Nurse-Midwifery

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Introduction

Born in 1893 in Holyoke, Massachusetts, Rose McNaught, known as “Rosie,” came from a family that immigrated to the United States just after the Revolutionary War.1 Her father was superintendent in a paper mill, and her mother stayed at home to raise McNaught and her four siblings. McNaught actively chose not to marry and have children because she wanted to travel and be a professional woman. When picking a career, she, like other girls of her race and class, had few real options. She attended normal school and prepared for teaching, and even taught primary grades for a few years due to family pressure, but ultimately she realized she did not want to teach. So, during World War I when recruiters came to her hometown from the Army School of Nursing in Washington, D.C., McNaught jumped at the chance to change her life. She began her nursing training at Camp Devens in Massachusetts and finished it at the Army School of Nursing at Walter Reed Hospital in Washington, D.C. After completing her nursing degree, she returned to Holyoke to work as head nurse at the obstetrics department in the local hospital. In 1922, McNaught pursued her interest in public-health nursing, finding employment as a nurse and supervisor at the Henry Street Settlement House in New York City. While at Henry Street, she learned about nurse-midwifery—through both a lecture by Maternity Center Association’s Hazel Corbin and exposure to two Frontier Nursing Service (FNS) nurse-
midwives who had done field work at Henry Street while getting master’s degrees at Columbia University. Further shaping her decision had been the frustration she experienced as a Henry Street nurse while attending births—a field in which she had no training.

These experiences led McNaught to FNS and Kentucky. She worked there for a year as a staff nurse, and then, in September 1928, FNS sent her on scholarship to the midwifery program at York Road General Lying-In Hospital shortly after Betty Lester had finished her midwifery training there.² After passing the British midwifery examinations, McNaught

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FIGURE 5. Maternity Center Association’s Lohenstine School of Midwifery instructor Rose McNaught teaches student nurse-midwife Margaret Thomas how to take a patient’s blood pressure, late 1930s. From the personal collection of Helen Varney Burst, CNM; originally from the Maternity Center Association.
returned to Kentucky, working as a nurse-midwife until fall 1931, when FNS founder and head Mary Breckinridge sent her to New York City to help set up the new nurse-midwifery service and school at Maternity Center Association (MCA). Although at first hesitant to leave her mountain life, McNaught devoted the rest of her career to MCA. The first nurse-midwife to practice at MCA’s Lobenstine Clinic and therefore in New York City, McNaught was nurse-midwifery supervisor at the clinic and instructor at the school until 1958. She was a strict teacher who both gave and expected much from her students. As one former student explained, sometimes she was “a very hard task-master. If you did something she did not like she would yell at you!” When physicians asked her why she chose nurse-midwifery, she said that women had always attended childbirth, but “then the men took over and some are very, very good but a lot of them are very, very . . . nothing.” Students and colleagues, while intimidated at times by her tell-it-like-it-is approach, deeply admired McNaught, felt her influence for years to come, and loved her great sense of humor. Before her death in 1978, McNaught received several honors from the American College of Nurse-Midwives in recognition of her accomplishments.

While the Appalachian Mountains offered the first location for nurse-midwives to practice, New York City provided the first American site for them to get an education. Actually, it provided the first two nurse-midwifery educational sites. The first, Manhattan Midwifery School (MMS), opened from 1925 until 1931 and affiliated with Manhattan Maternity and Dispensary, appears to have been invisible both to historians and contemporary public-health officials and to maternal and child health advocates in New York City. Proposed by Emily Porter, superintendent of nurses at Manhattan Maternity and Dispensary, the school admitted graduate nurses and trained them in midwifery, first for four months and later for six months. The school combined clinical work, during which students assisted in hospital deliveries and managed home deliveries, with classes, which were taught by obstetricians and nurses. Approved by the New York State Board of Health, the MMS graduated at least eighteen students, most of whom worked as missionaries in foreign countries or in American public-health settings. Two went on to work at FNS, and some taught obstetric nursing or worked as obstetric nursing supervisors in hospitals. The school closed because the maternity hospital lacked enough patients to train both medical and nurse-midwifery students. Although MMS played a pioneering role in American nurse-midwifery education, it was not well known either by contemporaries or by later nurse-midwives looking back at their history.
Chapter 3: New York City’s Maternity Center Association

New York City’s—and the nation’s—second nurse-midwifery school, the one Rose McNaught helped establish, is this chapter’s focus. The school and accompanying clinic had a long-lasting impact on American nurse-midwifery. Opened by MCA in 1932, the Lobenstine School of Midwifery was named after Ralph W. Lobenstine, a prominent New York obstetrician and one of the school’s founders. The school taught public-health nurses to supervise traditional midwives practicing in rural areas and to provide skilled care to some rural populations, under the guidance of obstetricians. At the same time, MCA established a nurse-midwifery clinic—the second in the United States after FNS—to give students the opportunity to apply what they learned in the classroom. The clinic served poor women in Harlem, offering complete maternity care to women who wanted home delivery and for whom a normal pregnancy and childbirth were expected.

