'sacred duty'.

State 'Problematization' of Maternal Mortality

Maternal mortality as a problem was approached in the same national and imperial context. It was proclaimed that Canada could not afford a maternal death rate that was greater than that existing in "most of the less favoured countries".[20] As well, it was asserted that the early death of women restricted the number of future children women could bear:

> The essential consideration is 'what has it cost the mother in health to produce the family she has, when the family is complete?' In many instances, the damage done has restricted the family to a small number, has cut short the woman's reproductive life.[21] (emphasis added)

This clearly reveals the importance of women as mothers, with little to no consideration to the health or happiness of women, beyond such designated tasks.

There was a strong ideology of motherhood which permeated all discussions and literature designed by state officials. The Federal Division of Child Welfare disseminated thousands of booklets coined the 'little Blue Books', in

part as a response to the high maternal death rate. These booklets contained advice on diet and hygiene, how the mother could take care of herself and her family, and generally, represent the trend towards 'scientific mothering and child-care'. These booklets were replete with national and patriotic appeals to women, to bear children as part of their patriotic duty. In relation to maternal mortality, it was stated: "In Canada over 1,337 women die annually from pregnancy and its complications. This is a heavy price for the women of this country to pay for doing their duty to the State...".[22] Bearing children was consistently presented as women's duty to the State. In the prenatal and postnatal letters or series published by the Canadian Council on Child Welfare, the elevation of motherhood in nationalist terms was also prevalent: "Throughout the entire series her morale is stimulated. She is truthfully told that she is very fortunate to be able to have this child and that Canada is not only interested in her but proud of her".[23]

Women were praised for doing their patriotic duty, and advised: 'No Baby-No Nation... No Home...No Nation'. In a quote from The Canadian Mother's Book, it was stated:

> What is a home without a mother? But what is a home without a child? Your greatest happiness is coming to you in the birth of a baby, a happiness that will be renewed by every child that comes to you... A home without children is a sad contrast. It

> lacks interest, happiness, reality, stability. Its end is in sight. It has lost the greatest loveliness and usefulness of the normal home. [24]

Women were reminded that their greatest fulfillment would be not only the birth of a child, but the rearing and socialization of children, as a life-long 'profession':

> Being a mother is the highest of all professions and the greatest of all undertakings. Nothing that she can know is useless to a mother. She can use all. The mother reports for special duty about 250 days before the baby is born and she is never demobilised until she meets the Bearer of the Great Invitation. Mother, at ninety years, is Mother still. [25]

Although the primary focus centred on the home and women's role as mothers within the home, the care and maintenance of husbands was also stressed, in other words, the daily reproduction of the labour force. There were constant references made to the need for the women to keep a clean, tidy well kept house, as a 'good' welcome for the husband when he arrived home from work. It was asserted that: "The disorganization of the home leads to household irritation and unhappiness. The man goes out in the morning <u>unhappy and unfitted for his work</u> and comes back at night to face the worst trouble of his day".[26]

The first national maternal mortality statistics were collected in 1925-6, and published in 1928, under the direction of the federal Department of Health.

The collection of statistics itself is one of the stages of 'problematization'.[27] It was found that in 1926, Canada had the fourth highest maternal death rate (5.6 per thousand living births) out of twenty-two countries. Not coincidentally, the statistics for Canada were compared with England and Wales (4.1 per thousand living births), and the losses were viewed as "a blemish on Canada's image and a waste of resources that would weaken the connection with Britain".[28]

In Ontario, a study of maternal mortality was conducted in 1922, and the statistics for Ontario were also compared with England and Wales, and the rest of the provinces. It was revealed that for a ten year period (1911-1920), England and Wales' maternal death rate was consistently lower. It was heightened national and imperialist concerns which led to extensive discussions on the need to lower the maternal death rate. The concern and response, however, was less a concern with the loss of human lives as it was a concern with the tasks left unfulfilled as a wife and mother, and the threat to the stability of home and family life. Out of these daily and generational concerns, it was generational reproduction which elicited more alarm. It was believed that with the loss of the mother in the home, the child's chances in life were severely impaired. This concern for generational reproduction also served to provoke attention to the health of women (morbidity) as well as mortality.

The generational reproduction concerns-children-could not be restricted to saving the child's life, or remain primarily involved with the problem of infant mortality. It was argued that healthy babies required healthy mothers. "The saving of child life does not depend altogether upon work among the babies themselves. Much in addition may be accomplished by supervision of the pregnant mother".[29] In a more blatant expression of this priority, the Director of the Child Hygiene Division stated: "The activities of the Division are intimately associated with all that directly, or indirectly affects child health. This, of necessity, presumes an interest in the physical status of the expectant mother".[30]

Following from this, women were told (in the booklets set out the 'Canadian' home), to pay attention to their health, in the context of how it would affect her ability to be a good wife and mother: "If you love your husband, and your baby and yourself-be well; keep your good health".[31] The way to keep good health was to 'live a normal life' and follow the prescriptions for proper diet and hygiene in The Canadian Mother's Book.

The actual studies completed by state officials and agencies further reveal the definition of women as wives and mothers, responsible for the daily and generational reproduction of labour power. The major federal enquiry completed in 1928 contained statistics of the number of motherless

children which resulted from maternal deaths. It was estimated that the number of children left motherless was 4,305, an average of 4.5 children to each mother who was not a primapara. Adding the number of living births (768), there was an estimated total of 5,073 motherless children. The life of the 768 babies was also threatened because the infant mortality rate was always higher for the children whose mothers died within a year after birth.[32] Once again, the ideology of motherhood was contained within this discussion: "Children who are motherless often lose their home too, and lose their chance in life".[33] In an emotional appeal to the importance of saving maternal life, a story of one family was given, whose mother had died in her sixth month of pregnancy:

> Since the last visit the mother had died of eclampsia in the sixth month of pregnancy. The hen house was torn down to provide boards for her coffin. The home was a home no more. Her children were growing up like wild creatures of the woods... The father, since the mother's death, had become an utter wastrel. The children were no better than wild animals... None of them could read nor write, their clothes were in tatters, and their skins were coated with dirt. Only another example of what one mother's life may cost this country.[34]

In a study on maternal mortality entitled Need Our Mothers Die?, completed by the Canadian Council on Child Welfare, the disruption of the home, and possible 'disintegration' remained a constant theme:

> Important and disturbing as is the unnecessarily heavy death toll of mothers in childbirth as a national problem and pathetic and disintegrating as are the consequences of the loss of the mother in the life of the home, the social agency concerned with child protection and family life is faced with a related problem of equal significance and even greater extent in the undermining and often, the disruption of the family group through the crippling or permanent invalidism of the mother, who survives childbirth.[35]

and again,

> The problem is one of unnecessary death, of unnecessary sickness, and ill health, and of unnecessary destruction of family life through the preventable loss of the young mother in the home, or through her inability to direct it because of ill health.[36]

One can see that the "functional" definition of health applied to men, in terms of working capacity, was equally applied to women. Health was important insofar only as it affected the woman's ability to labour.

Finally, the collection and reporting of statistics also exhibits the central concern with women as mothers. Although the total number of women who died was usually documented, the rate, which was established for comparison purposes, and was most frequently used in the reporting of findings, was primarily derived from the number of maternal deaths per 1,00 <u>living</u> births. In other words, the maternal mortality rate was usually not calculated for the number of

confinements (which would then include still births). Although the infant mortality rate was also calculated by the number of deaths per 1,000 living births, the classification system was more complete, as neo-natal, post neo-natal mortality and still-births were always included in tables. This classification system itself reveals the importance of child life.

At a Dominion Council of Health meeting, the Chief Officer of Health for Saskatchewan, cautiously noted the neglect to calculate the maternal death rate for the total number of confinements:

> One more point-a little criticism: I think that most of the statistics are founded on living births and that is an improper way to count maternal mortality. Maternal mortality should not be counted on living births; it should be counted on confinements. There is quite a distinction, but that is the true scientific way of calculating.[37]

Perhaps this procedure of counting maternal mortality rates reveals exactly what the officials intended to calculate. To not include the maternal mortality rate per number of confinements (therefore including still-births) displays a concern with women as mothers, and the unimportance of women beyond fulfilling their designated tasks of caring for and maintaining their husbands and children. Generally, this procedure of counting maternal death rates remained the same at the federal level, with the exception of a 'special'

analysis conducted by the Dominion Bureau of Statistics in 1927-28.[38] In this analysis, it was revealed that 49 percent of Canada's maternal deaths were associated with a live birth; 19 percent were associated with a still-birth; and 32 percent of the deaths occurred before delivery or age of viability. Therefore, approximately one-fifth of maternal deaths were excluded by the typical statistical reports. In light of this realization, it was suggested by officials within the Dominion Bureau of Statistics that: "Because of the fact that so many maternal deaths are not associated with a live birth, there has been some argument for striking the number of maternal deaths in relation to the total number of live and still-births".[39] The argument in favour of this has never been won.

The collection of statistics in Ontario are less easy to decipher. The Registrar General did not originally calculate the rate of maternal mortality to include still births. However, in subsequent reports, it was said to include still-births. It seems that this was not actually done, however, as the rates presented were the same when still-births were supposedly included. As with the special study completed on the federal level, a similar study was completed in Ontario, and it also revealed the higher maternal mortality rate when still-births were included.

Summary

In this chapter, the context in which the state 'problematized' maternal mortality has been examined. Women were defined as wives and mothers, responsible for the daily and generational reproduction of labour power. It was not until the state became concerned with the daily and generational reproduction of labour power, that it created a central health agency. The prevalent definition of health was conceptualized as the "capacity to work", which was applied equally to men and women. With men, there was a concern for their productivity, and also their military capacity. For women, the concern was for the care and maintenance of husbands-as present workers, with children-as the next generation of workers. The concern for both the health of men and women arose out of nationalist, imperialist and racist concerns. There was a perceived need to increase the 'native' Canadian population. In the vein of this perceived need, there was an attempt to elevate the status of motherhood, which was an ideological attempt to entice women to bear more children. This elevation of motherhood was placed in the context of a 'woman's duty to the state', as well as describing motherhood as the source of woman's fulfillment. The attempt to elevate the status of motherhood was accompanied by the 'problematization' of maternal mortality by state officials. An ideological campaign rings hollow, if on a material level,

thousands of women were dying in doing their 'patriotic duty'.

The following chapter will examine the strategies adopted by the state officials, at different levels of the state, to lower the maternal death rate. Although the state health officials were all in agreement that maternal mortality was a problem, disagreements arose as to who was responsible for alleviating it.

NOTES FOR CHAPTER TWO

1. It could conceivably be argued, from a pluralist or liberal democratic perspective, that the federal state became involved because of pressure from women's organizations. However, there is some evidence that female reformers were not taken seriously by policy-makers, essentially because they were women. For an empirical examination of this, see Buckley's (1979) account of Helen MacMurchy's difficulties in the education sector.

2. There was also an attempt to remove women from wage labour, so that the men who returned from the war could also return to their previous jobs. See Roussakis (1983) for an examination of the efforts to get women out of the work force.

3. Again, it is the involvement at the federal state level which is the primary focus, although the involvement at the provincial level is also incorporated.

4. The Dominion Council of Health was composed of: the Chief Provincial Officers of Health; one representive each from agriculture, trades and labour workers, health education, one woman to represent the women in urban areas, and one to represent rural areas.

