Nurse-Midwifery

Ettinger, Laura E.

Published by The Ohio State University Press

Ettinger, Laura E.
The Ohio State University Press, 2006.
Project MUSE. muse.jhu.edu/book/28184.

For additional information about this book
https://muse.jhu.edu/book/28184

For content related to this chapter
https://muse.jhu.edu/related_content?type=book&id=1178075
“Is nurse-midwifery the solution?” Sister M. Theophane Shoemaker, nurse-midwife and director of Santa Fe’s Catholic Maternity Institute, asked in an article written in 1946. For Shoemaker, the answer was obvious: nurse-midwives, working in collaboration with physicians, could provide a permanent solution to the problem of poorly distributed and inadequate maternity care that had existed for decades in the United States.

Born Agnes Shoemaker in 1913, Sister Theophane had become interested in nursing because she had wanted to help others and had admired an aunt who was a nurse. After joining the Medical Mission Sisters and graduating from Catholic University with a bachelor’s degree in nursing in 1941, she worked as a nursing supervisor in the maternity and newborn nursery units of a busy hospital. When the superior general of the Medical Mission Sisters asked her to study nurse-midwifery so Sister Theophane could establish a new nurse-midwifery service in Santa Fe, an area with high maternal and infant mortality rates and very few physicians, she eagerly accepted the challenge. As Sister Theophane explained, “I had been really quite unhappy with the way they [physicians] were treating maternity patients [in hospitals] at that time. They were giving them high doses of scopolamine [which causes amnesia], sometimes with morphine, and the women were really out of their minds . . . . They were really animalistic, and it was awful. . . . I’d never heard of nurse-midwives before, but I was willing to try it.”

Different from many of her counterparts, Sister
Theophane’s motivation for becoming a nurse-midwife had to do, at least in part, with her dislike of the way women acted—“animalistic” and not in control of their feelings—when they received the contemporary drugs of choice during labor.

After graduating from one of the only two nurse-midwifery schools then in existence in the U.S., Sister Theophane and another nurse-midwife founded Catholic Maternity Institute (CMI), a home delivery nurse-midwifery service, in 1944. She loved the change from her previous nursing job, as she perceived a huge difference between births attended by nurse-midwives and those attended by physicians. “We treated mothers as human beings—[seeing] mothers as part of families—and [making] maternity care a real physiological activity rather than a pathological activity. . . . It just was amazing . . . the difference . . . when a mother was conscious, knew what was going to happen to her, was able to control her feelings to some extent, was able to cooperate with you and was able to receive the baby with some kind of mental stimulation, some love. And to put the baby to breast right away after delivery, which we always did, . . . was a very physiologically healthy thing to do. And the simplicity of the whole operation—I don’t want to call it an operation—of the whole procedure was just wonderful.”

In addition to providing a very different kind of maternity care from what physicians were providing at hospitals, Sister Theophane and her fellow CMI nurse-midwives also helped improve the health of women and children in the area they served. Her nurse-midwifery work, however, did not stop with this pioneering service and school in Santa Fe. In the 1950s, Sister Theophane fought to organize and unite nurse-midwives, playing a central role in the formation of a national nurse-midwifery organization and serving as its second president. She and her colleagues constantly faced opposition from a health-care establishment that sought to limit nurse-midwives’ work. Physicians and nurses believed nurse-midwives were too independent and therefore threatened their positions. Physicians also charged that nurse-midwives were not sufficiently trained to practice obstetrics and that they used “bad,” old-fashioned approaches to childbirth. Some physicians were even unaware nurse-midwives existed at all.

Sister Theophane was not alone. She was part of a group of pioneering nurse-midwives in the early and mid-twentieth century who successfully changed maternity care in select regions of the United States and constantly fought relentless prejudice against and ignorance about their profession. Today, American nurse-midwives attend a small but steadily growing percentage of births. In 2003, nurse-midwives attended 7.6 percent of American births, a rise from less than 1.0 percent in 1975. Yet in an age
when modern has been equated with scientific, nurse-midwives, primarily through association with traditional and “unscientific” midwives, have been perceived as a vestige of a distant, best-forgotten past.

Contrary to this view, nurse-midwives were and are licensed professionals, with formal education in both nursing and midwifery. But in the twentieth century, as modern births in America came to involve physicians, hospitals, technological interventions, and quick, routine procedures, nurse-midwives seemed increasingly anachronistic. They delivered babies at home, intervened less in the birth process, and took considerable time with their patients. Yet nurse-midwives, who worked, at least theoretically, under the supervision of physicians, also served as agents of the professionalization and medicalization of childbirth.

Despite most nurse-midwives’ successful track records, the medical establishment, both directly and indirectly, discouraged the growth of their practice. Physicians actively sought to limit where nurse-midwives worked, whom they served, and the types of care they could provide. They also failed to promote nurse-midwives as modern health practitioners and to give them widespread support as birth attendants for the nation’s women, or even just for the poor. Nurse-midwives provided quality health care to their female patients and offered women practitioners an unusual amount of independence. However, fears among medical professionals and cultural concerns about the place of the midwife in modern society resulted in a limitation of nurse-midwives’ sphere, forcing these practitioners to make difficult choices about the directions their profession would take.

By exploring the birth of nurse-midwifery, my book analyzes the ways in which women professionals created a space of their own in the face of many obstacles. As the name “nurse-midwife” indicates, the profession was a hybrid. As nurses, nurse-midwives belonged to a profession whose members were not seen as autonomous professionals. Nurses were overwhelmingly women in a field dominated by male physicians. As historian Susan M. Reverby has shown, even nursing leaders were subordinate to physicians’ and hospitals’ needs, ordered to care in a society that did (and does) not value caring. Yet nurse-midwives were also part of midwifery. While early nurse-midwives identified with their European counterparts, well-respected and well-educated women on whom they based their profession, the American public and health professionals identified them with traditional midwives, many of whom were immigrants or African Americans. Increasingly, these traditional midwives were viewed as dirty, backward, and ignorant. In the early to mid-twentieth century then, the nurse-midwife occupied a strange and ambivalent position.
Chapter 1

She did have, however, some power, certainly more than many nurses or traditional midwives. Unlike many nurses, when nurse-midwives interacted with their patients, they made the important decisions, except in the relatively few cases where they needed to bring in physicians. Unlike traditional midwives, nurse-midwives had formal education and worked squarely within the mainstream health-care system. They supervised or replaced traditional midwives, and sometimes joined others in criticizing traditional midwives.