Compared with FNS, MCA had a radically different location and clientele, a different purpose, and different challenges. Leading male obstetricians helped create and shape MCA, and years before the association advocated nurse-midwifery, it performed pioneering work in maternity-care education. In the 1920s and early 1930s, MCA’s physician and nurse pioneers struggled to establish a nurse-midwifery school and practice clinic. They experienced difficulty persuading already-established health professionals that the nurse-midwife would not “follow in the trail made already by the granny midwife.” After several aborted attempts, MCA finally opened a nurse-midwifery school and clinic in the early 1930s, but faced several obstacles. While most early graduates of MCA’s nurse-midwifery school went on to supervise traditional rural midwives or nurses, performing important work to change the state of maternal health care, they remained few in number and isolated. MCA’s clinic, a professional home-delivery service in Manhattan, was radical, opening just as middle- and upper-class city dwellers were establishing hospital deliveries as the standard. The clinic served mostly African Americans and Puerto Ricans, a clientele that white America scorned. Compared with FNS practitioners, MCA’s urban nurse-midwives posed a greater threat to physicians, and thus local practitioners kept a more watchful eye on their activities. In response to this suspicious environment, MCA educated its student nurse-midwives with the assumption that upon graduation they would work in rural areas rather than stay in New York City. MCA administrators also downplayed the role of the new kind of birth attendant their school was training; instead, they emphasized less threatening messages aimed at educating the general public about the need for early prenatal care and early registration with physicians.
Early Pioneer in Maternity Care Education

Long before opening its nurse-midwifery school, MCA led New York City and the nation in attempting to reduce high infant and maternal mortality rates. Obstetricians, social reformers, and public-health nurses had established MCA in New York City in 1918, with well-known Progressive Era reformer Frances Perkins (who later became the first female cabinet member in the United States as Secretary of Labor under President Franklin Roosevelt) as its executive secretary. Unlike FNS, which specifically aimed to create a nurse-midwifery service, MCA was founded to provide maternity care education. In 1919, MCA public-health nurses began holding mothers’ classes, attended mostly by recent immigrants living in tenements. At these weekly classes, MCA nurses offered games, refreshments, and simple instructions on how to prepare for a new baby. They taught the prospective mothers how to keep cow’s milk fresh and unadulterated, how to streamline household duties, and the importance of prenatal care and seeing a physician early in pregnancy. By 1920, MCA had opened thirty maternity centers, three of which they operated in conjunction with the New York Milk Committee and the Women’s City Club. Located in churches and storefronts all over Manhattan, these centers offered prenatal care and instruction by nurses, social workers, and laypeople. Infant and maternal mortality dropped significantly for families who utilized the center’s services. MCA centers’ infant mortality was 25.1 per one thousand babies, compared with 36.6 per one thousand in New York City as a whole; MCA maternal mortality was 40 per ten thousand, compared with 50.9 per ten thousand in New York City. By 1921, MCA changed its emphasis from prenatal care to complete, intensive care through all phases of the maternity cycle at one center.

MCA quickly became a model for community maternity care for other communities that wished to establish similar programs. In 1922, MCA began a demonstration project of its maternity work within a square-mile district in Manhattan, providing prenatal and postnatal clinics staffed by public-health nurses, nursing assistance during delivery, and instruction in all aspects of maternity care. Again, MCA staff encouraged patients to make physician or hospital arrangements early in their pregnancies, and even when patients preferred traditional midwives, the staff prompted them to stay in close contact with clinic physicians. Analysis of the demonstration project’s records from 1922 to 1929 reveals a maternal mortality rate of 2.4 for the 4,726 patients who received maternity care at MCA,
compared with a rate of 6.2 for patients living in the same district but not under MCA’s care. This project also provided public-health nurses with field experience. Between 1921 and 1928, 2,500 nurses came to MCA, staying anywhere from one day to six months, to work and observe its approach to maternity; 240 stayed at least three months with the service. These nurses then returned to their own communities, where they often organized and conducted services similar to MCA’s.

From the early 1920s on, MCA focused more on education than practice. An MCA report from 1921 concluded:

> It is clearly the function of the Association to be a great educational agency; first, in arousing the public to the importance of the problem with which it is concerned, and, second, in stimulating public health agencies to a desire to participate in the solution of the problem. . . . The little work that it can do in the direct handling of patients in its clinics and centers can, at best, reach only a small proportion of the city’s total pregnant women. Our main conclusion is that the Maternity Center Association must more and more become an educational and experimental agency rather than a large local public health or nursing society.