5. See Buckley (1977,1979) for discussions of MacMurchy's activities.

6. The CCCW was funded by and under direct control of the federal government. The grant given contained the stipulation that it would continue "as long as it carried on a programme satisfactory to the Dominion authorities". 'Voluntary Effort in Maternal Care in the United States' Canadian Welfare X14(2), 1938. It will be argued later that the Child Welfare Division was disbanded by the federal government because they were beginning to address sensitive social/economic factors and reforms.

7. Hermann (1971), p. 135.

8. Canadian Council on Child Welfare, "Problems in Infant Mortality", 1921.

9. Hermann (1971), p. 134.

10. Hermann, p. 135.

11. Stated by Power, Chief of Ontario Child Welfare Bureau, in 'Child Welfare', Social Welfare, 1919, 1(9).

12. 'These Little Ones', Social Welfare, December, 1920.

13. Ibid.

14. Minutes of the Executive Council of the Victorian Order of Nurses, Hanington to Hughes, September 27, 1917 (deposited in the Public Archives of Canada).

15. Minutes of the Dominion Council of Health (hereinafter DCH), 2nd meeting, May 17-19, 1920.

16. Ontario: Department of Health, Division of Child Welfare, Sessional Papers, 1920.

17. Canada: History and Activities of the National Health Division of the Department of Pensions and National Health, 1938, p. 1.

18. Stated by McCullough, Chief Officer of Health for Ontario. Minutes of the DCH, 6th meeting, September 4-6, 1923.

19. Strong-Boag (1982), p. 161-2.

20. All of the preliminary discussions of maternal mortality included similar types of comments. At the risk of unnecessary emphasis, one final example will be given: "Certainly we cannot afford to have mortality statistics in this class of cases greater in this country than they are elsewhere". Maternal Mortality in Canada, (Ottawa: 1928), p. 26.

21. Canadian Welfare Council, Need Our Mothers Die? publication no. 76, December 1935, p. 55.

22. Minutes of the DCH, 22nd meeting, June 23-5, 1931.

23. 'The Importance of Prenatal Care', Canadian Welfare X(2) July 1934, p. 12.

24. Canada: The Canadian Mother's Book, 1920, p. 7.

25. Canada: How to Take Care of the Children, (1922) p. 3.

26. Canada: Mother, (1928) p. 9.

27. See Spector and Kitsuse (1977) for an examination of the process of 'constructing' a social problem.

28. Buckley (1979), p. 134.

29. Ontario: Department of Health, Division of Child Welfare, Sessional Papers, 1920.

30. Op. cit., 1921.

31. Canadian Mother's Book, p. 10.

32. The reason for this was assumed to be because the mother was not there to care for the child.

33. Maternal Mortality in Canada, Ottawa (1928), p. 16.

34. Canada: Mother, 1928, p. 3.

35. Need our Mothers Die?, 1935, p. 53.

36. Op. cit., p. 57

37. Minutes of the DCH, 11th meeting, Dec. 15-17, 1924.

38. The study was conducted because the maternal mortality rate was not showing any "appreciable decline".

39. Need Our Mothers Die?, p. 12.

CHAPTER THREE

Strategies to Alleviate the Problem of Maternal Deaths

Introduction

In the last chapter, it was argued that federal state intervention in the health sector generally, and the specific 'problematization' of maternal mortality arose out of two primary concerns: a perceived need to increase the 'native' Canadian population; and a concern about the daily and generational reproduction of labour power. In this chapter, the proposed solutions to the problem of maternal mortality, developed at the federal and provincial levels of the state, are analysed. As well, the actual state policies and services which were implemented to reduce the high number of maternal deaths are examined.

State definitions of the problem of maternal mortality-whether it was a national, public health or medical problem-involved a delineation of responsibility between the various levels of the state. The different definitions were formulated by the provincial and federal governments primarily out of political considerations. From the different definitions of what type of problem maternal mortality represented came a delineation of responsibility, in terms of the implementation

of concrete policies and measures. Correspondingly, this delineation, which was rationalized through the different definitions, was also used as a rationale for inaction. Although at the federal and provincial levels of the state, there was a concern and interest in lowering high maternal death rates, this did not include a willingness to absorb the costs of reproduction with any significant fiscal expenditures.

The responsibility was funnelled down from the federal to the provincial levels, and from the provincial to the municipal levels.[1] Eventually, the ultimate responsibility was removed from the state realm, as state health officials claimed that the medical profession and the people themselves- particularly women- were responsible for lowering the rate. Officials argued that the maternal death rate could not be lowered unless the medical profession showed greater interest and involvement, and the women, once educated to the need for prenatal care and medical and nursing supervision, could assist the profession through "intelligent cooperation".

In developing this argument, I make a conceptual distinction between state health officials on the one hand, and medical practitioners on the other. I argue that, although trained as physicians, full-time state employees were representatives of the state, and identified with state interests and concerns, rather than identifying with the medical profession. It is on the basis of this

conceptualization that I argue that health officials, as representatives of the state, channelled the problem of maternal mortality to the medical profession. Therefore, these state officials played an important role in defining the problem and solution to maternal mortality in medical terms. I further argue that a significant number of practitioners within the medical profession were apathetic to the problem of maternal mortality, and the profession itself did not seriously address the problem until there was outside pressure-from present and potential future patients. Although state health officials and practitioners shared a common training as medical physicians, I argue that the location of physicians in full-time state employment served to not only structure their identification with state concerns and interests, but also the responsibilities of officials as state employees sometimes placed them in opposition to practitioners.

The converse argument would be that, as physcians, state health authorities identified more closely with the medical profession. In relation to maternal mortality, it would be argued that health officials defined maternal mortality as a medical problem, and proposed medical solutions, in the interests of the profession. A medical definition and solution would have served to expand the area of expertise for the profession, and enable them to establish a monopoly over obstetrical care. This type of argument would have been

congruent with previous histories of childbirth, where it is argued that the medical profession capitalized on the issue of maternal mortality, to not only consolidate control over obstetrical care, but also used the issue to advance the neglected specialty of obstetrics.[2] The argument developed in this thesis, however, is that the majority of practitioners were disinterested in the problem, and the profession itself became involved only when their claims of altruism, expertise, and in general, their legitimacy, was perceived as threatened.

Medical Officers of Health as Representatives of the State

Medical Officers of Health(employed on a part-time and full-time basis), and Directors of the various divisions of the Department of Health, were most often trained as physicians.[3] Despite their common training they shared with medical practitioners, I am working on the premise that full-time state health officials were representatives of the state, and identified with state interests and concerns. The reasons for establishing this premise are as follows: officials were responsible for the implementation of the Public Health Act, and were therefore state administrators; and related to this, as state administrators, they sometimes came into conflict with the goals and interests of many practitioners; thirdly, on a daily basis, officials were absorbed in the interests, concerns and ideologies of the state, rather than subjected

on a daily basis, to the concerns and interests of the medical profession; and this final factor, combined with the other factors mentioned, leads to an identification of officials with state concerns and interests.

With their structural location as full-time state employees, health officials were responsible for implementing the Public Health Act. Certain responsibilities laid out in the Act sometimes placed officials into conflict with medical practitioners. The conflict between state health authorities and practitioners arose primarily because the focus of public health work centred on preventive medicine, whereas the practising physician was primarily concerned with clinical and curative medicine. As McCullough, Chief Officer of Health for the Ontario Department of Health stated:

> ...we have concerned ourselves with the preventive side although it must be admitted that circumstances have forced us to include to some extent the curative side in our venereal disease and tuberculosid clinic and in the work of supplying biological products for the cure of certain communicable affections such as diptheria, etc.[4]

Physicians in full-time state employment were reluctant to emphasize the curative aspect of medicine, while practitioners feared that the preventive emphasis favoured by public health specialists would significantly lower their income, because the elimination of disease and preventive medicine would restrict their practice.[5] McCullough, Chief Officer of Health

for Ontario, stated: "The work of preventive medicine is naturally a very much secondary consideration with the average medical practitioner".[6] Rosenkrantz, who studied the development of public health in Massachusetts from 1842 to 1936, argues that physicians who devoted themselves exclusively to preventive medicine served the state and not the individual citizen. She states further: "Salaried public health officials accepted their role as defenders of the state's special interest-the public's health".[7] In relation to Canada, Bothwell and English state that public health officials generally accepted and supported National Health Insurance because they were civil servants and "...could see few terrors and no degradation in the prospect of State medicine".[8]

The focus of state health officials on preventive medicine, and the focus of practitioners on curative medicine, was not however just a conflict of interests within the medical profession, or an opposition between two types of specialists within the profession. As administrators of state legislation, physicians who were state employees sometimes had to openly criticize the practitioners. As Freidson points out, it is an implicit agreement, or tacit understanding among physicians, that they will not criticize each other in public.[9] Public health officials, however, did criticize the activities of practitioners, and in fact argued that it was the lack of cooperation of practising physicians which inhibited progress and success in public health. Seymour,

Chief Officer of Health for Saskatchewan, stated: "I think our experience is somewhat similar in that in many instances the greatest obstacle to our making progress in the opposition we meet from certain members of the profession".[10]

The lack of cooperation of practitioners was often cited by health officials, in relation to such issues as reporting a communicable disease, and in the compilation of maternal mortality statistics. Bell, who conducted a study on the causes of maternal mortality, for the Ontario Department of Health in 1921, attributed the errors in statistics to the medical profession. He stated that underreporting was a serious problem, because "...some physicians prefer to report a death as due to any other cause rather than puerperal sepsis or one of the other causes of Maternal Mortality".[11] One of the responsibilities of state health officials was to document the numbers and causes of maternal deaths. These officials however, came into conflict with the practitioners, as the practitioners were not cooperating in the collection of these statistics. This problem was highlighted by Semour, in an address to other health officials:

> I mentioned the result of this compilation of statistics regarding maternal mortality at the meeting of the Saskatchewan Medical Association, and I was very strongly called to task by some of the members for even compiling these figures I told them I thought the proper place to give these figures was to a meeting of medical men.[12]

Despite the objections of some members of the profession to the compilation of maternal mortality statistics, public health officials not only collected these statistics, but the findings were widely circulated to the public.[13] This suggests that officials most closely identified with their responsibilities as state employees. As well, Seymour's comment reveals the fact that some practitioners were reluctant to have the issue of maternal mortality 'problematized'. Therefore, it was state health officials who were primarily responsible for highlighting the problem of maternal mortality, defining the problem in medical terms, and directing the problem to the medical profession.

Finally, the predicament of part-time medical officers of health reveals the conflicting locations of state employees and medical practitioners. Full-time health officials argued that the employment of part-time officers impeded the work of public health, because the part-time officers were reluctant to enforce public health regulations. Their reluctance stemmed from the fact that the enforcement of public health regulations was detrimental to their practice as physicians. McCullough, Chief Officer of Health for Ontario, stated:

> ...the work of public health by the part-time medical officer... is in reality detrimental to his interests for the reason that the operation of such work is likely to make enemies not only among his clientele, but also among his confreres.[14]

The full-time health officer, on the other hand, was more likely to criticize the profession and lay people because there were fewer conflicts not only in terms of loyalties, but financially, they did not have to supplement their income with medical practice.[15]

To conclude this section, I have argued that full-time health officials, although trained as physicians, align themselves with state concerns and interests, and fulfill their responsibilities as state employees. These responsibilities included documenting the number and causes of maternal deaths, and proposing solutions to the problem. The following section discusses the process whereby responsibility for the alleviation of high maternal deaths was delineated between the different levels of the state. Eventually, state health officials argued that the medical profession was primarily responsible for the solution to the problem of maternal mortality. The medical profession, however, according to health officials, was not showing enough interest and involvement in either the problem or solution to maternal mortality.