However, compared with physicians, nurse-midwives were much less powerful both because they were women in a male-dominated profession (obstetrics) and because they were not seen as fully credentialed. In many ways, they stood outside the health-care establishment, challenging the notion that childbirth required male physicians, hospitals, and interventions. They also challenged the health-care hierarchy: neither fish nor fowl, nurse-midwives could not be easily characterized. While individual physicians and nurses were supportive and active in the emergence of nurse-midwifery, the nursing and medical professions as a whole were not. troub 7

Troubled by nurse-midwives’ unique place within the hierarchy, many physicians and nurses aggressively sought to stop or at least limit nurse-midwives’ work. Nurse-midwives responded to the opposition by adopting a strategy of accommodation; they remained within nursing (unlike many European midwives), and they conceded a fair amount of authority to physicians.

This book also explores the changing practice of childbirth in America. In the United States, as in many other industrialized nations, childbirth gradually moved from home to hospital, birth attendants changed from female midwives to male physicians, and birthing practices replaced folk healing with scientific medicine. The history of nurse-midwifery provides an often-overlooked insight into these shifts. In a sense, nurse-midwives were and are an exception to the medicalization of childbirth during the twentieth century. They offered and continue to offer an important challenge to what scholars call the “male medical model” of childbirth. As Sister Theophane indicated, nurse-midwives offered their patients something radically different from what most physicians provided in hospital births. Nurse-midwives spent more time with their patients in labor and intervened less, and they saw birth as a normal, rather than pathological, process. Eventually, they also created collaborative, rather than hierarchical, relationships with their patients—an approach to patient care that ran (and runs) counter to modern notions of medical authority and treatment.
Finally, this book analyzes changing patterns of health care in the United States. The American health-care system was, and remains, chaotic. Unlike many economically developed countries, the United States has offered only private insurance (except for the very poor and the elderly, starting in 1965) rather than universal health insurance, demanding fee-for-service payments rather than providing universal care. Additionally, there has been no centralized planning for the distribution of health-care practitioners. Overall, this unique approach has not benefited Americans. Millions of Americans lacked and continue to lack access to professional health care because they are uninsured or underinsured, and Americans, on average, are less healthy and have a shorter life span than citizens of thirty industrialized nations.

Nurse-midwifery was developed to target groups traditionally left out of the American health-care system. In a few select places starting in the 1920s, nurse-midwives dramatically improved the health of poor and minority women and families. However, they never got the opportunity to give large numbers of people better access to health care in any systematic way. Nurse-midwives’ underutilization and marginalization indicates how unprepared Americans were to use innovative approaches to improve and more simply provide health care for all Americans.

The Medicalization of Childbirth

In order to understand the birth of the American nurse-midwife, it is necessary to explore what writer and social critic Jessica Mitford called the “American way of birth.” Historians have explained that American childbirth went from a social event controlled by neighbor women to a medical event controlled by male physicians. This process, commonly called the “medicalization” of childbirth, involved two important transformations: a change in birth attendants from midwives to physicians, and a change in birth location from home to hospital.

An understanding of changes in childbirth requires some background in American medicine. In the late eighteenth and nineteenth centuries, anyone could proclaim himself or herself to be a “doctor.” In this democratic culture, no special license, certificate, or education was required. This meant that the care that women received varied widely from practitioner to practitioner. During this time, medical practitioners could be loosely divided into two groups: orthodox, or “regular,” physicians and the others,
including Thomsonian botanists, homeopaths, eclectics (who used a mixture of remedies from the Thomsonians, homeopaths, and others), “quacks,” and midwives. Orthodoxy physicians organized and tried to eliminate the competition by claiming that they were better educated (although many were not), that many of the “irregulars” relied on erroneous therapeutic concepts (although the “regulars” also tended to believe in theoretical medical systems), and that their remedies were more effective (although many of the treatments—such as massive bloodletting, purging, and heavy drugging—were not, and patients often disliked them). They tried to establish professional medical societies and licensing laws to advance their own interests and keep other practitioners out.

Until the twentieth century, birth was a female activity that took place in the home. When a woman went into labor, she gathered her female relatives, friends, and neighbors around her. These women helped the laboring mother, sharing stories of their experiences, comforting the woman, walking around with her, and assisting her in delivering her baby. They also provided an important support system at a vulnerable time in a woman's life when she feared death during childbirth. Many of these women stayed for days or weeks after the birth to lend their continued support.

The midwife was just one of the many women in the “birthing room.” Midwives usually had no formal training, but a lot of experience based on an informal apprenticeship with another midwife. No rules regulated these apprenticeships, and while some of these women were highly skilled, others were not. Nature and gravity were central to midwives’ work. Indeed, midwives spent most of their time supporting the birthing woman and waiting.

In cases of difficult or long labors, midwives sometimes intervened by turning the fetus or by giving the mother liquor. While some used drugs and forceps, which urban male physicians by the mid-eighteenth century increasingly employed, most did not; they feared criticism for incorrect use of forceps (and most had not received training in their use). When faced with a very difficult birth, the best midwives often had little to offer a suffering or dying patient except comfort. After a birth, a midwife typically stayed for hours, making sure the new mother and baby were well, changing the bed linens, and spending time with the roomful of relatives and friends.

Starting in the late 1700s, urban middle- and upper-class families began to employ male physicians, known as “man-midwives,” to attend their babies' births. Man-midwives brought scientific medicine into the birthing room; this scientific medicine was male, white, and middle or
upper class. Contrary to contemporary beliefs, however, the increased presence of these men and their so-called scientific methods in birthing rooms likely caused more problems for parturient women than did traditional, female midwives.

Just as female midwives’ skills varied because of a lack of regulation, so too did those of man-midwives. Most had no formal training in anatomy and had never attended medical school. Yet male physicians had several attractions: 1) they used forceps and drugs that midwives generally did not use, 2) they were thought to have had formal education in anatomy, and 3) their sex conferred a certain amount of prestige. More interventionist than midwives, male physicians felt that a doctor, as one explained, “must do something. He cannot remain a spectator merely, where there are many witnesses, and where interest in what is going on is too deep to allow of his inaction.” Physicians typically used bloodletting, chloroform (starting in the 1840s), and/or forceps. Bloodletting and chloroform accelerated the labor and relieved pain (among other things), while the forceps could deliver the baby in a prolonged, difficult labor, potentially saving two lives. Despite these tools, male physicians had serious limitations. Historians have shown that too often they were overeager to use forceps and caused disability and death for many mothers and babies. In addition, the man-midwives, like female midwives, did not understand the cause and prevention of puerperal fever (bacterial infection of the genital tract shortly after birth)—the leading cause of maternal death in the nineteenth century. Doctors, like midwives, unknowingly spread the infection with their hands and their tools.