By 1925, MCA had distributed 14,000 copies of its book, *Routines for Maternity Nursing and Briefs for Mothers’ Club Talks*, a handbook of instructions to public-health nurses on informing pregnant patients about maternity care, as well as outlines for a series of classes for mothers. *Routines for Maternity Nursing* included a series of short talks on prenatal care, nutrition for pregnant and nursing women, maternity clothes, baby clothes and other items, how to give baby a bath, preparation for delivery, and aftercare. Also by 1925, MCA had sent out 500,000 copies of *Twelve Helpful Talks*, a series of pamphlets addressed to prospective mothers and fathers explaining the value and content of maternity care; 20,000 maternity care record forms; and 150 educational exhibits to public agencies, private services, and individuals throughout the world. Starting in 1929, MCA taught public-health nurses about all aspects of prenatal and postnatal care in maternity institutes conducted throughout the country. By the time MCA opened its nurse-midwifery clinic in 1931 and school in 1932, it had become the leading advocate for prenatal and adequate maternity care in the United States and excelled in training public-health nurses in prenatal, labor and delivery, and postnatal care.
Aborted Attempts to Establish a School and Practice Clinic

Despite MCA’s resounding successes by the early 1930s, the road to establishing a nurse-midwifery school and clinic at MCA had been long and difficult. Several of New York City’s leading obstetricians on MCA’s Medical Advisory Board led the campaign to create a school and clinic to improve maternity care for the poor. These men believed that nurse-midwives could retrain traditional midwives and handle normal labors and deliveries. Noting that traditional midwives attended over 8 percent of the deliveries in New York City in the early 1930s, George W. Kosmak, founding editor of the *American Journal of Obstetrics and Gynecology*, suggested midwives could not be eliminated immediately, “even if their final elimination might prove desirable,” because they worked with a needy population that valued their services. Kosmak argued the “only solution” to the problem of poorly trained midwives was to create “a body of more highly trained midwives from the registered nurse group, who shall act as teachers and supervisors” to traditional midwives.¹⁶ Lobenstine, one of the founders of MCA, agreed, explaining that nurse-midwives should focus on training the large numbers of midwives in rural areas because “there are not now in the United States enough doctors in rural or small communities to attend women at the time of delivery or during pregnancy.”¹⁷ Lobenstine added that some nurses already supervised midwives but that they lacked training in attending childbirth, making their supervisory role “both difficult and ineffective.”¹⁸

According to MCA’s medical advisors, in addition to training midwives, nurse-midwives could also learn to attend births when normal labor and delivery were expected. Frederick W. Rice, professor of obstetrics and gynecology at New York University’s medical school and obstetrician at Bellevue Hospital, argued that nurse-midwives should attend births in rural areas where there were few physicians because he wanted poor women to have access to “modern” medical care (as opposed to care by “granny” midwives).¹⁹ Lobenstine suggested that mortality and morbidity would decline if all rural physicians had nurse-midwives working with them.²⁰ He also thought that nurse-midwives should handle normal cases “in large foreign communities” if authorities restricted the practices of traditional midwives through strict supervision and gradual elimination.²¹ Making an even more radical argument than either of his colleagues, Benjamin P. Watson, professor of obstetrics and gynecology at Columbia University’s medical school and chair of the department from 1926 to 1946, stated that *all* physicians who delivered babies should have one or more nurse-midwives conduct
deliveries in normal cases. He noted that although his proposal might seem unorthodox in the American context, a similar plan had worked well in Europe.\(^{22}\)

MCA’s forward-thinking medical men believed that educating nurses in midwifery would call attention to the problems poor people faced. They believed that not only inadequately trained birth attendants but also “deplorable” economic conditions caused high infant and maternal mortality rates.\(^{23}\) They hoped, as Lobenstine explained, that nurse-midwives’ “presence in the different states, particularly where they will act as supervisors of midwives, will at once stimulate interest and improve the standards and the care given to the very poor.”\(^{24}\)