Funnelling of Responsibility

It was agreed by both federal and provincial health authorities that the solution to the high maternal death rate was prenatal care, and medical and nursing supervision and

attendance at birth. The compilation of statistics on maternal mortality, and the analysis of causes and solutions, centred on clinical conditions and clinical causes of death. From this compilation, health officials argued that prenatal care would enable physicians to recognize early symptoms of complications which often led to death.[16] Should complications arise in labour, physicians could intervene and prevent the death of the 'mother'. State health officials argued that what was needed was education of the public and the medical profession, of the necessity for prenatal care and medical and nursing supervision and attendance at birth.[17] In terms of the education of the public, what was first needed was a redefinition of childbirth as a medical event, rather than as a natural or social event. It is worth recalling here that middle and upper-class women were already under the care and supervision of a physician during parturition, and therefore,had already accepted and defined childbirth as a medical event.[18] This redefinition of childbirth, therefore, was directed primarily to working-class women. In fact, officials often addressed the meetings of the National Council of Women-composed almost exclusively of middle and upper-class women - to solicit their support in the dissemination of knowledge on the need for prenatal care, diet, hygiene, and the necessity for constant supervision of a physician during parturition.[19] McCullough, Chief Officer of Health for Ontario, explicitly stated what class of women these educational

campaigns were directed to: "Our work is not among the well-to-do, who are likely to have medical supervision during pregnancy. There is a greater need among the middle and poorer classes of people".[20]

Bell, who conducted a study of maternal mortality for the Ontario Department of Health in 1921, expressed the predominant attitude and approach to the problem in terms of redefining childbirth as a medical event:

> To the public the function of reproduction and parturition is an old story... It has gone on along certain lines since time was, and from time to time assistance has been given in labor, but the public as a whole are grossly ignorant of the dangers incident to pregnancy and parturition... The attitude of the public appears to be that it is usually attended without mishap. It is, and has been an attitude of "laissez-faire" and this must be the main point of attack in dealing with the problem.[21]

Although officials often referred to the necessity of educating the 'public', this education was primarily directed to women, with the use of public health nurses to "get to the hearts and minds of mothers". The attempts to educate women continued to be the "main point of attack" throughout the 1920s and 1930s. In 1938, Phair, the Director of the Division of Maternal and Child Hygiene and Public Health Nursing, made the same type of statement:

> Much of the effort of those responsible for the introduction of corrective measures was directed at public education, in order to correct the fixed conception that pregnancy was a physiological process and as such should be medically and surgically ignored until disaster presented.[22]

It was the fiscal expenditures needed for "public education" which became the point of contention between the different levels of the state. Federal authorities argued that public health- and within this, maternal mortality- was the responsibility of the provinces. While provincial authorities agreed that it was their responsibility, they also asserted that the federal government should contribute more financially, because public health was of national concern as well. Finally, the provincial authorities argued that the 'real' public health work-which included paying for a public health nurse -was the responsibility of the municipalities.

At the federal level of the state, officials perceived their role to be advisory, in the form of gathering and disseminating information about causes and solutions to the high maternal death rate. The implementation of policies and services, and the fiscal costs necessary to do so, were perceived by federal officials, to be a provincial responsibility. The federal government provided minimal financial aid for public health work in general, and for maternal welfare in particular. At the Dominion Council of Health meetings,

this lack of financial aid was criticized by provincial health officers. For example, McCullough, Chief Officer of Health for Ontario, argued that all three levels of the government should contribute financially. In relation to federal involvement, he stated:

> The Dominion Government has disclaimed any obligation in this respect because under Section 7 of the Act, under which the Department of Health is established, they have waived any right or privilege to interfere with public health in the provinces or municipalities, but that does not prevent the Dominion Government from giving financial aid. They have given some financial aid in respect to venereal disease, tuberculosis, but the amount they have given is very small compared with what I think their obligation is.[23]

McCullough claimed that although public health-and within this, infant and maternal welfare- was a provincial responsibility, infant and maternal welfare were also national questions for which the federal government should accept greater financial responsibility. The federal government, he argued, displayed misguided priorities, with the care of animals and immigrants placed above the 'native' population.

> There is more attention to agriculture and disease of animals by this and other governments than there is to the care of children. These conditions- maternal and infant mortality and all great public health questions- are surely national questions that belong to the whole country. This government is doing very notable work in getting the right kind of immigrants from a physical point of view, but I think

> that they have quite as large an obligation to take care of the native born child.[24]

One can see that the definition of maternal mortality as either a national or public health problem was being used to rationalize the delineation of responsibility for its alleviation. At the federal state level, the problem was defined as primarily a public health problem, and public health work was under the jurisdiction of the provinces according to the Federal Health Act. It will be remembered that it was argued in the preceding chapter that the Federal Department of Health, the Child Welfare Division within this Department, and the Dominion Council of Health, were established because of a concern about the quantity and quality of the population. The federal government played an important role in the 'problematization' of maternal mortality. However, this interest or concern in reproduction-biological reproduction, and the daily and generational reproduction of labour power-did not include a willingness to absorb the costs of improving the health of the population, or providing financial aid to make the process of childbirth safer (in other words, the costs to lower the number of maternal deaths). At the federal level of the state, it confined itself to an advisory role, and channelled the responsibility for the provision of services and measures, and the costs necessary for the implementation of these services and measures, to the provincial levels of the state. As well, the amount of expenditures to improve

the health of the population was minimal relative to the expenditures for immigration (a point frequently made by McCullough). Immigration policies were the exclusive responsibility of the federal government. The foreign migration was promoted by the federal government, in order to fulfill one of the state functions of facilitating capital accumulation. Immigrants served as a cheap source of labour, and provided Canada with much needed consumers.[25] Therefore, criticisms made of the federal government for the priority of immigration over the health of the 'native' Canadian population may be seen as an example of the conflict which may arise over the state responsibility for the different functions of accumulation, legitimation and reproduction.[26] It may be said that, although the federal government had admitted an interest in reproduction, it focused its attention on fulfilling the function of capital accumulation. The responsibility for fulfilling the function of reproduction was assigned by the federal level of the state, to the provincial levels. Although provincial health authorities criticized the federal government for its lack of financial assistance given to the provinces, the provinces in turn, argued that the 'real' responsibility for public health work- policies and education of the public- rested with the municipalities.

The provincial health authorities argued that the role of the provincial Departments of Health was to educate

the municipalities and the medical profession to the need for prenatal care and medical and nursing supervision and attendance at birth. McCullough, in a summary of the activities of the Department of Health for 1922, argued that the provincial Department of Health could but "point the way" in which policies and education of the public should be directed:

> To adopt the language of Sir George Newman, it is not the central but the local authority in whose hands rests the main business of public health policy... The provincial Board, as the central authority, can but point the way in maternal and child hygiene, in the prevention of disease, and in the education of the public.[27]

This funnelling of responsibility was not just from the provincial to the municipal level of government, but the responsibility was extended to include the people within these municipalities, and ultimately to the 'family' and individuals. Therefore, even at the provincial level of the state, there was an unwillingness to absorb the costs of reproduction. The government restricted itself to a role as educators, in a form of promoting self-help:

> It must be remembered, however, that the Government department can at best only guide and direct. The real, intensive public health work must, as has frequently been pointed out, be carried on by the local community, and by the people themselves in their homes and as individuals.[28]

Although the provincial health authorities had claimed that the municipality was responsible for the 'real' public health work, this conception of municipal responsibility was not directed to the local government, or local authorities (in other words, to another level of the state). Individually oriented responses were given by officials, to both the perceived cause of public health problems and responsibility for public health (and within this, infant and materal welfare). On an ideological level, attention is being directed away from social and economic conditions as they relate to public health and infant and maternal welfare. In Navarro's words, this individualization of the problem places it at a less threatening level.[29]

The activities at the provincial level mirror its perception of its role as educators of the municipalities. The Provincial Department of Health reorganized the Child Welfare Division in 1920, under the new heading of Maternal and Child Welfare and Public Health Nursing. Eight public health nurses were hired, and assigned to the eight districts in Ontario.[30] The task of these nurses was to educate the municipalities of the need to acquire and pay for their own community nurses. They were to "stimulate local effort" by demonstrating the need and benefits of a community public health nurse. The role of the community health nurse, once hired by the municipality, was to provide some advice on diet and hygiene to the local women, but more fundamentally,

she was to ensure that women contacted and were under constant supervision of a physician during parturition.[31] These nurses were not to provide treatment or care, but instead had their role defined as educators. Once advised of the need for medical supervision, and proper diet, these women were supposed to help themselves, by following the advice given. Education of women was perceived as the key to lowering the maternal death rate, and there was little discussion of the possible inability for women to translate the advice into action, because of lack of means in terms of finances. It will be remembered that it was stated explicitly by McCullough that their work was directed primarily to the 'poorer classes of people'. Although the possible problem of the lack of financial means of the 'people' was rarely mentioned, the problem of low finances of the municipality to implement concrete measures and services and educate the public was acknowledged by provincial health authorities.

The municipalities were poorly equipped in terms of finances and organization, to fulfill their responsibility as the provincial government had defined it. This applied to public health work in general, and to the particular responsibility of supplying community public health nurses. Middleton, Director of the Division of Public Health Education, asserted in 1921:

> The question of finance is, I find the only serious impediment in the carrying out of all the reforms the Provincial Board is advocating. This is particularly true with regard to the appointment of a Public Health Nurse, where some of the municipalities in which such a nurse is needed most, are saddled with a high tax rate. Education is required to show the citizens generally, and more particularly the local authorities, that the money spent on a community nurse is more of an investment than an expenditure, owing to the preventive measures she carries out...there would be less mortality, less sickness, and since disease is the highest cause of poverty, greater prosperity and individual comfort.[32]

In terms of financial problems of the municipalities, McCullough, Chief Officer of Health for Ontario, asserted: "The defect in our municipal system of local health administration, is that the municipality, such as a small town, village or township, is financially unable to bear the burden of an efficient health organization".[33]

Even by 1939, there were 901 municipalities and only 13 full-time health officers to organize local health authorities.[34] Although many municipalities did attempt to provide community health nurses, many discontinued this service because of a lack of funds, or made no initial appointment for the same reason.[35] The provincial government was not oblivious to the lack of finances of the municipalities, but as a solution, it was suggested that some of the municipalities combine, pool their resources, and form a health unit.

Statutory provision for this was implemented in 1934, with a provincial subsidy available.[36] In 1936, the provincial government established a demonstration health unit (referred to as the Eastern Counties Health Unit), for the purposes again of "stimulating local effort".[37]

The other solution to the problem of providing prenatal care was the provincial encouragement of municipalities to establish prenatal clinics. Toronto was the most advanced in this direction, as it was in public health work in general, and established five prenatal clinics in 1920. However in 1928, the clinics were closed because of the lack of support given to them by the medical profession- an indication of the lack of cooperation of the medical profession.[38] These clinics were reopened again in 1932, but only accepted patients sent by private physicians. As with public health nurses, the clinics provided no treatment, but only routine care, in the form of weight and temperature checks and urine analysis.[39] The fact remained, however, that few women during the 1920s and 1930s had access to prenatal care. As late as 1933, the Director of the Maternal and Child Hygiene and Public Health Nursing Division stated: "The problem of providing all pregnant women with the maximum of prenatal and postnatal care is still a long way from solution".[40] Even by 1947, only 39.4 percent of all pregnant women had received prenatal examinations, and in the previous year (1946), the

provincial government had enacted legislation which provided pregnant women with one free medical examination.[41]

Despite the fact that the municipal responsibility to provide prenatal care and public health nurses was not being fulfilled by the municipalities, the provincial authorities did not continue to address this problem. Instead, the emphasis of provincial officials began to shift away from municipal responsibility, as they argued that the maternal death rate could be lowered only by the medical profession, combined with the "intelligent cooperation" of the parturient woman.