Until the mid-nineteenth century, women who employed male physicians still maintained some control over the birthing process. They and their female support system (including the midwives) decided if and when to call on a physician, and together they decided what tools and techniques would be used during labor and delivery. Many man-midwives, later called obstetricians, viewed midwives as competitors and sometimes attacked them. They denounced midwives in their writings, suggesting that women who practiced midwifery should have stayed at home in their proper sphere and that midwives were unsafe. Over the second half of the 1800s, likely due in part to public, male-generated criticism of female midwives, a growing number of middle-class urban women chose physicians to deliver their babies, believing in the promise of science and medicine to make childbirth safer and associating a physician-attended birth with higher status. By 1900, 50 percent of American births were attended by midwives and 50 percent by physicians. At this point, midwives generally
attended the births of rural, African American, or immigrant women, and shared the same background as the women they attended. Thus, among middle-class urban women giving birth, physicians were seen as status symbols, while midwives, commonly associated with the poor, were seen as déclassé.

The second transformation in the history of American childbirth occurred when birth moved into the hospital. In the nineteenth century, hospitals never attracted more than 5 percent of pregnant women, and even they did not come by choice. The women were usually poor or unmarried, and the maternity hospitals, called “lying-in hospitals” and established by private charities, were often dirty, dangerous places where patients frequently died from puerperal fever. These hospitals aimed more to provide moral uplift to the poor souls who ended up there than to guarantee safe labor and delivery to women (and their offspring) already perceived to be on the road to perdition. 

By the 1920s and 1930s, white middle- and upper-class women increasingly went to hospitals to deliver their babies. This change stemmed from several factors. By the 1920s, hospitals had transformed themselves into middle-class institutions by marketing modernity to paying patients; they advertised standardized medical procedures, notably surgeries and obstetrical deliveries, and a restful, modern environment—clean rooms, good food, radios, telephone, and call buttons for nurses. Some obstetricians, armed with a basic understanding of the new science of bacteriology, also claimed that the hospital could be made into a more sterile environment for deliveries than the home. In addition, obstetricians made increasingly systematic use of pain-relieving drugs, labor-inducing drugs, and technological interventions, such as forceps and episiotomy, in childbirth. They argued that these procedures, now seen as necessary, required access to nursing and anesthesiology staff that only hospitals could provide. Professional jockeying also motivated obstetricians, who tried a variety of ways to gain control of birth management from general practitioners who were attending the majority of physician-managed births.

Women had their own reasons for choosing hospitals. First, they believed that the new science and medicine, and the institution that represented those things, would make birth less dangerous. Second, they liked the predictability of the new birthing procedures. A woman and her physician could decide in advance the day she would deliver her baby, and she could know that she would have medication to induce her labor, as well as medications to forget her pain. And finally, for urban women the traditional women’s support network was often no longer available. With the
increasing mobility of American society, many women did not have female relatives and friends living near them to assist once they went into labor, yet they still needed help. The hospital seemed like the perfect place to get such assistance. In fact, as some women explained, a hospital birth provided new mothers welcome respite from busy home lives with older children and husbands demanding attention. Lillian Gilbreth, engineer, industrial psychologist, and mother of twelve, had her first eleven babies at home but chose to have number twelve in the hospital, which she found to be “marvelous”: “I would have to wait until my dozenth baby was born to find out how much better it is to have them in a hospital. The nurses here wait on me hand and foot. You don’t know what a comfort it is to have your baby in the hospital.”

Yet, many women giving birth in hospitals felt isolated—“alone among strangers,” as one patient explained. Even more important, hospital births were actually, more often than not, more dangerous than home births because new mothers were exposed to other patients’ germs, and because of the aggressively interventionist approach physicians practiced. In fact, maternal mortality rates actually increased from sixty-one deaths per 10,000 live births in 1915 to seventy in 1929, during the exact time that many women first chose to give birth in the hospital. As historian of childbirth Judith Walzer Leavitt has argued, although a direct connection between the increases in hospital births and maternal mortality cannot be drawn statistically with available information, it is suggestive that both increases occurred simultaneously. Indeed, three landmark studies of maternal mortality published in the early 1930s noted the connection as well.

Joseph B. DeLee, a preeminent early-twentieth-century obstetrician, even concluded that “home delivery, even under the poorest conditions, is safer than hospital delivery.” At home, an expectant mother exposed herself and her fetus to germs every day, so her immune system built up natural defenses against the germs by the time she delivered her baby. However, new germs entered a hospital all the time, and there was no way to prevent completely the transmission of these germs, even under the best circumstances. Without natural defenses against the new germs, mother and baby were in danger of developing an infection.

Many obstetricians in the 1920s and 1930s agreed with DeLee that hospital births presented serious dangers to women’s lives, often blaming their own profession for the deaths by citing excessive use of drugs and instruments in physician-managed hospital births. These obstetricians—along with several important groups studying infant and maternal
mortality—denounced the practice of “meddlesome obstetrics,” whereby physicians too often used the invasive procedures of forceps, version (turning the fetus within the uterus to bring it into a favorable position for delivery), and Caesarean section, as well as drugs such as pituitrin, a uterine-stimulating drug that sometimes sent mothers into shock and/or ruptured their uteri, and the popular combination of scopolamine and morphine, which produced a semi-narcotic and amnesiac effect known as “twilight sleep” (described by Sister Theophane at the beginning of this chapter).32 While these techniques did not cause a crisis in the majority of cases, such interventions sometimes led to disaster.

Despite these problems, over one-third of all American births took place in hospitals by 1935. The rate was 65 percent for white urban women, and 88 percent for white urban women with family incomes of $2,000 or more (in other words, middle-class families).33 For those who could afford it, the ideal birth was one that was physician-directed and hospital-based.

The “Midwife Problem”: The Birth of the Nurse-Midwife and a Lost Opportunity

So where did the nurse-midwife fit into childbirth trends? To answer that question, it is necessary to understand how health and social-welfare professionals came to view the traditional midwife. At the same time that more births were attended by physicians and in hospitals, several groups, including social reformers, physicians, nurses, and public-health officials, claimed that the United States had a “midwife problem.” Interest in the traditional midwife intensified around 1910 as mortality statistics showed American maternal and infant death rates to be substantially higher than those of most European countries.34 Physicians and public-health officials tried to determine why these rates were so high, and what role the midwife might have played in creating them. They incorrectly argued that midwives were the cause of the problem.

The traditional midwife was an easy target. Typically, these women were African Americans or immigrants. During an era of anti-immigration sentiment and legalized racial segregation and discrimination, people who were not white and native-born were at the bottom of the social hierarchy. While midwives attracted birthing women because of
their shared race, ethnicity, and language, those same qualities made white professionals deeply suspicious of them. Midwives' birthing practices and general lack of formal training also made them the targets of physicians and social reformers. Early twentieth-century health professionals commented frequently that midwives were ignorant and superstitious. Anna Rude, physician and director of the U.S. Children's Bureau's Division of Maternal and Infant Hygiene, reported that midwives “retain[ed] most of the practices, traditions and superstitions that have been transmitted for generations” among African Americans and the foreign-born. She condemned immigrant midwives for high rates of tetanus among newborns, “undoubtedly due to dirty cord dressings,” and decried African-American midwives’ use of raw pork pacifiers for newborns because of their supposed laxative effect, “supplemented at frequent intervals by curious and oftentimes obnoxious concoctions known as ‘teas.’”