According to MCA obstetricians, the nurse-midwife would stir public concern not only about the plight of the poor but also about the sad state of American obstetric care. MCA medical advisors, along with leading obstetricians in other cities, argued that general practitioners deserved a good part of the blame for high rates of maternal and infant mortality. Lobenstine was one of many obstetricians who noted that most medical students received little hands-on experience in obstetrics, and that general practitioners often interfered unnecessarily during childbirth. As Lobenstine explained, “meddlesome midwifery accounts for many deaths, many needless complications and much invalidism.”\(^{25}\) Rice agreed with Lobenstine, arguing that “meddlesome midwifery” occurred precisely because physicians lacked knowledge about normal labor and delivery.\(^{26}\) Rather than waiting for a normal childbirth, they insisted on interfering. Rice, Lobenstine, and their colleagues believed that with appropriate training, nurse-midwives would be better birth attendants than general practitioners. Even more than that, they hoped that the presence of well-trained nurse-midwives would push the American public to demand better maternity care from physicians. As Rice said, “When this demand becomes overwhelming and not until then, are we going to have the medical profession interest themselves in obtaining better obstetrical training.”\(^{27}\)

Finally, some MCA obstetricians noted that nurse-midwives would actually improve their professional and personal lives. John Osborn Polak, professor of obstetrics and gynecology at Long Island College Hospital from 1911 to 1931, said the nurse-midwife would “relieve [the physician] of much of the wear and tear of his work.”\(^{28}\) Watson believed that if nurse-midwives performed normal deliveries, obstetricians would deal with fewer complications during and after childbirth, perform fewer Caesarian sections, have more time to read medical journals and attend medical meetings, and become richer.\(^{29}\)
Prominent MCA nurses also strongly advocated nurse-midwifery. Hazel Corbin, Louise Zabriskie, and Nancy E. Cadmus all were involved in conferences designed to investigate and promote an MCA affiliation with Manhattan's Bellevue Hospital School for Midwives (the first city-sponsored school to train American traditional midwives) for the purpose of training nurse-midwives. Corbin (general director of MCA from 1923 to 1965) drew up a plan for training nurses in midwifery in her 1929 “Suggestions for Improving Existing Maternity Service in New York City.”

In 1930, she urged Lobenstine to write to the Commonwealth Fund, a private philanthropic organization to which FNS founder Mary Breckinridge also appealed, to explain why he thought the nurse-midwife was so important. Compared with the obstetricians, MCA nurses said less—at least in the available documents—to promote nurse-midwifery before the Lobenstine School and Clinic opened. As women and as nurses, they believed (and likely were told) that their voices carried less weight than that of the obstetricians. Still, their support prior to the establishment of the school and clinic, along with their life-long commitments to nurse-midwifery afterward, indicate that MCA nurses played an important role in establishing nurse-midwifery education in the United States.

Despite the many justifications for a nurse-midwifery school and clinic, these programs faced numerous barriers from both physicians and nurses. To address these hurdles, MCA organized a conference in 1921 of physicians and nurses to discuss training and using nurse-midwives. Although many opposed the idea, several leading obstetricians associated with MCA, as discussed earlier, supported it. In the mid-1920s, the National Organization for Public Health Nursing organized a committee, which included MCA nursing leaders, to investigate the possibility of starting a nurse-midwifery school, and the nurses talked about how much opposition they anticipated facing. Throughout the 1920s, MCA made several failed attempts to establish an affiliation with Manhattan's Bellevue Hospital School for Midwives. In the early 1930s, MCA tried to work with New York Nursery and Child's Hospital to establish a field service for nurse-midwives; again, they failed. MCA leaders finally gave up trying to work with established institutions and decided to found their own nurse-midwifery school and clinic.

One cause of MCA's difficulties in establishing a nurse-midwifery school and clinic was the attitude of nursing leaders, which letters and minutes from meetings about the attempted Bellevue-MCA partnership reveal. The partnership was designed to give public-health nurses a course
in midwifery, “known as an advanced course in obstetrics,” for a total of six months—two months at MCA, one at Bellevue Hospital to observe clinic work, and three at Bellevue School for Midwives to gain delivery experience. The goal was to train public-health nurses “1. to practice as midwives in rural communities; 2. to supervise the work of the now existent midwives; 3. to supervise the work of obstetrical nurses; 4. to do obstetrical nursing in the public health field, taking care of midwifery where the need arises.” MCA administrators planned for nurse-midwives’ rural patients to be “under medical control,” and they hoped to work out an arrangement with physicians from local bureaus of child hygiene to have them determine which of the cases were routine enough for MCA students to care for. In 1923, after internal discussions between Bellevue and MCA about their plan, MCA gathered together public-health nursing leaders from New York City and around the country, and sent out questionnaires to divisions of maternity and child welfare in every state, to explain and solicit opinions about the plan. Although many nurses supported the plan, noting the “disgraceful record of large numbers of the mothers still not receiving proper care” and benefits to both nurses and mothers if nurses were prepared to deliver babies in emergencies, nurses’ voices were some of the loudest in opposition to training nurses in midwifery. Their words help clarify MCA’s long struggle to create a nurse-midwifery education program.