In 1929, the Director of the Child Hygiene Division of the Ontario Department of Health commented on the importance of prenatal care and public health nursing, but these factors were deephasized in his final analysis of factors which would lower the high maternal death rate:

> Granted a fully enlightened womanhood, and all physicians skilled and painstaking, and the problem becomes relatively easy of solution. The Department is attempting to assume its responsibility in bringing about the first of these desired ends, by all of the means at its disposal, and awaits, with hope, the early development of the second.[42]

There was not only a shifting emphasis away from the municipality to implement concrete measures and services, but one can see that there was now consideration being given to the competence of the physicians. The earlier assertions of the

need to educate the profession to the need for prenatal care and medical supervision and attendance at birth were being accompanied with assertions of the need for the physicians to be "skilled and painstaking".

According to provincial health authorities, the role of health departments was now restricted to efforts to bring about a "fully enlightened womanhood". This change in emphasis began in the late 1920s, and continued throughout the 1930s. There were no longer discussions of the responsibility of either the provincial or municipal governments to provide and implement concrete measures, which removed the state from an involvement which would require significant fiscal expenditures. This delineation may be seen in part, as arising from the contradiction of, on one hand, espousing the necessity for the municipalities to provide policies and services on one hand, but on the other hand, not providing financial assistance to enable the municipalities to fulfill their designated responsibilities. It was clear to the provincial state authorities that the municipalities were financially unable to implement concrete policies and services. However, rather than continue to address this problem, or attempt to alleviate it, provincial officials absolved themselves from complete responsibility for the implementation of services and policies.

Another important factor which may have influenced the shifting emphasis of officials, was the fact that the

maternal mortality rate was not going down. For example, in the late 1920s, when this shifting of responsibility was taking place, the maternal mortality rate ranged from 5.5 per thousand living births in 1925 to 5.4 in 1931. For years state health officials had been involved in efforts to reduce the numbers of maternal deaths. The fact that the maternal death rate was not declining, despite the efforts made to alternate this problem, may partially explain the changing focus of responsibility. In other words, the lack of previous success may have provoked the change in strategy. Although efforts to bring about a "fully enlightened womanhood" was seen as a continuing necessity, an emphasis on the medical profession and the treatment of medical science increased. Phair, Director of the Division of Maternal and Child Hygiene, stated in 1930:

> There is an apparaent feeling on the part of certain groups of people in this province and other provinces, that official health agencies are not sufficiently seized of their responsibility in the matter of maternal deaths... maternal deaths fall into two large groups- those that are influenced by the physical state of the woman prior to confinement and those that result from circumstances definitely associated with the period of labour. Both are, primarily, problems of treatment... No health department can do any more than urge that the two parties concerned, namely, the expectant mother and the attending physician, should establish a professional contact at the earliest possible moment... and further, to place before the profession,

> their responsibilities in terms of the maximum of obstetrical care. When the importance of these facts is appreciated by organized medicine, and those in charge of medical education, a forward step of considerable magnitude will have been made.[43]

There is an acknowledgement of the importance of the "physical state of the mother prior to confinement", however, as Phair points out, this was seen as a problem of treatment. There was no consideration given to factors which would help explain why women would be in the physical condition whereby they required treatment. Furthermore, the emphasis on the clinical condition of the woman removes the likelihood that other factors would be discussed. The problem for officials now, however, was that the profession was not sufficiently seized of their "responsibility in terms of the maximum of obstetrical care".

In 1931, it was asserted by the Director of the Child Hygiene Division of the provincial Department of Health, that until the interest in the subject of maternal deaths" ... becomes sufficiently active to motivate the medical profession generally, one hesitates to say how much can be accomplished".[44] The lack of interest and apathy of the profession, and the need for "skilled and painstaking" physicians was constantly asserted by state health officials. This was obviously a source of frustration for officials because the medical profession was now being held responsible for the alleviation of high maternal death rates. This ultimate responsibility

of the medical profession was clearly stated in the report of the Director of the Division of Child Hygiene in 1932:

> The lessening of the morbidity and mortality associated with maternity is primarily a task for the medical profession. No other agency can willingly, or otherwise, assume this responsibility. The interested woman, can however, materially lighten the load of the physician by consulting him at the earliest possible moment and by following his advice literally.[45]

The assertions of the responsibility of the profession were always accompanied with the equal responsibility of the "interested" woman to "follow to the letter" the instructions of her physician. It will be remembered from the second chapter that women were told to pay attention to their health, if they loved their husband and baby. Officials further argued that the efforts of both the medical profession and health departments would be of no avail, if the woman did not take care of her health. If the woman did not do so, it was implied that she was either unwilling, or not sensible: "But all this is no use unless the Mother is sensible and takes care of herself";[46] and, "Persuade Mother to take care of herself. Nothing the rest of us is of much use unless the Mother knows and feels that she should take care of herself and is willing to do it".[47]

Coinciding with the responsibility of the 'mother' to take care of herself, was the responsibility of the woman to consult a physician and be under constant supervision

during parturition. Women were advised to place their complete trust in their physician and nurse. In the typical patronizing tone of MacMurchy's writings to the public, she stated: "The good Doctor and the good Nurse know how to carry the Mother right through with courage, cheer and safety and how to save her a lot of suffering. Give them a chance. You can trust them".[48] In relation to the prenatal and postnatal letters published by the Canadian Welfare Council, it was stated:

> They are in no way intended to replace the advice of the family physician. Throughout from the first to the last letter, insistence is placed upon early and continuous consultation of the family physician and frequent warning is given against taking other than professional advice.[49]

What is particularly important is the fact that women were being strongly urged to seek the care and supervision of a physician, when at the same time, officials were expressing dissatisfaction with the disinterest of the profession, and professing the need for the profession to improve their obstetrical practices and education. This, in part, may explain the reluctance of many women to seek the care of a physician.

The criticisms made of the profession, and the contradictory appeal to women to seek the supervision of a physician are clearly displayed in the federal enquiry on maternal mortality, which was released and widely circulated

to the public in 1928. In this enquiry, claims of the disinterest of many practitioners, the poor obstetrical training of the profession, and claims of the responsibility of practitioners for many maternal deaths, were all made. MacMurchy, who compiled the report, argued that in order to "stop this long march to the grave", what was necessary was: to make the facts known to the public and the profession; to change the thoughts of the public and the medical profession. That is, to take maternity cases more seriously and give them more attention. In this report, the profession was chastized for their complacency regarding prenatal care:

> Many doctors and nurses say they believe in pre-natal care, but their actions speak louder than their words and it is well known that some mothers who have been persuaded, often with difficulty, to consult a doctor for prenatal care have been dismissed by the doctor without any directions about examination of the urine, and without any arrangement to see her again even for the estimation of blood pressure and pelvic measurements.[50]

Criticisms were also made of the poor obstetrical training and practices of many practioners, and it was asserted that the intervention of many practitioners contributed to the high maternal death rate. It was noted that, out of the 1,532 women who had died in one year (1925-6), 19 percent of these deaths were associated with forceps deliveries, and a further 21 percent were associated with the use of pituitrin,

a drug used to induce labour. In response to this finding, it was soberly concluded: "... the teaching and practice of obstetrics can and should be improved. Obstetric instruments have saved many lives. How many lives have they destroyed"?[51] Despite these findings, women were encouraged to seek the care and supervision of a physician during parturition as it was argued that prenatal care and physician supervision and attendance at birth would reduce the maternal death rate.

Summary

In this chapter, the proposed solutions to the problem of maternal mortality have been examined, from the perspective of state health officials. It has been argued that different definitions were formulated by the provincial and federal governments primarily out of political considerations. From the different definitions of what type of problem maternal mortality represented came a delineation of responsibility for its alleviation- in terms of the implementation of concrete policies and services. Correspondingly, the different definitions were also used as a rationale for inaction. Although at the federal and provincial levels of the state, there was a concern and interest in lowering maternal death rates, in the broader concern of the daily and generational reproduction of labour power, this did not include a willingness to absorb the costs of reproduction with any significant

fiscal expenditures.

Eventually, the responsibility for the alleviation of maternal deaths was removed from the state realm, and placed almost exclusively in the hands of the medical profession, combined with the "intelligent cooperation" of the woman. Health officials, however, claimed that the medical profession was both not showing enough interest in the problem of maternal mortality, and was itself partially responsible for a number of maternal deaths, because of their poor obstetrical practices and techniques. The following chapter will examine the involvement of the medical profession, to determine whether the criticisms made of the profession by state health officials was warranted. Also, because the profession was being held responsible for alleviation of high maternal deaths, the efforts of the profession will be discussed, in terms of proposed solutions and actual activities.

NOTES TO CHAPTER THREE

1. The policies and services implemented at the federal, provincial and municipal levels of the state are examined. The response of the municipalities, however, will not be dealt with, other than from the perspective of provincial health authorities, because the number of municipalities was in excess of 900.

2. For example, see Lewis (1980).

3. There were exceptions, in that nurses were also sometimes the Directors. For example, Mary Power was the Director of the Child Welfare Division for some years.

4. Ontario: Resume of Transactions of the Board of Health, Sessional Papers, 1922.

5. Shorrt (1982). Shorrt provides a sympathetic portrayal of the "rise, fall and rebirth" of general practice in Canada, 1890-1940.

6. Ontario: Resume of Transactions of the Board of Health, Sessionsal Papers, 1924.

7. Rosenkrantz (1972), p. 171.

8. Bothwell and English (1981, p. 480.

9. Freidson (1975) provide a detailed examination of colleague relationships, on an internal level, and their general presentation to the 'public'.

10. Minutes of the DCH, 12th meeting, June 11-13, 1925.

11. Ontario: 'Maternal Mortality', Report of the Department of Health, Sessional Papers, 1922.

12. Minutes of the DCH, 17th meeting, Oct. 13-15, 1928.

13. It will be argued in the following chapter that the profession did not seriously address the problem of maternal mortality until the release of the public report.

14. Ontario: Resume of Transactions of the Board of Health, Sessional Papers, 1922.

15. Criticisms of the public were usually directed to the breaking of public health regulations, such as the purification of milk.

16. Prenatal care is usually seen as a type of preventive medicine. However, in this context, the major emphasis was on curative medicine, because the focus was on the treatment needed after complications arose.

17. The education of the profession primarily involved giving addresses to the meetings of the profession at both their national and provincial meetings.

18. See Mitchinson (1976).

19. National Council of Women Yearbooks, 1930, 1932.

20. Ontario: Division of Maternal and Child Hygiene and Public Health Nursing, Sessional Papers, 1939.

21. Ontario: 'Maternal Mortality', Report of the Department of Health, Sessional Papers, 1922.

22. Ontario: Division of Maternal and Child Hygiene and Public Health Nursing, Sessional Papers, 1939.

23. Minutes of the DCH, 19th meeting, June 19-21, 1928.

24. Ibid.

25. Armstrong and Armstrong (1983).

26. In this particular instance, the function of accumulation conflicted with both legitimation and reproduction.

27. Ontario: Resume of the Transactions of the Board of Health, Sessional Papers, 1922.

28. Ibid.

29. See first chapter.

30. The Ontario Division of the Red Cross was solicited for eight additional nurses, which they continued to provide throughout the 1920s and 1930s.