Concerns about medical professionalization played a role in debates over midwives. General practitioners cared for most American women not attended by midwives, while obstetricians attended the births of very few urban women. At this time, obstetrics, with weak training programs and low status, was not a popular specialty for physicians. Obstetricians worked to convince fellow physicians and the public that midwives had set back their field by decades. Noting that midwives were often foreign-born or African American, obstetricians described them as dirty, backward, unprofessional, and female. Many obstetricians conceded that the general practitioner often caused as much damage as the midwife, but they used the general practitioners’ poor record to justify further why midwives should be eliminated. According to this line of thinking, midwives stood outside the legitimate medical hierarchy, degraded the profession of obstetrics, and discouraged potentially good practitioners from going into the field. General practitioners could be taught to refer complicated cases to obstetricians, and with the elimination of the financial and professional threat posed by midwives, obstetricians could increase their caseload and therefore the clinical material available to train better future physicians.

Obstetricians’ discussion of the “midwife problem” coincided with demands by lay women for better obstetrics. A significant decrease in immigration occurred in the 1920s, which lowered the number of ethnic midwives attending births in immigrant communities. A decreasing birthrate, with an accompanying emphasis on the now fewer deliveries, further compounded the issue. As a result, the use of midwives rapidly declined in the 1910s and 1920s. In Washington, D.C., midwives attended 50 percent of births in 1903, but only 15 percent in 1912; in New York
City, midwives delivered 30 percent of the babies in 1919, but only 12 percent in 1929. Decrease in midwife use was part of a social trend, begun in northeastern cities and eventually spreading to the rest of the United States.

Even popular literature eventually enshrined the idea that obstetricians were a better choice over midwives. In *A Tree Grows in Brooklyn*, a popular novel about immigrants in the early twentieth century, Sissy has ten still-born babies, all delivered with midwives. In her eleventh pregnancy, when her husband “insisted on the doctor and the hospital,” “her mother and sisters were stunned. No Rommely woman had had a doctor at childbirth, ever. It didn’t seem right. You called in a midwife, a neighbor woman, or your mother, and you got through the business secretively and behind closed doors and kept the men out. Babies were women’s business. As for hospitals, everyone knew you went there only to die.” But Sissy stands her ground, insisting that her mother and sisters “were way behind the times; that midwives were things of the past.” When Sissy pushes out her eleventh baby at the hospital, “she closed her eyes tightly [because] [s]he was afraid to look at it.” Once again, Sissy fears that her child has died because the baby is blue and does not move. In anger, she questions God: “‘Oh, God, why couldn’t You let me have one? Just one out of the eleven? . . . Oh, God, why have You put Your curse on me?’” But then she watched her obstetrician use his magic—the latest science—to make the baby come to life. He gave the baby oxygen, and Aunt Sissy “saw the dead blue change to living white. . . . For the first time she heard the cry of a child she had borne.” She names her baby boy after the obstetrician who saved his life.

Despite the fact that Betty Smith’s fictional character Sissy reflected a growing trend among women to turn away from midwives, and despite obstetricians’ prejudices, midwives were only a small part of the problem. Many factors contributed to high rates of morbidity and mortality for mothers and babies. First, midwives, general practitioners, and obstetricians all needed better training. As medical education reformer Abraham Flexner explained in his famous report (later known as the Flexner Report) for the Carnegie Foundation in 1910, most medical schools had extraordinarily low standards or even no standards at all. They did not require their students to have a college, or for that matter high school, education prior to admission, and they offered little in the way of laboratory or clinical instruction. Flexner also warned that training in obstetrics was particularly abysmal. Second, as noted earlier, physicians intervened too quickly and too frequently in the birthing process—often with disastrous results. Third, hospitals contributed to rising rates of infection for new mothers.
Finally, lack of prenatal care contributed to poor outcomes. Although public-health officials, social workers, and some pediatricians agreed with obstetricians that midwives provided poor obstetrical care, many argued that eliminating midwifery would not solve the problem. These professionals claimed that general practitioners and obstetricians needed better training. But given that a cadre of adequately trained physicians would take years to produce, the complete abolition of midwifery would be impractical if not impossible. In addition, as director of the New York City Bureau of Child Hygiene S. Josephine Baker argued in the 1910s and 1920s, many immigrant and African-American women preferred traditional midwives and could not afford the care of a physician. The solution to the “midwife problem,” then, was not to eliminate midwives but rather to train, license, and regulate them.

Supporters of the regulated, trained midwife pointed to the successes of the few American cities and states with comprehensive training and regulatory programs for their midwives. New York City and New Jersey, for example, had sponsored lectures, conferences, and other educational programs for their midwives, and had experienced corresponding reductions in maternal and infant mortality rates. In 1911, for example, New York City opened the Bellevue Hospital School for Midwives, the first municipally sponsored American midwifery school, and one with much higher standards than nonacademic, for-profit proprietary schools. At first six months long, the course eventually expanded to eight months, with instruction by physicians and nurses in prenatal and postnatal care, procedures for normal labors and deliveries, feeding and care of infants, and the “housewifely duties” to be performed by the midwife. Mostly Italian, German, Polish, and Hungarian immigrants, students were required to witness or assist at least eighty deliveries, deliver at least twenty babies, and pass oral and written examinations, administered by a visiting obstetrician, at the end of the course. Maternal and infant mortality rates for births attended by Bellevue-trained midwives were dramatically lower than the rates for births in New York City as a whole.

A few physicians, nurses, and public-health advocates believed that a special type of trained, regulated midwife could solve the “midwife problem.” These participants in the midwife debate invented a new type of birth attendant, the nurse-midwife. The first call for American nurse-midwives came from two leading public-health nurses, Lillian Wald and Carolyn Conant van Blarcom, who issued a proposal for “the nursing profession to extend its usefulness by including training for practice in midwifery for normal cases” at the second annual meeting of the American
Association for the Study and Prevention of Infant Mortality in 1911. The proposal generated controversy and was tabled after three months of debate. In her Russell Sage Foundation–funded study of midwives in the United States, fifteen European countries, and Australia, van Blarcom concluded that the United States was “the only civilized country” that did not train, license, and regulate its midwives sufficiently. In particular, she compared the United States to Britain, finding that while most American states allowed midwives to practice without restriction or regulation, the British required midwifery education, registration, licensure, practice, and supervision—with excellent results.