One reason given for opposing the Bellevue-MCA plan was that nurses would not want to assume midwives’ responsibilities. Two nursing leaders—one with extensive experience with urban public-health nurses and the other with rural public-health nurses—argued that few nurses would be interested in midwifery because they already felt prepared enough to handle occasional emergency deliveries and would not want to extend their duties beyond that. Edna L. Foley, superintendent of the Visiting Nurse Association of Chicago, noted that she knew British nurses who also had certificates in midwifery. These women “did not like the midwife part of their work at all, [because] . . . too much responsibility was placed on them and . . . it was not as easy to secure physicians for complicated cases as it sounded.” Elizabeth G. Fox, from the National Organization for Public Health Nursing (NOPHN), indicated that many rural nurses had expressed that they were far too busy to add midwifery to their duties.

Some nurses opposed the Bellevue-MCA plan, arguing that nurses should not assume responsibility for deliveries because they would upset the “medical fraternity.” Fox argued:
I think it is the definite duty of the medical profession [to assume responsibility for the delivery of patients]. Whether they fall down or not is not for me to say....I cannot quite see that the way to influence the medical group is through our undertaking to deliver patients ourselves. I am inclined to think that the way to influence them is through our doing better pre-natal and post-natal work, and better service as nurses; that doctors should do the actual delivery, rather than by our taking upon ourselves the practice of midwifery, whereby to show the medical profession how it ought to be done. I think our influence will be much more acceptable, much more likely to reach the goal [of improving maternity care] which [MCA’s] Dr. Rice wants us to reach, if we approach it through those avenues which are properly ours, rather than through a field which the medical profession itself essays.

Fox wanted to avoid stepping on physicians’ toes, or appearing to take over their territory, for fear of hurting public-health nursing. Although her comments seem obsequious, she was, in some ways, right; throughout their history, nurse-midwives have faced physicians who saw (and continue to see) nurse-midwives as competition and who have worked to limit them.

Even prominent nurses who supported nurse-midwifery expressed deep concern about physicians’ responses. In 1927, Elizabeth F. Miller, nursing consultant for Pennsylvania’s Department of Welfare and chair of NOPHN’s Committee to Study the Need of Midwifery for Nurses, and Isabel M. Stewart, director of nursing education at Teachers College, Columbia University in New York City and a member of Miller’s committee, corresponded about the need for caution when presenting nurse-midwifery to physicians. They strategized about who would approach certain physicians with proposals and talked about “the delicacy of the problem and the need for much preliminary inquiry and the need for stimulating thought,” as well as the fact that they were “confronting some very definite handicaps.”

Nurses like Fox, who opposed the Bellevue-MCA partnership, felt that such a delicate problem was worth avoiding.

Finally, nurses opposed the Bellevue-MCA plan to train nurses in midwifery because it would potentially hurt public-health nurses’ status within the medical profession by more directly associating them with much-maligned traditional midwives. As Fox said, “there is a tremendous controversy within the medical profession as to the place of the midwife, and as to its obligation or duty to that group of workers, the importance of having such a group, which also influences me in feeling that it would be rather unfortunate to interject the public health nurse question into that
controversy when it is so far from being settled in the minds of the medical profession itself.”

Prominent nurses who opposed the Bellevue-MCA plan sought to tread lightly and not anger physicians. Recognizing that their status depended on association with physicians, they insisted that nurses should not assume full responsibility for patients. They also were aware that the profession of nurse-midwifery might ultimately hurt nursing because physicians saw midwives as unprofessional and dangerous.

Of course, nursing leaders were not the only ones with concerns about training nurses in midwifery. New York City Commissioner of Welfare Bird Coler was the man who actually ended any dreams of a Bellevue-MCA plan just as it appeared to be coming to fruition. Coler argued: “I see midwives only as poor women trained to take care of poor women. If graduate nurses are trained to be midwives they will charge such prices that women in the lower income level will not be able to afford them.” An MCA report explained that the commissioner “didn't see the nurse-midwife as a paid public servant or as part of a public health organization.” Few known surviving documents specifically reveal which physicians opposed MCA’s nurse-midwifery plans before 1931. However, judging from nurses’ concerns and from documents dating to the early years of the MCA nurse-midwifery school that mention physician resistance, resounding physician opposition to MCA's plans clearly existed.

When the Bellevue-MCA plan failed, MCA leaders tried to collaborate with New York Nursery and Child’s Hospital to create a nurse-midwifery school. Lobenstine, chair of MCA’s Medical Advisory Board and a tireless advocate of a school and clinic, received an appointment at the hospital, “with the understanding that as soon as funds could be raised, the long awaited school for nurse-midwives would be opened under his direction.” Although Lobenstine became gravely ill, MCA’s Board of Directors continued to work with the hospital under the assumption that the partnership could still work. After Lobenstine's death, however, “his medical associates in the Nursery and Child's Hospital, who had helped in planning for the opening of the new school, immediately vetoed it and refused to cooperate.” MCA's leading obstetricians and nurses were foiled again.