31. It was believed that the public health nurse was the "cheapest and most effective" method of educating women. This perception was shared by all provinces. Young, health representative from British Columbia on the Dominion

31. (cont'd)

Council of Health, stated: "...we (the public health departments) ...are pinning our faith on public health nurses". Minutes of DCH, 11th meeting, December 15-17, 1924.

32. Ontario: Division of Public Health Education, Sessional Papers, 1921.

33. Ontario: Resume of Transaction of the Board of Health, Sessional Papers, 1925.

34. Op. cit., 1940.

35. Ontario: Division of Maternal and Child Hygiene and Public Health Nursing, Sessional Papers, 1927.

36. Amount unknown.

37. The funding for this was provided by the Department of Health, and the International Division of Rockefeller Foundation.

38. Hastings, Medical Officer of Health for Toronto, was responsible for establishing these clinics. See 'Prenatal Work in Toronto', Canada Lancet and Practitioner, 1932, 79(2).

39. Volunteer organizations also provided some prenatal care. However, they had lobbied the federal government for assistance arguing that a private organization could not deal sufficiently with the matter.

40. Ontario: Report of the Division of Maternal and Child Hygiene and Public Health Nursing, Sessional Papers, 1933.

41. Biggs (1983).

42. Ontario: Report of the Division of Child Hygiene, Sessional Papers, 1930.

43. Ontario: Report of the Division of Maternal and Child Hygiene, Sessional Papers, 1931.

44. Ontario: Report of the Division of Child Hygiene, Sessional Papers, 1932.

45. Ontario: Report of the Division of Child Hygiene, Sessional Papers, 1933.

46. Mother, Department of Health publication, 1928.

47. Maternal Care, Department of Health publication, 1928.

48. Ibid.

49. Child Hygiene Section, Canadian Welfare, 1929.

50. Maternal Mortality in Canada, 1928, p. 34.

51. Ibid., p. 27.

CHAPTER FOUR

Response of the Medical Profession

Introduction

In the previous chapter, it was argued that state health officials eventually defined maternal mortality as almost exclusively a medical problem, and coincidingly, a problem to be resolved by the medical profession. Officials claimed however, that the medical profession needed to show greater interest in the problem, and further claimed that the profession needed to improve their obstetrical methods and practices. Questions which arise from the preceding chapter are: 'Was the profession as apathetic as officials claimed?, and if so, why?'; 'Did the profession need to improve their obstetrical practices and training?'; and finally, because the responsibility for the alleviation of the problem was placed almost exclusively in their hands, 'What efforts were made by the profession to reduce maternal death rates?'.

It is important to distinguish between proposed measures and policies espoused by leading members of the profession to improve maternal welfare, and the actual activities of most of the practitioners. In the medical literature, leading members espoused the need for more careful obstetrical

methods, less intervention, and more lengthy and practical obstetrical training. However, the data on maternal mortality during the 1920s and 1930 reveal that poor obstetrical practices and techniques continued, including the extensive use of intervention. As well, few changes were made in either the length or content of obstetrical training.

The response of the medical profession is determined through an examination of the editorials and articles published in the Canadian medical journals during the 1920s and 1930s.[1] The following section focuses on the period in which the profession seriously addressed the problem of maternal mortality and the context out of which this evolved. It is argued that the profession was relatively silent about the problem of maternal mortality until there was an anticipation of public pressure to improve their obstetrical methods and practices.

'Problematization' of Maternal Mortality by the Profession

In the last chapter, it was shown that state health officials perceived the medical profession to be apathetic to the problem of maternal mortality, and stressed the need for education of the medical profession as well as the public. To fulfill their perceived role as educators, officials gave addresses to national and provincial medical association meetings, stressing the need for prenatal care and nursing and

medical supervision and attendance at birth.[2] It is important to keep in mind that physicians were already supervising and attending the births of middle and upper-class women. Although few women generally received prenatal care, those women who did were primarily middle and upper-class women.[3] Therefore, the profession did not need to be educated on the need for physician attendance at birth, as much as it needed to be appealed to, to extend this medical care to working-class women.

Despite the attention directed to the problem of maternal mortality by state health officials, and the speeches given to the profession by these officials, the medical profession was relatively silent about the issue until 1928. From 1920-27 inclusive, there was a scant five editorials and articles published which addressed either obstetrical care, childbirth or maternal mortality. Out of these five articles, two were written by the Director of the Division of Child Welfare (Federal Department of Health), who made appeals to the profession to cooperate with the federal enquiry on maternal mortality being conducted, and who argued that a large number of maternal deaths were preventable: "The dangers of childbirth are to a great extent preventable and the more clearly this idea is grasped and acted upon by the medical profession and the general public, the lower will be puerperal mortality and morbidity".[4]

Following the publishing of the federal enquiry on

maternal mortality in 1928, the issue of maternal mortality suddenly received considerable attention in the medical literature, which continued throughout the 1930s. In 1928 and 1929 alone, there were thirteen articles and editorials published on the subject. The sudden response of the profession was directly related to the release of the federal enquiry, as the profession perceived a crisis in legitimation, and a fear that the public would soon demand better obstetrical practices and services. It will be remembered that the enquiry, which was widely circulated to the public, included a negative portrayal of the profession; many practitioners were accused of disinterest in maternal cases and they were held responsible for maternal deaths because of their poor obstetrical procedures and practices. Leading members of the profession appealed to practitioners to show greater interest and involvement. This appeal centred around a perception of a potential crisis in legitimation, as their benevolence and expertise was brought into question with the negative protrayal in the public report. There were acknowledgements made by leading members, and in editorals, that the profession had been disinterested, and was not attempting to improve maternal welfare: "Motherhood deserves this assurance. Yet we are far from that goal and we are not striving with all our strength to cover the distance".[5] All of the articles which stressed the need for greater interest were accompanied by proposed solutions to the problem: proper aseptic

procedures, more 'conservatism' at birth (less intervention), and more lengthy obstetrical training, with a greater emphasis on the practical aspects of obstetrical care. The call for improved obstetrical practices and techniques, however, was in the context of an anticipation that soon the public would demand it: "The medical profession ought not to wait until public sentiment forces them to do better and more careful work, but should take the initiative". In an editorial which espoused the need for improved obstetrical practices, there was a recognition of growing public pressure/concern:

> And the lamentable part of this whole wicked business is that there seems to be an immense amount of apathy toward it among members of the medical profession. Is it not time the awakened to the gravity of the facts and took live action to improve matters? The laity are learning the facts and are beginning to protest.[6]

If the public had an image of the profession as apathetic, and responsible for many maternal deaths, the future practices of physicians might have been threatened.

In relation to prenatal care, it was asserted that if the practitioners could only realize its importance in preventing maternal deaths, and then proceeded to provide this care, the accusations of complacency would be reduced:

> Ballantyne's clarion call for adequate prenatal care has not gone forth to so many classes at college, and perhaps has not had the attention it should have in the medical press. At any rate, a much larger number of doctors fail to recognize the importance of prenatal

> care... It may be reasonably hoped that with more general knowledge of the benefits resulting from watchfulness during the prenatal period, there will be less of what now seems like complacency chargeable to the profession.[7]

The concern about the legitimacy of the profession is further revealed by an assertion that one maternal death which could be attributed to complacency was a concern for the whole profession. In an editorial written in direct response to the 1928 federal enquiry, it was stated: "The number of these (maternal) deaths attributable to "medical omission" is not stated. We trust that it is really very small. But a single death which may be fairly charged against complacency is a matter of concern to the whole profession".[8]

Accusations of complacency, it was believed, served to tarnish the medical profession's projected image of itself as 'benevolent experts', and therefore, on an implicit level, potentially threaten their future practices. Somewhat obviously, the likelihood of people to place themselves under the care and supervision of a physician is reduced, if there is negative publicity about their lack of interest and incompetence.[9] As well, the profession had been granted autonomy to deal with cases of incompetence and malpractice, without outside interference (from either lay people or the state). There is no evidence which suggests that the unprecedented concern in 1928 was precipitated by state pressure,

or an anticipation of state pressure. That is, there were no fears expressed of possible state intervention, which might have been expected, given that it was through the state that the profession had been granted the right to 'self-govern'. Although state health officials had encouraged the profession to improve their obstetrical practices, and had stressed the need for prenatal care prior to 1928, the profession was relatively silent on both of these issues. It was not until the federal enquiry was released to the general public, that the profession seriously addressed the problem of maternal mortality. The following section will pose possible reasons to explain the apathy of the profession.

Apathy of the Medical Profession

The question of why the profession did not seriously address the issue of maternal mortality, and was in fact complacent until they perceived a potential crisis in legitimation, is an important question, particularly because it contrasts sharply with previous histories of childbirth. In histories of childbirth in England and Wales, it is asserted that the profession capitalized on the issue of maternal mortality to secure a monopoly, and to advance their neglected specialty of obstetrics.[10] A similar argument is presented in discussions of the history of childbirth in United States. It is claimed that the medical profession made an aggressive

attempt to secure a monopoly over obstetrical care, by campaigning vehemently against midwives in order to appropriate their clientele.[11] Although there was no formal system of midwifery in Canada, or in Ontario, many women were attended by lay midwives, or had their births unattended. Therefore a campaign to secure a monopoly and extend their clientele would have been considerably easier for the medical profession in Canada. Furthermore, state health officials attempted to direct women to the doorsteps of the practitioners' offices (save paying the fee). Therefore the question as to why the profession was disinterested in expanding their practice- shown through their disinterest in the problem of maternal mortality- becomes a crucial one. A number of possible factors are postulated to explain this disinterest: the low status of obstetrical work, with its emphasis on preventive care (in theory) and possibly a form of misogyny because of the female clientele; the minimal economic benefits in obstetrical work; and finally a class bias. Some of the solutions proposed to alleviate the problem will be incorporated into this discussion, because they help to illuminate why the profession was disinterested.