Around the same time Wald and van Blarcom made their proposal, Clara Noyes, another nursing leader and superintendent of the nursing school at Bellvue Hospital (the same hospital that had opened a school for midwives), argued publicly that public-health nurses should be educated as midwives because they would be better equipped to do their nursing jobs. Like van Blarcom, she looked to Britain, noting that the British nurse automatically received midwifery training as part of her general education, thus “enhance[ing] her value to the community and increas[ing] her prestige.” Noyes continued:

Someone has suggested that she [the nurse trained as a midwife] will encroach upon the territory of the obstetrician. Not at all, her superior training will enable her to distinguish abnormalities and serious symptoms far more quickly than does the partially trained midwife. It has been proven in England that far more calls are made upon the physician and greater discrimination shown in the selection of physician since the nurses have practiced midwifery than ever before, while the number referred to maternity hospitals and wards has increased very markedly.

Noyes argued that the nurse with “advanced obstetrical training” could solve the American “midwife problem.” She explained, “If the midwife can gradually be replaced by the nurse who has, upon her general training super-imposed a course in practical midwifery, which has been clearly defined by obstetricians, it would seem a logical economic solution to the problem. . . . We should be able to provide better teaching, better nursing and eventually better medical assistance to the less highly favored classes.”

While public-health nurses like Noyes called for nurses trained in midwifery, the term “nurse-midwife” was first introduced into the American
vocabulary in 1914 by a St. Louis physician, Frederick J. Taussig, in a paper presented to the National Organization for Public Health Nursing. He suggested that the nurse-midwife could be a qualified nurse with obstetrical training who would attend normal births. Taussig argued that “the nurse-midwife will . . . prove to be the most sympathetic, the most economical, and the most efficient agent in the case of normal confinements.” According to these proponents of the trained, regulated midwife, nurse-midwifery would resolve the problem of ignorant, unsupervised, unlicensed, and untrained midwives.

Although American public-health nurses and physicians introduced the idea of the nurse-midwife in the 1910s, no attempts to put nurse-midwifery into practice were made until 1923. During that year, obstetrician Ralph Lobenstine at the Maternity Center Association (MCA) in New York City made one attempt, but it was derailed after the city’s Commissioner of Welfare, along with many leading obstetricians and nurses, refused to lend their support. Two years later, a New York City hospital specializing in maternity care, the Manhattan Maternity and Dispensary, managed to open successfully the Manhattan Midwifery School, the nation’s first school to educate graduate nurses in midwifery. This school existed for six years and graduated at least eighteen students before closing due to a lack of patients to accommodate the training of both nurse-midwifery and medical students. Very little is known about this pioneering school.

In 1931, the year the Manhattan Midwifery School closed and nine years after MCA’s first attempt to establish a school, MCA finally began its program—the nation’s second—to educate nurse-midwives. Students came to the school as registered nurses and graduated as nurse-midwives ten months later, after receiving instruction and clinical experience in midwifery. Public-health nurse Mary Breckinridge made a third attempt to begin the practice of nurse-midwifery in the United States, modeling her proposal on midwifery in Britain, where she had received training in both nursing and midwifery. With support from obstetricians, nurses, and social reformers, Breckinridge opened the first American nurse-midwifery service, Frontier Nursing Service (FNS), in the Appalachian mountains of eastern Kentucky in 1925.

In many ways, FNS and MCA faced different challenges. FNS was located in an isolated, rural area where few physicians wanted to practice, and served white, native-born, Appalachian patients, while MCA was located in the largest urban center in America and therefore had the advantages and disadvantages of proximity to physicians. While FNS
cared for native-born women, MCA served African-American and Puerto Rican immigrant patients—patients on the margins of American society. (Actually, both sets of patients were on the margins of society, but Breckinridge claimed that unlike people from racial and ethnic minorities, FNS patients were the “worthy poor” who deserved help.) However, leaders at both FNS and MCA faced one similar roadblock: antagonism, and their anticipation of antagonism, by the medical establishment. Thus, both institutions conceived of the profession as one in which nurse-midwives would attend only women who were not otherwise served by physicians. The role of nurse-midwives was, in other words, limited from the very beginning.

Lessons from Western Europe

The nurse-midwife’s role did not have to be so limited. In Western Europe, well-educated midwives, including nurse-midwives, played greater roles and produced excellent results. Today, the international comparison is useful for American historians, health professionals, and public-policy makers trying to understand how and why American nurse-midwifery developed in such a circumscribed role.

In the early twentieth century, all Western nations saw childbirth, maternal and infant mortality, and midwives as key issues of concern. The general trend in Western childbirth was medicalization, but the move from home to hospital, and from midwives and general practitioners to obstetricians, occurred at different rates in different places. In the United States in the 1930s, the debate over the midwife’s place in childbirth seemed to be over. The American medical establishment had severely curtailed the midwife’s role; middle-class women increasingly sought out physicians and especially obstetricians—and where middle-class women went, lower-class women followed; and the new nurse-midwife only practiced in a few areas. However, in this same decade, most other Western nations assumed that midwives would continue to have an important place in childbirth. These nations focused on expanding the midwife’s education and redefining her responsibilities. Thus, while Europeans regulated midwives, Americans tried to eliminate them. European physicians were less defensive about their professional status than American doctors and therefore had less need to push other health practitioners to the margins. European governments had long regulated physicians’ education, and this education was
generally superior to that of American physicians. European physicians did not need to try to eliminate midwives, pharmacists, and other perceived competition to strengthen their position. In addition, almost all of the European nations were far more successful than the United States in decreasing maternal mortality. While the United States had high rates of maternal mortality, the Netherlands and the Scandinavian countries, for example, had low rates, with the much-praised Britain in the middle.

In terms of midwifery, the Netherlands was, and still is, at the opposite end of the spectrum from the United States; the Dutch have held trained midwives in high esteem for a long time. The Dutch government began regulating midwives in the early nineteenth century, although training for midwives dated back to the late seventeenth century. Since the Medical Act of 1865, Dutch midwives have been able to practice independently with normal cases of pregnancy and childbirth. Early twentieth-century Dutch midwifery schools were very competitive, offering a three-year course, in which students witnessed on average 1800 deliveries and attended home deliveries under supervision during their third year. After deliveries, Dutch midwives turned postpartum nursing duties over to trained nursing assistants. These midwives enjoyed a status somewhere in-between nurses and physicians. Today, the Netherlands is known for the independence of its midwives (who attended 33.9 percent of all births in 2000, and approximately half of all births when counting those completed in cooperation with a gynecologist) and its high percentage of home births (30.3 percent of all births in 2000). These midwives operate within a health-care system that guarantees health insurance to all of its citizens.

Scandinavian countries provide more examples of well-trained, well-regarded midwives in the early twentieth century—and today. Renowned New York obstetrician and advocate of nurse-midwifery George W. Kosmak argued in 1927 that Americans could learn from the good work of Scandinavian midwives, after meeting some on a trip with the American Gynecological Club. “In the[ir] training schools for midwives,” he found “bright, healthy looking, intelligent young women of the type from whom our best class of trained nurses would be recruited in this country, . . . whose profession is recognized by medical men as an important factor in the art of obstetrics, with which they have no quarrel.” Scandinavian midwifery schools provided their students with extensive, thorough training, and the results, Kosmak said, “are evidently excellent because the mortality rates of these countries are remarkably low and likewise the morbidity following childbirth.” Scandinavian countries’ strong public-health systems also contributed and continue to contribute to their low maternal and
infant mortality rates—and to their long history of a desire to create an excellent cadre of midwives to serve all classes of women.