**Educating Agents of Change**

After a decade of efforts by MCA physicians and nurses to convince their colleagues of the value of establishing a nurse-midwifery school and two
failed attempts—one at Bellevue Hospital and one at New York Nursery and Child's Hospital—to establish a practice clinic for nurse-midwifery students, MCA leaders decided to forge ahead on their own. In early 1931, they established the Association for the Promotion and Standardization of Midwifery, Inc. The new association's certificate of incorporation included three men and one woman: Ralph Lobenstine, George Kosmak, and Benjamin Watson, who were members of MCA's Medical Advisory Board, and Hazel Corbin, a nurse who was MCA's general director. The Board of Trustees consisted of these four people, as well as other leading obstetricians and nurses, including FNS's Mary Breckinridge. When Lobenstine died in March 1931, Evelyn Field, ex-wife of Chicago department store heir and banker Marshall Field, led approximately sixty women, friends and patients of the deceased obstetrician, to pledge enough money to maintain a clinic and school for three years. The Lobenstine Midwifery Clinic was established in November 1931 and the Lobenstine Midwifery School in February 1932. Both organizations were licensed by the New York City Board of Health and supervised by the Health Department's Bureau of Maternal and Child Hygiene; the clinic also received licensure and supervision from the New York State Department of Social Welfare. The Lobenstine Clinic provided students with field experience, and gave prenatal, labor-and-delivery, and postpartum care to women expecting a normal pregnancy and delivery who wanted home delivery. The Lobenstine School taught midwifery to public-health nurses to enable them to 1) supervise and teach untrained midwives and 2) bring skilled maternity care, under the direction of obstetricians, to women in remote rural areas.

It may come as a surprise that MCA was so concerned with educating nurse-midwives to serve in rural areas given that it served a poor African American and Puerto Rican population in the middle of the largest American city. Several factors seem to explain this irony. First, a number of leading physicians on MCA's Medical Advisory Board argued that rural communities had the highest need for professional maternal care because they lacked access to physicians and continued to employ local midwives in large numbers. Second, the percentage of midwife-attended births in the urban northeast continued to decline dramatically over the 1920s and 1930s, as the Lobenstine School was being conceived and developed, and therefore, residents of northeastern cities would theoretically have less of a need for nurse-midwives. Third, and most important, the physicians and nurses who invented the Lobenstine School were being realistic. In the early years, some of the members of MCA's Medical Advisory Board had
suggested that professionally trained nurse-midwives could serve women in urban areas. But most recognized that even in poor urban areas where few physicians wanted to work, physician resistance to nurse-midwives would be very high. Thus, the physicians and nurses affiliated with MCA crafted a plan with the greatest chance for success: the creation of a school to train nurse-midwives primarily to supervise traditional midwives (and to a lesser extent provide professional maternity care) in remote areas of the United States and in developing countries, where they would be invisible to most health professionals.

MCA spent the first eight months of 1932 developing a curriculum, selecting staff, formulating policies regarding student and patient admission, fostering relationships with cooperating hospitals and social welfare agencies, creating standing orders for the clinic, and trying to gain the acceptance of local welfare agencies, nurses, and physicians. The school and clinic opened with one resident physician and four attending obstetricians. Hattie Hemschemeyer, a public-health nursing educator and director of the school and clinic, who then completed her nurse-midwifery degree in the first class at Lobenstine, and Rose McNaught, the American nurse-midwife with British midwifery training who had worked for several years at FNS, were also on staff. The first nurse-midwifery class at the Lobenstine School graduated in 1933 with seven students. The school required applicants to have four years of high school and be graduates of an accredited school of nursing; they also needed at least “two years of professional experience, one of which has been spent in public health nursing” and to be registered to practice nursing in at least one state. As an MCA publication later explained, “exceptions were made for applicants whose professional accomplishments justified special consideration, or who were referred by organizations training local personnel to become midwife supervisors.”