The first factor which partially explains the apathy of the profession is the low status of obstetrical work in comparison with other aspects of practice- particularly surgery. Prenatal care was/is preventive in nature, and the predominant and most prestigious aspects of medical

practice were/are curative medicine and surgery. Because of this, it was difficult to increase the time devoted to preventive medicine and obstetrics in the educational curriculum of physicians:

> But how to get more time for the study of obstetrics during the college course? The surgeons will, doubtless, raise a cry of protest, but it may be suggested, humbly, that some of the time devoted to surgery might be better employed in giving more adequate practical instruction in obstetrics and gynecology.[12]

As a solution to this problem, one member of the profession suggested that lectures in obstetrics should be made "attractive":

> Lectures by prominent men, given regularly, should be made so attractive that they would be eagerly attended. Secondly, (we need) more practical training and ward work for the student. The tendency today is to magnify medicine and surgery at the expense of obstetrics.[13]

Another factor which partially explains why the status of obstetrics was low, and there was a lack of interest in the problem of maternal mortality, relates to a misogynist attitude of the profession- disinterest in what is exclusively a female event:

> To many medical men obstetrical practice is sordid, drab, uninteresting, and unrenumerative... It is a regrettable fact that so many men practising obstetrics today are indifferent to the

> the claims of the lying- in room and a good many known to me have a positive dislike for their work... Men have told me frequently that they have a positive abhorrence of obstetrics.[14]

A woman who spoke at a London conference on maternal mortality, and was quoted in an editorial in a Canadian medical journal, stated:

> I have always felt that if Nature had been more generous with her gift and had let us share this childbearing between male and female, this very important subject would have been dealt with long before this.[15]

One of the solutions proposed to lower the number of maternal deaths was the training of female obstetricians. This would not only remove the male physicians from an uninteresting component of their work, but it was also implied that maternal health care would improve because the women would have greater interest and sympathy for other women:

> Discussions at recent conferences seem to suggest that the general practitioner is unable to give the time and watchful study desirable in maternity cases. "To the general run of the profession, obstetrical work appears to be an irksome side issue", says one authority, referring, of course, to the male members... It is a strange and deplorable coincidence that the already limited openings for the training of medical women should be further cut down at the very time when public sentiment has been directed to the urgent need for keener and more skilled obstetricians.[16]

In an editorial which stated the need for patience and careful obstetrical work (proper asepsis), the suggestion that women obstetricians would be best was again asserted:

> These requirements can best be met by a supply of women well trained in this especial (sic) department of medicine. Given equal training, the woman obstetrician has an advantage over one of the male sex in her greater patience and sex-sympathy, both of which may be drawn heavily in a protracted case.[17]

Finally, in response to the fact that midwives consistently had a lower rate of maternal mortality, one physician proclaimed:

> What an indictment of our training in obstetrics to admit that a midwife, with poor schooling and short medical training, is a more effective obstetrical agent than is a graduate in medicine! No, the fault lies with our methods, and the earlier we recognize this and apply the remedy the sooner will obstetrics enjoy the immunity which it so highly deserves. Were men the parturients the writer ventures to state that we would have acted with greater celerity. (emphasis added) [18]

The disinterest of the profession may also be partially explained by the pragmatic monetary concerns of practitioners and their class bias. In relation to the latter, the medical profession was predominantly composed of middle and upper-class males, and the practitioners therefore, may not have been favourably disposed to caring for the 'lesser classes'. It will be remembered that physicians already

attended the births of middle and upper-class women. It was working-class women who were more likely to be unattended at birth. McCullough, Chief Officer of Health for Ontario, explicitly revealed the class bias (and monetary concerns): "The middle class people are the best patients. They are the best pay(sic) and most satisfactory to deal with".[19] Finally, contemporary analyses show that physicians consistently prefer patients of the same social-economic class.[20]

The class bias would most likely interact with the concern of physicians for ensured payment. During the 1920s and 1930s, the profession was quite concerned about the lack of ensured payments, and related to this, there were minimal economic benefits for maternity cases, which may again help explain why the profession was disinterested in obstetrical work in general, and the problem of maternal mortality. Contrary to a widely held opinion, the medical profession has not always opposed national health care insurance. Up until 1930, the profession, through its representative, the Canadian Medical Association, approached this question with uncertainty, opposition and limited support. However, there was strong support for medical insurance in the 1930s, as physicians began to view it as an "antidote for economic ills".[21] In 1929, 77.5 percent of doctor's work was renumerative, and by 1932, as a consequence of the Depression, this had fallen to 50 percent.

In relation to these monetary concerns of the

profession, there were minimal economic benefits for maternity cases generally, let alone the risk of not securing payment from those with limited incomes. The issue of poor renumeration of maternity cases was mentioned at the Dominion Council of Health meetings: "The only ones I know who are getting a fairly adequate renumeration for attending maternal cases are some of the more highly paid physicians in our cities".[22] An editorial in one of the Canadian medical journals stated that one of the solutions to the problem of maternal mortality was greater payment to the physician, who could then afford the time to be conscientious and careful. It was stated that the public must be "willing to pay the price- a possible minimum of forty or fifty dollars - for the eight or nine months of supervision.[23] In another article, a similar sentiment was presented: "Our feeling is that held by other leaders of the profession elsewhere, namely: the present appalling yearly sacrifice of mothers at childbirth is largely preventable, provided that the Canadian people will pay the price".[24] (emphasis added)

In sum, the reluctance of the majority of practitioners to consolidate control over obstetrical care, and expand their practices, and finally, the apathy of the profession towards the problem of maternal mortality, may be attributed to the following factors: the low status of obstetrical work; the class bias of practitioners; and finally, the minimal economic benefits of obstetrical work.

The low status of obstetrics, and the slow reaction of the profession is clearly evident in the amount of time devoted to obstetrical training in the educational curriculum. Despite assertions that practitioners needed a more lengthy and practical obstetrical training, the amount of time devoted to practical training remain unchanged until 1935-6. Also, from 1925-36, the average time devoted to clinical teaching in obstetrics was 20 days a year. Because there were few changes made in the content and length of obstetrical training, it is not surprising that obstetrical practice also showed few changes. For example, the use of intervention continued. The following section will deal with the effects of intervention on the maternal death rate. Although there were appeals made by leading members to practice more careful work with proper aseptic procedures, and pleas were made for less intervention at birth, the majority of practioners continued in the same manner.

Intervention and its Consequences

There were acknowledgements made of the legitimacy of the argument made by MacMurchy in the 1928 federal enquiry, that intervention in the process of labour and delivery contributed to the high maternal death rate. In the medical literature, the iatrogenic consequences of intervention and poor obstetrics were enumerated: gynecological problems related to interference at birth; use of pituitrin; lack of

proper aseptic procedures which contributed to puerperal septicaemia (infections); use of forceps; and finally, cesarian births. To help ascertain the extent to which practitioners were responsible for maternal deaths, data on the leading causes of death from 1931-40 will be examined.

I have chosen this period because it was at the height of the controversy, and the profession had been made aware by both officials and leading members within the professions, of the negative consequences of intervention.

Bell's study of maternal mortality, completed for the Ontario Department of Health for the period of 1911-20, revealed that puerperal septicaemia was the primary cause of death, followed closely by toxaemia. In 1920, puerperal septicaemia and toxaemia accounted for 31.5 and 25 percent respectively, of the total percentage of maternal deaths. Yet this is not a clear or true indication of either the number of maternal deaths, or the causes of these deaths. Bell had stated that underreporting was a serious problem that inhibited precise statistics - a further indication of the lack of cooperation of the medical profession. It was concluded that bad obstetrics, along with the ignorance of the public, contributed to the number of maternal deaths. Bell cautiously stated: "It is not my intention to criticize the profession further than stating that bad obstetrical work

is occasionally the result of an attempt on the part of the obstetrician to direct nature, rather than assist her efforts in the delivery".[26]

All of the studies completed on the causes of maternal deaths (on both a federal and provincial level) came to the same conclusions in relation to clinical causes of death. Puerperal septicaemia, toxaemia, haemmorhage and abortion were consistently identified as the leading causes of maternal deaths for the entire 1920-1940 period. These causes accounted for over 75 percent of all deaths.[27] As for general trends for the period of 1931-40, in Ontario, sepsis remained the leading cause of death until 1936, when there was a sharp decline which continued well into the 1940s. Toxaemia as a cause of death during this time period accounted for the largest number of deaths, averaging 23.7 percent. This was followed by "accidents of pregnancy" (21.6 percent) and septicaemia (19.3 percent).

Further analyses revealed the consistency of other variables: multiparous women (particularly with four or more pregnancies), and primaparous women (first pregnancy) were the women most likely to suffer a maternal death; urban rates were consistently higher than rural rates of maternal mortality; and finally, the maternal mortality rate was consistently higher in hospitals than in homes.[28]

Most of the discussions by both state health officials and leaders of the medical profession centred on the

elimination of septicaemia as a cause of death, as it was not only one of the leading causes of death, but was also seen as preventable. This was because the medical practitioners who attended many of these births and subsequent deaths, were the main carriers of infection because of faulty aseptic techniques and procedures. Earlier studies and findings by researchers such as Lister and Semmelweiss had clearly shown that the bacteria, haemolytic streptococcus, was responsible for the infection, and the major carriers of the bacteria were physicians and nurses.[29] Of course it is the application of principles of septic conditions and procedures which is important for improvement, rather than the theory.

In the medical journals, there was an acknowledgement of the practitioners' poor aseptic procedures and methods, and the need for more careful work was constantly presented:

> ... many a hardy practitioner on the completion of the third stage, without preliminary sterilization thrusts his ungloved hand into the uterus to clear out the clots and see that nothing is left within.[30]

> Among the causes of sepsis may be mentioned infection from the hands of the obstetrician, his instruments or ligatures.[31]

Despite the generally accepted finding that puerperal septicaemia was primarily caused by poor asepsic procedures, there was still some insistence by medical practitioners that the source of infection lay within the patient herself. This was clearly an application of a

commonly- held male belief that women's bodies were essentially pathological.[32] Even with the previous research findings, there remained two major schools of thought: the endogenous (the source of infection lay within the patient), and exogeneous (the source of infection came from outside the patient). In an article in one of the Canadian medical journals, it was stated that the truth probably rested somewhere between the two major schools of thought.[33] Even as late as 1940, the argument that the source of infection rested within the patient herself was still prevalent:

> The interior of the uterus is most suitable for the growth of organisms. The disorders of pregnancy with such complications as the toxaemias and haemorrhage are predisposing factors, as is labour itself with the attendant bleeding trauma, exhaustion, and in some cases, shock.[34]

This type of emphasis served to absolve the practitioners from their own part they played in introducing infections. The state health officials had asserted that the poor education of women was a reason for the high maternal death rate, and now women were held partly responsible for their deaths because of the unfortunate predicament of being born with an inadequate body.

The high number of deaths from haemorrhages and abortion may also be directly related to interference by physicians, and poor obstetrical methods and practices. First of all, most abortions (spontaneous-miscarriages-and/or

induced) were associated with sepsis, and over half of these abortions were miscarriages. Sepsis was caused by the thrusting of aseptic hands and instruments into the uterus' of women.[35] In relation to spontaneous abortions, it seems that curretage was still being practised during this time period, and the germ-infected hands and instruments of attending physicians increased the likelihood of infection.[36]

In relation to haemorrhages, the medical evidence presented in the medical journals suggests that they were often caused by the interference of physicians in the birth process:

> Of the varieties of puerperal haemorrhage, post-partum haemorrhage claims by far the most victims. Too often post-partum haemorrhage results from improper treatment, especially in the third stage. There is a tendency among some medical men to pride themselves on the shortness of time required to complete a maternity case. No sooner is the child delivered than the unfortunate uterus is squeezed and rubbed over the vertebral column as over a washboard, the placental cord is pulled on, and in less than five minutes the placenta is away and the doctor walks away, leaving the nurse to deal with the haemorrhage which, unfortunately is occasionally excessive, but practically always occurs.[37]

In the article from which the above quote is taken, there is an account of virtually all of the iatrogenic consequences of obstetrical interference. However, it was concluded: "It must be conceded that, even with the greatest possible care,

there is a certain inevitable risk attaching to childbirth".[38] It was stated that the pathological aspect of midwifery should not be over-emphasized. Instead, valuable work could be done with the further education of women:

> The formation of Little Mother classes should be encouraged. Many young mothers enter upon motherhood without any preparation for its highly important and manifold duties. If malpractice has slain its thousands, ignorance has slain its ten thousands. Before a woman can enter upon any other profession a long period of training is required, yet public opinion does not demand any training for these priestesses of the sacred fire of the home, with duties higher and holer than those of the vestal virgins of Rome.[39]

Other forms of intervention: rupturing the bag of membranes; the use of pituitrin; and use of forceps, also contributed to complications and often death for women in labour and delivery. Maternal mortality was consistently higher when forceps were applied and cesarian births performed. In the medical literature, there was an acknowledgement of the dangers involved:

> It is probably true that instrumentation is often appealed to when watchful waiting would have accomplished the labor.. The hand that rocks the cradle is said to be the hand that rules the world, but the hand that pulls with might and main on the forceps is the hand that fills the gynecological wards...[40]

The need for services of the gynecologist increased to deal with the consequences of intervention:

> My task... is to focus your attention more especially on the milder forms of puerperal infection which lead to morbidity amongst those who are said to recover. As a matter of fact and observation, these women do not in the majority of instances, recover, or rather, escape morbidity; the best proof of this is being demonstrated by experience in the out-patient department or wards of a gynecological clinic where one sees the great number of women suffering from chronic pelvic disease which dates from confinement or abortion.[41]

In relation to the rupturing of the bag of membranes, and the use of forceps, it was asserted that the likelihood of infection increased because the bag of membranes is a natural provision which serves to protect and prevent the growth of bacteria. It was stated, however: "In spite of this and often with little excuse, men every day are rupturing the membranes too soon, forcibly dilating the cervix, applying forceps and doing version. All of these procedures potentially infect the uterus by converying infection from below upwards".[42]

Finally, the statistics reveal that puerperal mortality was consistently higher for hospital births than for home births. In the federal enquiry published in 1928, it was revealed that 25 percent of all maternal deaths occurred in hospitals. Because only 17.6 percent of all births in Canada were in institutions during the year of the study, there was a disproportionate number of maternal deaths in hospitals to the actual number of deliveries in hospitals.