The Danish model provides an interesting example of this phenomenon. In Denmark, trained midwives had existed since the early 1700s, when the government passed a law decreeing that midwives receive instruction from a physician, do an apprenticeship with an experienced midwife, and pass an examination from a Board of Midwifery. Despite the legislation, midwives, who attended most Danish births, did not enjoy high status. In the late nineteenth and early twentieth centuries, Danish physicians and midwives initiated a campaign to modernize the midwife—in other words, to make her use antiseptic procedures to prevent puerperal fever. They raised the status of the midwife by improving wages, encouraging a better class of women to apply to midwifery schools, extending the length of study, creating a more challenging curriculum, and pushing midwives to trade folk healing for science. By the early 1900s, the Danish midwife was well educated and highly regarded. By 1914, in a midwifery act, the medical establishment went on record saying that physicians did not want to attend normal births. Through the 1920s, midwives attended the births of women from all classes. In the 1930s, when women’s demand for analgesics increased physician attendance at normal births, midwives and physicians jointly attended many births. For decades thereafter, the two types of health-care practitioners came together into the laboring woman’s home, where the midwife generally guided the birth while the physician sat off to the side and intervened only if necessary. Today Danish midwives attend nearly all normal births.

In Sweden, the government and medical profession had controlled the training and regulation of midwives since the seventeenth century. By the early twentieth century, Swedish midwives received two years of instruction, delivered 100 to 125 babies under supervision, and worked for a month on probation before receiving final approval to become midwives. Once trained, they had a great deal of autonomy, as well as the ability to use instruments if physicians were not available. Swedish midwives today provide 80 percent of prenatal care, attend all normal births in public hospitals, and manage labors but not deliveries in private hospitals.

While the efficacy of Scandinavian models was widely admired, early-twentieth-century American public-health leaders frequently cited and praised British midwifery. American nurses van Blarcom, Noyes, and Breckinridge, as well as Mary Beard, another public-health nursing leader, all looked to Britain for a model. In Britain, unlike in the previously mentioned countries, midwifery became a part of nursing. In 1924, the Rockefeller
Foundation invited Beard to study “maternity care in England, with special reference to the relations of midwifery to nursing.” Based on this study, Beard promoted the nurse-midwife as the answer to the nation’s “midwife problem,” and eventually convinced the Rockefeller Foundation to provide money for tuition and living expenses for twelve of the first twenty-five nurse-midwifery students at the MCA Lobenstine Midwifery School.

In fact, although early-twentieth-century British midwives held higher status and encountered less opposition from physicians than their American counterparts, Britain lagged behind continental Europe in the training, regulation, and, therefore, status of its midwives. Unlike its continental neighbors, the British government was less involved in public health care. Additionally, because the British were more devoted to the principle of laissez faire, they were less likely to support professional regulation. As a result, British obstetrics was less prestigious, and general practitioners and obstetricians feared competition from midwives.

The Midwives Act of 1902 changed the situation of the British midwife. That act created the Central Midwives Board, which examined and supervised midwives and established a roll of midwives. While the act prohibited practice by uncertified midwives, it continued, for practical reasons, to certify untrained midwives (called “bona fides” because they were certified “by virtue of bona fide practice”), although their numbers declined steeply after the passage of the act. For the new kind of midwives who took and passed an examination from the Central Midwives Board, the act required three months of training; later this was lengthened to two years, and, eventually, as developers of the act had hoped, most certified midwives were also trained nurses. The board required midwives to call physicians in difficult, dangerous cases.

In another important piece of legislation, the Midwives Act of 1936, British midwives received more status and recognition. This new act required local health authorities to provide a salaried midwife service to meet the needs of local communities, mandated that certified midwives be provided free or at reduced cost, and said that certified midwives would be employed as maternity nurses in situations when general practitioners directed deliveries. Developers of the act specifically wanted to raise midwifery’s status, and many would say they succeeded. By the 1930s, British midwives attended approximately 60 percent of births, compared with 50 percent in 1909. In Britain today, midwives attend 70 to 80 percent of normal births.

Just as Americans created a circumscribed role for their nurse-midwives, Europeans encouraged the creation of a large group of well-
trained, well-regulated midwives, offered—and in some cases guaranteed—maternal health care to their citizens, and had relatively low maternal mortality rates. The United States had none of this. Instead it had a weak, fragmented public-health system, a lack of commitment to providing health care for all of its citizens, physicians engaged in turf wars, traditional midwives dying out, and a small group of nurse-midwives providing care for a few poor women outside the purview of most Americans.

Independent Women

Although American nurse-midwives were intended to serve as a stopgap only until physicians could attend the births of all women, the women who became nurse-midwives saw an opportunity in this new occupational sector. Nurse-midwifery gave its practitioners a power that many of their contemporaries did not have. These women controlled only a small space—and even then they never had full control over it—but still the women who became nurse-midwives enjoyed a kind of independence and power unusual for their era.

This new occupation came at an opportune moment; increasing numbers of women from educated backgrounds were choosing to enter the workforce in the 1920s. This era saw the full-blown emergence of what came to be known as the “New Woman.” No longer content to be bound to the home, the “New Woman” spoke her mind, joined organizations, and worked in the public eye as a secretary, salesclerk, teacher, librarian, social worker, or nurse. Many of these women became involved in government programs and social reform efforts directed toward women and children (such as the U.S. Children’s Bureau and the Sheppard-Towner Act).

Even when they remained within the home, so-called modern women professionalized homemaking and motherhood. This period also witnessed the development of both “scientific motherhood,” the belief that women needed expert advice to raise their children in a healthy way, and maternalism, the argument that women’s unique capacity for motherhood united all women, regardless of race, religion, or class. Under this model, all women were responsible for caring for all children, and since mothers produced the state’s citizens, they deserved the government’s help.  

Nurse-midwifery was part of the larger trend of expanding job options for women and of increasing numbers of women working with needy women and children. But because of the isolated, marginalized nature of
the profession, nurse-midwives had more autonomy than the salesclerk, secretary, teacher, or social worker. In addition, although nurse-midwifery was a female occupation like the others, it remained an odd choice for a woman to make in the 1920s or 1930s, and even later. In those early years, becoming a nurse-midwife generally meant leaving one's family for one's job. Nurse-midwifery then was akin to joining the Peace Corps today, offering excitement, adventure, and independence to the idealistic and dedicated.