With no American nurse-midwifery schools in existence, MCA looked to European, especially British, examples to develop its curriculum. British nurses took a six-month midwifery course, and non-nurses took a one-year course; in 1938, the program lengthened to one year for nurses and two for non-nurses. MCA modified the British experience to meet American needs; its students were nurses with three months of obstetric training as part of their nursing degree. Although the school’s admission requirements included public-health nursing experience, most of the early students did not have formal coursework in the subject. Thus MCA established a ten-month program, with the first four in instruction, supervision, and practice in public-health nursing, through the Department of
Nursing Education, Teachers College, Columbia University, and the last six months, spent at MCA, in instruction and practice in midwifery. During the six months at Lobenstine, nurses attended lectures and watched demonstrations by obstetricians and supervising nurse-midwives. They gained practical experience by working with prenatal and postnatal mothers at the clinic, as well as teaching mothers’ classes and working with social-welfare and health agencies to help their patients. An MCA student delivered twenty babies during her program, while many medical students observed only six deliveries during their training. In general, the Lobenstine School taught its students “how to provide good obstetric care under conditions which they may find in their own communities, and . . . how to improvise with small financial outlay a clinic which will provide safe care to mothers and babies.”

MCA gradually changed and adapted the curriculum to fit new needs. In 1935, at the Rockefeller Foundation’s expense, Hazel Corbin and Hat-
tie Hemschemeyer studied midwifery schools and services in England, Scotland, France, Norway, Sweden, Denmark, and the Netherlands, countries with low rates of maternal morbidity and mortality. Eager for Lobenstine graduates to meet the educational standards of other nations so that their nurse-midwifery training would be recognized regardless of where they worked, Corbin and Hemschemeyer applied knowledge from their visits back home. 

Later in the 1930s, MCA eliminated the four months of public-health nursing because most applicants had bachelor's degrees in public-health education, or had taken courses in public health and the social sciences. However, it maintained a connection with the Department of Nursing Education at Teachers College, albeit one which did not affect directly its own nurse-midwifery students. In later years, MCA provided field experience in obstetric nursing for interested public-health majors, and members of the MCA staff taught various courses at the college. 

### Table 3.1 Employment of the First Twenty Graduates of the Lobenstine School of Midwifery (Years of Graduation, 1933–1935) 

<table>
<thead>
<tr>
<th>Number of Graduates</th>
<th>Place of Employment</th>
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<tbody>
<tr>
<td>4</td>
<td>The State Departments of Health in New York, Kentucky, Florida, and Alabama</td>
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<tr>
<td>1</td>
<td>Frontier Nursing Service</td>
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<td>1</td>
<td>Victorian Order of Nurses in Canada</td>
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<td>1</td>
<td>Midwife instructor in Spain</td>
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<td>2</td>
<td>Maternity instructors in schools of nursing</td>
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<td>1</td>
<td>United States Children’s Bureau; holds midwife institutes to teach traditional midwives</td>
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<td>1</td>
<td>Director, Brooklyn Maternity Center</td>
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<td>1</td>
<td>Director of rural public health nursing program in Ramsay, New Jersey</td>
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<tr>
<td>1</td>
<td>Nursing supervisor in tuberculosis maternity hospital</td>
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<td>1</td>
<td>Attending college full-time to prepare herself to teach obstetric nursing in a nursing school</td>
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Graduates of the Lobenstine School brought the philosophy and practices of nurse-midwifery to communities around the country. Of the first twenty graduates, who received their degrees between 1933 and 1935, most worked in public health, supervising or teaching midwives; a few supervised or taught nurses. (See table 3.1 for specific places of employment.)

One example of early Lobenstine graduates’ work can be seen in Maryland. In 1936, with money from the Social Security Act earmarked for maternal and child health, especially in rural areas hit hard by the Depression, J. H. Mason Knox, director of the Maryland State Department of Health’s Bureau of Maternal and Child Hygiene, contacted the Lobenstine School with a request for help in educating Maryland midwives. Just thirteen years before, Knox had indicated his disapproval of nurse-midwives, explaining that he “questioned [the] advisability of public-health nurses doing obstetrical work in Maryland” because it was the “medical profession’s responsibility.” By the mid-1930s, however, his opinion of nurse-midwifery had improved enough that he hired Lobenstine graduates Elizabeth Ferguson and Martha Solotar to work for the Maryland State Department of Health, where they started “a demonstration in the supervision, teaching, and control of indigenous midwives” in a rural region of southern Maryland. Each worked in a different rural county, mostly with African-American midwives. Both Ferguson and Solotar registered the midwives, taught them about obstetrics, cleanliness, postpartum care, and when to contact a physician, got to know the families the midwives served, observed their deliveries, kept records of their work, and, when necessary, reported problems to local authorities. The two nurse-midwives also conducted prenatal care clinics for local families. Ferguson, employed in a county with a part-time public-health officer, mostly worked on her own “with a minimum of medical help,” while Solotar and her county’s public-health officer worked together—although Solotar conducted many deliveries on her own.