The Ontario Department of Health began to collect statistics on maternal mortality in hospitals and homes in 1929, and once again, the maternal death rate for homes was lower than for hospitals. In 1929, the rate for hospitals was 11.1 whereas the rate was 3.3 for home deliveries. During the 1929-45 period, the home birth maternal mortality rate was low and stable, ranging from 3.3 to 1.6. For the hospitals, there was a greater range, from 11.1 to 2.1.

Phair and Sellers completed a study of maternal deaths for Ontario in 1933, and found that the puerperal mortality rate for hospitals was 5.3,and domiciliary rates were 2.3 percent. It was presumably the higher rate of sepsis in hospital births (1.7 to 0.7) that accounted for the discreprancy between hospital and home birth mortality. However, as it has been argued, physicians were often responsible for poor aseptic procedures, and thus the higher death rate in hospitals may be attributed in part to poor obstetrical practices, and thus the responsibility of practitioners. As well, conditions in the hospital during the 1920s and 1930s were less than ideal, and there was greater likelihood of infections.[43] Related to this, the urban/rural rate for 1933 was 5.7 and 4.7 respectively. The incidence of Cesarian births among fatally delivered cases was found to be more than twice as high among urban than rural women. These differences may

be partially explained by the fact that in urban areas, women were more likely to experience a hospital birth, and with a hospital birth, there was a greater likelihood of a cesarian being performed. The effects of the poor living conditions and its relation to sepsis, will be dealt with in the following chapter.

NOTES TO CHAPTER FOUR

1. There were occasional articles selected for publication which were written by public health officials. These articles have not been utilized for the analysis in this chapter, except where noted. See chapter two for a discussion of the conceptualization of public health official, as representatives of the state, rather than as representatives of the medical profession. As well, it should be noted that it is not suggested that the medical profession is homogeneous group. However, there is little evidence which suggests that there was inter-professional rivalry between obstetricians and general practitioners. As well, women were directed to general practitioners, and not specialists.

2. Department of Pensions and National Health, Annual Report, 1939. This educational campaign to the medical profession continued up until 1940.

3. It is argued in the following chapter that the issue of cost was an important factor which inhibited the visit to a physician.

4. MacMurchy, Canadian Medical Association Journal 15(9):942.

5. Editorial, Canada Lancet and Practitioner LXXXI(2):47.

6. Editorial, Canadian Medical Association Journal 21:433.

7. Editorial, Canadian Medical Association Journal 20:647.

8. Ibid.

9. See Freidson (1975) for an extensive examination of colleague relationships, and the inner unity of the profession.

10. Lewis (1980).

11. Ehrenreich and English (1979); Litoff (1979); Donnison (1977).

12. Editorial, Canada Lancet and Practitioner LXX:166.

13. Editorial, Canadian Journal of Medicine and Surgery 65:131.

14. Goddall, Canadian Medical Association Journal 21:448.

15. Editorial, Canada Lancet and Practitioner LXXVI(4):94.

16. Editorial, Canadian Medical Association Journal 20:647.

17. Editorial, Canadian Medical Association Journal 21:434.

18. Copeland, Canadian Journal of Medicine and Surgery 75:41.

19. Dominion Council of Health Minutes, 8th meeting, 1922.

20. Freidson (1970); Davidson (1978); Conrad and Kern (1981).

21. Bothwell and English (1981). For a further discussion of the incomes of physicians during this time period, see Shortt, 1981

22. Minutes of the DCH, 11th meeting, 1924.

23. Editorial, Canada Lancet and Practitioner LXXVI(2):36.

24. Cosbie, Canadian Medical Association Journal 43:39.

25. Bell, Ontario Department of Health, 1922.

26. See for example, Bow (1930); Copeland (1934); Goodall (1929); Maternal Mortality in Canada (1928); Need Our Mothers Die? (1935); A Study in Maternal, Infant and Neonatal Mortality in Canada (1945).

27. Ibid.

28. See for example, Copeland (1934); Goodall (1929); McLeod (1940).

29. Jackson, Canadian Medical Association Journal 45:139.

30. McLeod, Canadian Medical Association Journal 42:54.

31. Goddall, Canadian Medical Association Journal 21:449.

32. For an examination of this, see the Canadian work by Mitchinson (1982). Although physicians defined women from their perceived role as childbearers and child-rearers, they argued that women's reproductive system was letting them down.

33. McLeod, Canadian Medical Association Journal 42:55.

34. The reason postulated for this in the medical literature, was that the "busy physician" did not have the time for watchful waiting.

35. Curretage is the "emptying of the uterus".

36. Editorial, Canadian Journal of Medicine and Surgery 64:132.

37. Ibid.

38. Ibid.

39. Editorial, Canadian Journal of Medicine and Surgery 65:131.

40. Editorial, Canada Lancet and Practitioner LXXVI(4):94.

CHAPTER FIVE

The Narrow Focus on Maternal Mortality and Its Consequences

Introduction

There was an appreciable decline in the maternal death rate which began in 1936 and continued well into the 1940s. After almost twenty years, state health officials could optimistically report that the "stubborn" problem was under control. In this final chapter, the political implications of the medicalization of maternal mortality by state officials is discussed. It is argued that the medicalization and individualization of the problem by officials, served to obfuscate the significance of underlying socioeconomic and environmental causes of maternal deaths.

Review of State Perspective

In the period prior to the substantial reduction in the number of maternal deaths (1919-1936), state officials had argued that the solution to the problem lay in increased medicalization of pregnancy and childbirth. They proposed medical supervision during parturition and physician attendance at birth, and as a component of this, improved obstetrical procedures and techniques. A major hindrance to this

medicalization, officials claimed, was that women's ignorance inhibited them from placing themselves under the care of a physician. State activities centred on educational campaigns which were designed to combat this ignorance. Public health nurses were assigned the task of convincing women that childbirth was a medical event, and hence an event which required physician supervision and attendance at birth. The eventual success of the campaign to direct women to the medical profession is revealed by the fact that by 1938, the majority of births were attended by physicians and hospitals were the predominant place of birth.[1]

Ironically, a further impediment to the reduction of maternal deaths, according to state officials, rested with the medical profession itself. The reduction was impeded by the profession because of their disinterest in the problem of maternal mortality, and because of their excessive and unsanitary interference at birth. Officials attended federal and provincial medical association meetings, to both solicit the interest of the profession and to make appeals for the improvement of their obstetrical methods and procedures.

The medical profession, however, did not seriously address either the problem of maternal mortality or the issue of obstetrical care in general, until the release of the federal enquiry in 1928. In Ontario, it was not until the mid 1930s that officials assuredly reported the interest and involvement of the profession. It was state officials

who were responsible for the 'problematization' of maternal mortality, and it was state officials who were responsible for defining medicalization as the solution.

The 'problematization' of maternal mortality has been explained in terms of a growing state concern for the daily and generational reproduction of labour power. Both the quantity and quality of the present and next generation of workers was perceived as threatened. There was, therefore, an ideological attempt to entice women to bear more children, as well as a recongnized need to make the process of childbirth a safer event. Maternal mortality itself was conceptualized as a problem in terms of the tasks left unfilled by women as wives and mothers.

It is the solution of medicalization proposed by state officials which needs to be further examined. State officials played an important role in determining the course of contemporary childbirth practices and services. Contrary to findings in previous histories of childbirth, the medical profession did not capitalize on the problem of maternal mortality either in order to establish a monopoly over obstetrical care or to advance the neglected speciality of obstetrics. In other words, the medical profession was a reluctant participant in the increased medicalization of pregnancy and childbirth.

This reluctance of the profession has been explained in terms of the minimal economic benefits in obstetrical

work; the low status of obstetrics in comparison with other aspects of medical practice; and finally, the class bias of the profession. What remains unanswered is why state officials single mindedly defined the problem and solution in medical terms. In light of the medical profession's apathy, it is important to suggest an answer to this question. As well, the state officials' approach can be seen as an apparent contradiction. Officials claimed that obstetrical iatrogenesis contributed to the high number of maternal deaths. At the same time, however, they argued that the solution to the problem lay with the medicalization of pregnancy and childbirth. In the following section, there is an attempt to explain and understand this contradiction. It is argued that the state solution of medicalization and the contradiction of this solution, is best understood in the context of the broader political implications and consequences of this focus.

Politics of Medicalization

One could conceivably argue that the state officials expected the medical profession to improve their obstetrical methods and practices. Therefore, the officials' perception of the medical profession as both part of the problem and solution, is not necessarily an anomaly. In other words, once the problem of iatrogenesis was resolved, physician supervision and attendance at birth would serve to lower

the number of maternal deaths. However, for over seventeen years (1919-1936), the medical profession had also been unsuccessful in the prevention of deaths which had not been attributed to iatrogenesis.

It has been suggested that it is necessary to discuss the broader political implications and consequences of the medical approach adopted by officials. By definition, this approach ignores the possible importance of socio-economic and environmental factors, both in terms of underlying causes and in terms of solutions. In other words, the adoption of the ideology and practice of medical science, which is central to the process of medicalization, rendered the socioeconomic and environmental context in which women were becoming pregnant and giving birth, as irrelevant. Within medical science, the cause of ill health and death is viewed as primarily individual, and thus the solution is individually oriented. Medical science is primarily curative in nature (in other words, treatment oriented), and does not emphasize preventive measures. For example, the germ theory of disease, and its application with antibiotics, fails to stress the importance of general resistance to infection.[2]

I propose that the state officials viewed the curative model in medical science, with the medical profession as its agents, as an <u>alternative</u> to initiating or promoting any significant socioeconomic and/or environmental changes.

It is argued that there were underlying factors such as low income, poverty and low standards of living, which contributed to the high number of maternal deaths. It is further argued that curative medicine was only partially successful in the reduction of deaths, and subsequently, many women continued to die in childbirth until there was a substantial improvement in the social and economic conditions in the late 1930s and early 1940s.