It is unlikely that the women who chose nurse-midwifery in the 1920s and 1930s would have opted for medicine instead. The medical profession at that time was changing and contracting, and women physicians, in particular, declined in numbers. Several factors discouraged women from applying to medical school. In the wake of the Flexner Report, many medical schools, including nearly all women's medical schools, closed, and the remaining schools required more time and money of their students than they had previously. This era also saw the decline of the general practitioner and the ascent of the hospital-based specialist who spent less time on direct patient care. While some women physicians pursued careers as specialists, many remained committed to more traditional ideals of what historian Ellen S. More calls “medical benevolence.” Further compounding this was the fact that women in hospital medicine often faced discrimination. While medicine offered fewer opportunities for women, nurse-midwifery gave women a chance to pursue a relatively autonomous profession with the safety of a more traditionally female role involving nurturing and direct patient care.

Given the nature of the job, it is not surprising that many women who became nurse-midwives, both leaders and rank-and-file, were single and devoted their lives to the fields of maternal and child health. Early leaders of Frontier Nursing Service and Maternity Center Association embodied these trends. FNS founder Mary Breckinridge dedicated her life to improving the health of women and children after the deaths of her own two young children and divorce from her husband. MCA general director from 1923 to 1965, Hazel Corbin planned to become an Army nurse during World War I, and instead became involved with the precursor to MCA, beginning her lifelong commitment to maternal and infant care, public health, and nurse-midwifery. Rose McNaught, who worked at FNS in the 1920s and then at MCA starting in 1931 as supervisor of the new Lobenstine Nurse-Midwifery Clinic and teacher at the new Lobenstine School, remembered making a conscious decision not to marry: “I had no wonderful chances, but I could have married. . . . Yeah, I had a couple of
chances, but I couldn’t see it myself. I wanted to go around and see the world. . . . I saw a pretty good part of the world in my day and that’s what I enjoyed. I couldn’t be bothered to get married and [rear] children.”

Nurse-midwifery presented special potential conflicts for married women. Because so few nurse-midwifery schools existed, student nurse-midwives usually had to attend school far from home. Following graduation, many nurse-midwives moved to isolated regions, such as Indian reservations in the West or rural areas in the South, where they supervised traditional midwives or public-health nurses. These jobs were impossible for most married women.

Women who chose nurse-midwifery were able to make this choice for other reasons. Most were white and native-born (like most other kinds of nurses), many were from the middle and upper classes, and many were well educated, often receiving college degrees (usually in nursing) prior to entering nurse-midwifery school. These women generally had familial and financial backing that allowed them to pursue their passion.

In the interwar years and even much later, many of these women took a missionary approach to their jobs. Although, as chapter 5 explains, missionary nuns founded one important nurse-midwifery service and school during World War II, most nurse-midwives were not necessarily missionaries per se. They wanted to serve those in need, and devoted their lives, or a portion of their lives, to the cause of maternal and infant health. For these women, nurse-midwifery was not just a job; it was their mission. MCA reported that its graduates traversed the globe preaching the MCA way of maternal and infant health. In Iran, one MCA alumna worked to change beliefs that nurses and midwives did not need education. In Korea, another MCA graduate on a Presbyterian mission reported setting up a midwifery course for graduate nurses, and trying to raise obstetric nursing education to a higher level. In Mexico, an MCA-trained nurse-midwife tried to teach new mothers to abandon harmful superstitions, such as waiting forty days after the birth before washing their hands. These nurse-midwives believed in the “universal applicability of the [MCA] philosophy, methods, and attitudes.” Many FNS nurse-midwives also had a missionary zeal. A former FNS nurse-midwife recalled that before the existence of such organizations as Peace Corps or VISTA, “FNS was one of the few places adventuresome young women could find creative, idealistic jobs other than with missionaries.”

Many women liked the challenge and adventure involved in nurse-midwifery. While the traditional image of the nurse centered on the white, starched uniform and an unwillingness to improvise, the public-health
nurse and nurse-midwife was “rough and ready,” making do whenever necessary. Helen Browne explained that the “challenge of the rural area” brought many women to FNS, located in the Appalachian Mountains. When FNS nurse-midwives switched from riding horseback to driving jeeps in the 1940s, Browne and other FNS staff feared the work might lose “its glamour,” but found “it was still rural enough that it made a challenge.”

By the late 1930s and early 1940s, many of the women who attended nurse-midwifery school sought something beyond what their regular nursing education provided them. They had experience in maternity nursing, but wanted a different and fuller knowledge of the maternity cycle, as well as more autonomy and responsibility in caring for their patients. Although it is sometimes difficult to determine whether nurse-midwifery attracted women for these reasons or whether they liked these aspects of nurse-midwifery in hindsight, at least some women clearly went to nurse-midwifery school because of the possibilities for greater knowledge, responsibility, and independence. These women enjoyed taking responsibility for every aspect of pregnancy, labor and delivery, and postpartum care. They also wanted to be able to handle deliveries by themselves when necessary. According to a group of six MCA alumnae, nurse-midwifery school filled gaps in their maternity nursing education; these gaps had left them feeling unprepared to attend births without a physician, something they had all faced.

The quality of independence, fostered by their nurse-midwifery education, was both an advantage and disadvantage for nurse-midwives struggling to gain recognition for their new profession. On the plus side, their independence helped them succeed in challenging jobs in places off the beaten path, geographically and/or medically. Also, the profession’s independence provided them with something they wanted—authority over their daily work lives. But as independent nurses, midwives, and women, they ruffled the feathers of both physicians and nurses, who sought to keep them in their place. They upset the status quo of the American medical establishment—and of the larger culture. That is why, despite the great potential of nurse-midwives to transform American maternity care, they were forced into a limited role.

_Nurse-Midwifery_ is the first book-length study to document the emergence of nurse-midwifery in the United States. By documenting the education, training, practice, and professional development of nurse-midwives, this book shows the professional tightrope that they and their nursing and medical allies walked because of the opposition of the medical
and nursing establishments. It reveals the limitations that nurses, physicians, and nurse-midwives placed on the profession of nurse-midwifery at the outset because of the professional interests of nursing and medicine. My book argues that nurse-midwives challenged the “male medical model” of childbirth, but the cost of the compromises they made to survive was that nurse-midwifery did not become the kind of independent, autonomous profession it might have been.  

Several works on midwifery and women’s health explore the creation of the nurse-midwife, but few sources have placed nurse-midwifery in a larger social and historical context and only Frontier Nursing Service has been analyzed in any detail. In an excellent article on FNS, Nancy Schrom Dye analyzed the struggles Mary Breckinridge faced as she tried to establish her pioneering organization, and Dye argued that despite the service’s successes, nurse-midwifery was seen as irrelevant as “operative intervention, hospitalization, and universal medical management became the hallmarks of American birth management during the 1920s and 1930s.” My work on FNS builds upon Dye’s by explaining in greater depth the nurse-midwives’ approach to birth and health, the reactions of the local people, and the romantic imagery Breckinridge and her friends used to gain support for FNS. In addition, I contribute an original interpretation of FNS through a focus on eugenics, race, and nativism and by placing FNS in the broader context of other nurse-midwifery organizations.