It is now well established in the medical literature that multiparious women and women who suffer from poor physical health, are less likely to experience a safe and uncomplicated birth. Under these conditions, a woman is more susceptible to infections, haemmorhages and toxaemia.[3] My argument that state officials viewed curative medicine as an alternative to eliminating the underlying causes of obstetrical complications and deaths, assumes that officials did in fact recognize factors such as low income, poverty and poor living conditions as underlying causes of maternal deaths. Although there were few statements made by officials which explicity acknowledged the significance of these underlying and contributory factors, these broader issues were occasionally raised.

Merson, the Labour representative on the Dominion Council of Health, provided the perspective on the problem of maternal mortality which most sharply deviated from the predominant medical focus adopted by officials. Merson

argued that many people could not afford the services of a physician. As well, in 1924, without the benefit of contemporary medical wisdom, he had asserted that poor economic conditions prevented the provision of a proper diet, and thus impeded the likelihood of a safe delivery:

> The necessary factors in childbirth would be a healthy expectant mother and one deserious of having a child. In our conditions of today where there is so much unemployment and distress, the expectant mother cannot have the nourishment necessary to ensure a safe pregnancy and delivery... Regarding the pay of doctors is too large; the fact is they have not got the money. 4

Merson was not the only person to raise the possibility that financial difficulties prevented some people from seeking the services of a physician. MacMurchy, although a strong promoter of the need to educate women, also proclaimed in the 1928 federal enquiry that: "...the large expenses of the professional visit inhibits a call except in an emergency".[5] And, the Director of the Ontario Division of the Canadian Red Cross stated: "How can we make it possible for patients to call a doctor as often as our nurses feel is necessary when each trip represents a financial outlay of $25 to $50?"[6]

What was primarily neglected by officials who advocated prenatal care and medical supervision and attendance at birth, was that without financial assistance many

women would be unable to obtain medical attention. Such financial assistance was not made available. When the issue of financial difficulties was occasionally raised, officials reverted to the argument that the 'real' problem was one of ignorance. In accordance with this, the solution was education and advice. Officials effectively diverted attention away from the significance of, in this instance, the broader problem of low incomes.

The significance of further socioeconomic factors was avoided by officials through the medicalization of the problem of maternal mortality. In relation to poverty and the attendant poor living conditions and general poor health of some women, officials emphasized the application of medical treatment. According to officials, it was not poverty that needed to be attacked, it was the treatment required for the alleviation of complications which resulted from poverty. The following quote reveals the prevailing prespective held by state officials:

> But even poor housing and over-crowding of themselves do not seem to contribute to a higher rate; it is, however, the greater danger of infection common in such conditions of life and the general debilitation too frequently found in the health of all women living under such circumstances, which though they may not affect the death rate directly, affect the health of the mother and too often the life and health of the child. [7]

Although it was acknowledged that unmarried pregnant women tended to suffer from additional social and economic problems, the focus remained on the provision of medical care:

> ... even with all the added economic and social disabilities incidental to unmarried parenthood in ordinary community life, with careful prenatal supervision and assurance of proper care at the time of birth, almost incredible results can be obtained in the preservation of maternal and infant life. [8]

The above quotes reveal the officials' avoidance of directly addressing the underlying causes of maternal deaths. They viewed the curative medical model as an alternative to initiating or promoting socioeconomic and/or environmental changes. Was this curative medical approach a successful alternative? Critical analysts of the advancement of medical science argue that public health and general improvement in nutrition and living conditions were responsible for the decline in deaths from the nineteenth century on. In relation to maternal mortality, Dorzal argues that:

> Although medical intervention played some part in improving infant and natural mortality rates... it is now generally accepted that improved standards of housing and nutrition probably played the most significant role. [9]

In the following sections, septicaemic and toxaemic deaths (two of the leading clinical causes of maternal

mortality) are examined, in an attempt to ascertain the reasons for the decline. It is argued that both medical intervention and improved standards of living served to lower the maternal death rate. In 1936, curative medicine - in the form of antibiotics - eventually enabled the medical profession to successfully prevent deaths caused by septicaemia. They were able to prevent these deaths without any significant socioeconomic or environmental changes. Deaths from toxaemia, however, did not decline until the late 1930s, and more significantly, in the early 1940s. In fact, the number of toxaemic deaths increased during the mid 1930s. It is argued that neither curative medicine, nor physician supervision and attendance at birth, had much to offer in the prevention of toxaemic deaths. The cause of toxaemia was primarily malnutrition and a poor level of general physical health. The solution, therefore, was improved diet, nutrition, and general state of physical well-being.

Septicaemia Deaths

In Chapters three and four, it was argued that medical practitioners contributed to the high number of maternal deaths. Physicians, with their faulty aseptic techniques and procedures, were the major carriers of the bacteria, haemolytic strepcoccus. This bacteria was responsible for infections, and hence deaths clinically

classified as septicaemia or sepsis. Sepsis remained the leading clinical cause of maternal deaths until 1936, when there was a sharp decline and the beginning of a downward decline which was to continue well into the 1940s. The reduction in deaths caused by septicaemia served to considerably lower the overall maternal death rate. In Ontario, the maternal mortality rate in 1936 was 5.7 and by 1940, had declined to 3.7.

The sudden decline in deaths caused by sepsis was attributed to the introduction of sulphanilamide (sulpha drugs) in 1936. The provision of antibiotics, and their more general use, proved to be lifesaving, and led officials to positively report that:

> The more or less dramatic results from the widespread use of the drugs of the sulphamide groups in infections are reflected in the appreciable lowering of the incidence of maternal deaths from septicaemia. [10]

The data collected on maternal mortality did not include attempts to correlate the women who were dying with their living conditions, or socioeconomic variables such as income or occupation (of either the husband or wife). Therefore, it is impossible to empirically determine the extent to which infections, and deaths from sepsis, were a result of poor living conditions. What we do know, however is that the medical profession and state health officials acknowledged the fact that practitioners themselves were responsible for

a number of deaths from sepsis. What cannot be determined is the exact number. The eventual decline in deaths from sepsis cannot be utilized to explore the importance of underlying social, economic and environmental factors. This is because, despite the cause of infections, the application of curative medicine succeeded in the prevention of a number of maternal deaths.

Curative medicine or treatment, however, had little effect on the reduction of toxaemic deaths. It is suggested that a decline in toxaemic deaths occurred primarily because of improved nutrition and living conditions, rather than because of the advancement of medical science.

Toxaemic Deaths

Toxaemia also remained a leading cause of death during the 1920-40 period. Although there was little known about the cause of toxaemia until the late 1930s, it was considered preventable with prenatal care, bed rest and a salt free diet. The influence of a poor diet and malnutrition on the rate of toxaemic deaths is suggested by the fact that, during the 1930s, when Canadians were suffering from the effects of massive unemployment and/or exceedingly low incomes, the number of toxaemic deaths increased. Apart from a drop in the rate in 1932, there was a steady increase until the late 1930s. The League for Social Construction states that the majority of all Canadians lived below the bare standard

of decent livelihood during the Depression years.[11]

The significance of malnutrition as an underlying cause of toxaemic deaths, and coinciding with this, the importance of proper nutrition, was acknowledged by officials in the early 1940s. The rate of toxaemic deaths began a downward decline in 1939, and the reasons postulated by officials for this decline was improved nutrition and higher standard of living. Initially, however, officials cautiously admitted the significance of malnutrition as an underlying cause of toxaemic deaths. In 1943, Phair, Director of the Ontario Department of Health, stated that, although some workers had insisted that malnutrition had a bearing on the number of maternal deaths, a well-controlled study would be needed to establish the validity of this claim. In the tradition of the prevailing medical perspective, Phair stated: ... it would seem imperative to continue to stress as a prophylactic measure, the value of prenatal care".[12]

It was only after 1939, when the diet of many Canadians improved as a result of a higher standard of living, that there were acknowledgements of its significance re toxaemia:

> It is generally conceded...that the Canadian public since 1939 has benefited from a richer and better balanced diet. The reasons given in support of this view are that economic conditions have made it easier for the people to provide themselves with proper food.[13]

It may be concluded, therefore, that officials attempted to avoid the underlying causes of maternal mortality. The medicalization of the problem served this purpose, as the socioeconomic and environmental context in which women were living and dying, was rendered unimportant. The medicine profession, however, was unable to provide treatment which would reduce the number of toxaemic deaths. Where they were successful was through the elimination of infections, and hence, a reduction in deaths from sepsis.

CONCLUSIONS

Deaths associated with the process of pregnancy, labour and delivery were second only to tuberculosis for women of childbearing age in Canada and Ontario during the 1920s and 1930s. Prior to this period, primarily women reformers had addressed the issues of infant and maternal welfare, but asserted that greater success required the finances and "authority of the Government".

The population losses suffered during the war, the poor physical quality of many army recruits, and the declining birth rate of the 'native' Canadian population evoked the involvement of the state at the federal level in the health sector generally, and the specific 'problematization' of maternal mortality. The loss of 'mothers' posed a perceived threat to the daily and generational reproduction of the labour force.

The statistics revealed that sepsis and toxaemia were the two leading clinical causes of death. State health officials medicalized the maternal problem of mortality, which had the effect of obfuscating the underlying social and economic factors which contributed to the high number of maternal deaths.

Officials at all levels of the state were in agreement that what was needed was education of the public and the medical profession, to the need for prenatal care and medical supervision and attendance at birth. Conflicts arose however, over what level of the state was responsible for educating the public, and providing prenatal care through either clinics of public health nurses. Although officials admitted an interest in reproduction - both biological and daily and generational reproduction - they were not willing to absorb the costs in the interests of fulfilling this function.

Eventually, the problem was defined by officials as almost exclusively a medical problem, that could be resolved only by the medical profession, combined with the "intelligent cooperation" of the parturient woman. The above solutions however, did not address the poor socioeconomic conditions facing many women, or the financial inability to either seek the care of a physician, or follow the advice given. No treatment was provided in the prenatal clinics or by public health nurses. Furthermore, the medical profession itself was apathetic to the problem of maternal mortality, and disinterested in maternal cases generally. This apathy applied to the reluctance to extend their care to working-class women, as middle and upper-class women were already under the supervision of a physician during parturition. The profession did not seriously address the problem of

maternal mortality until they anticipated a crisis in their legitimation. As a solution to the problem, leading members of the profession stressed the importance of more careful aseptic procedures, and made pleas for practitioners to interfere less in the birth process. However, practitioners did not heed this advice. As a result, physicians were responsible for a number of maternal deaths because of their excessive and unsanitary interference.

There was no significant decline in the maternal mortality rate until antibiotics were introduced in 1936. These antibiotics served to reduce the number of septicaemic deaths. The second leading cause of death - toxaemia - was not alleviated until socioeconomic conditions improved in the late 1930s and early 1940s.

NOTES TO CHAPTER FIVE

1. Oppenheimer (1983).

2. Powles (1973).

3. See, for example: Brenner (1973); Brewer (1966); McKeown (1966); McKinlay and McKinlay (1977); and Powles (1973).

4. Minutes of the DCH, 11th meeting, June 23-5, 1924.

5. Maternal Mortality in Canada, Ottawa (1928), p. 11.

6. Op. cit., p. 12.

7. Need Our Mothers Die?, 1935, p. 51.

8. Op. cit., p. 40.

9. Doyal (1979), p. 228.

10. Ontario: Department of Health, Division of Child Welfare, Sessional Papers, 1941.

11. Social Planning for Canada (1975). See also: Broadfoot (1973); Copp (1979); and Marsh (1938).

12. Op. cit., 1944.

13. Op. cit., 1943.

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