This book also adds to a growing literature on the development of nursing and the complex roles women have played in the medical profession. Analyzing the history of women in medicine, Regina Morantz-Sanchez and Ellen S. More have shown that women physicians experienced many conflicts: between their commitment to “sympathy” and “science,” between their interests in home, work, and community, and between their desires to advance their careers and the barriers they faced in educational and professional settings. Unlike women physicians, nurse-midwives were in a female profession, and did not experience the same conflict between their professional values and their lives as women. However, like women physicians, they encountered barriers to advancement from a medical profession that simultaneously looked down on and was threatened by them. Morantz-Sanchez and More also explain that women physicians tried to resolve their multiple, and seemingly competing, interests by using holistic methods of care despite contemporary medical trends, and by entering specialties seen as feminine, such as obstetrics, gynecology, and pediatrics, as well as public health. Nurse-midwives,
already in a feminine specialty, bucked nursing trends and emphasized the importance of looking at all aspects of their patients’ lives—social, psychological, and physiological. Along with these other historians, my book argues that many women in the health professions have focused on looking at a patient as a whole person, rather than simply an individual diseased part.\footnote{Susan M. Reverby and Barbara Melosh have shown that nurses historically have disagreed about what constituted “good” nursing, the education necessary to become a “good” nurse, and reasonable work conditions, arguing with one another as they faced “patriarchal constraints imposed from above by hospitals, physicians, and the broader culture.”}

I found that nurse-midwives, like nurses in general, faced both internal and external conflicts, even as they had more in common than nurses as a whole did. Other historians, like Darlene Clark Hine and Karen Buhler-Wilkerson, have examined specific groups of nurses.\footnote{Hine explored the issue of race and American nursing, showing how black nurses, denied access to all-white training schools, hospitals, and nursing organizations, fought to become trained nurses, even though their numbers were limited. In chapter 5, I augment Hine’s work by analyzing the development of two schools of nurse-midwifery for African American women. While the number of African American nurse-midwives was very small (and thus my discussion of them short), their story is important and complicates our understanding of nurse-midwifery. Race and ethnicity are important themes in this book. Mary Breckinridge, founder of the Frontier Nursing Service, used her racism, and that of her potential supporters, to raise money for FNS, which served mostly white women and families. The other four early schools of nurse-midwifery (not counting the Manhattan Midwifery School about which little is known) trained nurses to supervise and ultimately replace traditional African American and Latina midwives; these nurse-midwives had varying degrees of sensitivity to the women with whom they worked and their traditions.}

Buhler-Wilkerson demonstrates that public-health nurses had a central place in the American health-care system at the turn of the twentieth century, but that this role diminished in the 1920s as infectious disease declined and as more patients sought hospital, rather than home-based care. My book expands our understanding of public-health nursing by studying one group of public-health nurses (since nurse-midwifery began within the context of public-health nursing). And a major goal of this book, like Buhler-Wilkerson’s, is to analyze “why a movement that might have become a significant vehicle for delivering comprehensive health care
Chapter 1

[or in nurse-midwives’ case, maternal health care] to the American public failed to reach its potential.” As I indicated earlier, the United States was unique; while professional midwives in many other countries played a central role in twentieth-century maternal health care, they did not do so in the United States. This book examines and explains how that happened.

This book is organized both chronologically and topically. Part I, “Early Labor Pains, 1925–1940,” explores the creation and development of America’s first long-standing nurse-midwifery services and schools, Frontier Nursing Service in eastern Kentucky and Maternity Center Association in Harlem, as well as the compromises these organizations had to make to avoid criticism and craft a place for nurse-midwives. Chapter 2 focuses on FNS, where Mary Breckinridge carefully constructed her nurse-midwives as exotic frontierswomen, riding horses to save native-born white babies in the Appalachian Mountains. She used the then-popular language of eugenics to gain acceptance and funding for her radical-seeming nurse-midwifery service. Chapter 3 focuses on MCA, whose leaders slowly convinced New York City’s physicians that nurse-midwives were not their competitors. MCA nurse-midwives received more supervision from physicians than their FNS counterparts did, and they worked with a minority clientele whom physicians had no interest in serving. Chapters 2 and 3 also analyze FNS and MCA nurse-midwives’ approach to birth, and conclude that they offered their patients something different from many obstetricians, general practitioners, and traditional midwives. They attended their patients at home, providing frequent prenatal care, good care in labor and delivery, with few unnecessary interventions, and close contact with mothers and newborns after birth. In spite of serving low-income people, many of whom had poor nutrition and housing, early nurse-midwives lost astoundingly few mothers at a time when maternal mortality was high.

Part II, “Active Labor, 1940–1960,” analyzes nurse-midwifery as it expanded in new directions and faced new challenges as the fledgling profession sought to become more mainstream. Chapter 4 explains that many nurse-midwives began working in hospitals because that was where the majority of births were taking place. Some established nurse-midwifery services at major medical centers like Columbia, Johns Hopkins, Yale, and Downstate Medical Center, State University of New York; nurse-midwives at these elite institutions provided prenatal and postnatal care, managed labor and delivery, and took part in demonstrations of the new “natural childbirth” method. Most nurse-midwives, however, were unable to find work in their profession, so they served as more subordinate mater-
nity nurses and maternity nursing supervisors in hospitals. When compared with counterparts who attended home births, hospital nurse-midwives were not on the margins. But they lost autonomy as they became part of the male-dominated, physician-dominated hospital hierarchy. Chapter 5 follows the nurse-midwives who continued to attend home births in the World War II and post-war era, with a focus on Santa Fe's Catholic Maternity Institute. In an age of increasing hospitalization and medical technology, these nurse-midwives bucked the national birthing trends more than ever. They show that medicalization of childbirth did not go unchallenged. Chapter 6 discusses nurse-midwives' arguments among themselves over how to deal with misunderstandings about and intense opposition to their work. Ultimately, they chose to accommodate physicians. This strategic choice made sense given the way nurse-midwifery developed and the opposition that its practitioners faced. Nonetheless, accommodation created limitations on individual careers as well as setting up unintended roadblocks for the future of nurse-midwifery as a profession.

The epilogue brings nurse-midwifery up to the present. Since the 1970s, the profession has grown significantly under the influence of the women's health and consumer movements and sky-rocketing health-care costs. But today the profession still is both misunderstood and ignored; nurse-midwives continue to face opposition from some physicians and hospital administrators, and they continue to be underutilized. The book ends by explaining the strengths that nurse-midwives have as they labor to improve the health care of American women and babies, and the barriers they face as they try to do so.