Available accounts discuss the demonstration’s success. Rates of maternal mortality and morbidity declined in the demonstration areas, and Johns Hopkins Medical School obstetricians were impressed by the results. One argued that a good nurse-midwifery service improved rural obstetrics more than any other available method of maternity care. In particular, the Johns Hopkins obstetricians appreciated that Ferguson and Solotar instructed their charges to seek medical help if necessary. One frequently told story was that of Ferguson and a particular “mammy midwife” whom she had taught. This midwife “made a very clever diagnosis of the wrong position of a baby and got the patient into Johns Hopkins Hospital
in time [although thirty miles away] for the doctor to deliver the patient of a live baby and secure health for the mother." After Ferguson told this story at a professional meeting, “the obstetricians at Hopkins arose and confirmed this statement and said that if American obstetrics were to be improved in Maryland, at least, we must have more midwives like Miss Ferguson.” While the “mammy midwife” was the one who made the diagnosis, Ferguson received the praise because the Hopkins obstetricians and MCA leaders assumed that the midwife would not have done this without Ferguson's influence and teaching. MCA leaders hoped that with more successes like Ferguson's and with more supporters like Hopkins obstetricians, nurse-midwifery would grow. Despite such success stories, the Lobenstine School failed to expand due to financial difficulties along with medical and lay ignorance about the nurse-midwife's efficacy.

A Clinic with a Clientele No One Wanted

Ferguson, Solotar, and their fellow Lobenstine School alumnae gained nurse-midwifery experience at Lobenstine Midwifery Clinic. Nurse-midwifery was so controversial that MCA had established a separate organization to create the clinic in 1931; Lobenstine Clinic was not officially affiliated with MCA, even though most of the clinic’s officers were members of MCA’s Medical Advisory Board or staff. Later events proved the wisdom of MCA’s strategy. In 1934, MCA consolidated the clinic under its own organization after some felt that the clinic had proven itself. H. J. Stander, H. C. Williamson, and James A. Harrar, all prominent obstetricians at New York Hospital and members of MCA’s Medical Advisory Board, resigned in protest. Harrar explained that he regretted his resignation, “as I have always been a great admirer of the work the Maternity Center Association has accomplished; but I am not in sympathy with plans to educate any more midwives, whether as nurse-midwives or as midwives educated to be supervisors of midwives.” Now that MCA’s Medical Advisory Board had “the medical responsibility for the Lobenstine Midwifery Clinic,” these men wanted no part of MCA, or of this new kind of birth attendant, the nurse-midwife.

The MCA Medical Advisory Board, Board of Directors, and staff always considered physicians’ response to nurse-midwifery when making decisions about Lobenstine Clinic. In order to diminish physician opposition, the clinic specifically targeted patients who could not afford to pay
the fees of private physicians. As chair of the Medical Advisory Board George Kosmak explained in a letter to 200 physicians in the clinic district, “It is our aim to interfere in no way with the private obstetric practices in the district.” MCA had to prove to local physicians, who were skeptical about Lobenstine Clinic and the new nurse-midwives, that it was not in competition with them. As Rose McNaught said, it “took years” for the obstetricians and other physicians to get used to the nurse-midwives. Despite the ambitions of Benjamin Watson, the member of MCA’s Medical Advisory Board who thought nurse-midwives should conduct all normal deliveries, Lobenstine Clinic claimed (at least publicly) its only aim was to serve people who would have never been seen by physicians in the first place.

Lobenstine Clinic patients, like those at FNS, were generally poor. Through the 1940s, the clinic asked patients with the ability to pay to contribute five dollars (the same amount FNS asked of its patients); if the patient was unable to contribute that sum, the clinic asked for two or three dollars to help cover its prenatal, labor-and-delivery, and postpartum services. According to New York State Department of Social Welfare reports on the clinic, although paying for the services gave “the patient a feeling of self respect,” “the greater proportion of cases [were] taken free of charge.” Clinic statistics from 1932 to 1936 show that 40 percent were “dependent upon relief organizations for support,” 40 percent had incomes of less than $20 per week (less than $14,852 per year in 2006 dollars), and 20 percent had incomes of over $20 per week. Clinic records from 1932 to 1939 provide a more specific breakdown of incomes, indicating that the clinic received increasing numbers of poor patients as the Depression progressed. Between 1932 and 1939, 40 percent of clinic patients “were on Home Relief or Work Relief,” 10 percent had incomes of less than $10 per week (less than $7,426 per year in 2006 dollars), 34 percent had incomes of less than $20 per week (less than $14,852 per year in 2006 dollars), 10 percent had incomes of less than $30 per week (less than $22,278 per year in 2006 dollars), and 6 percent had incomes of more than $30 per week. According to an MCA publication from the late 1930s, many clinic patients lived in “tenement homes, cold water flats with the most primitive facilities,” and struggled with “[health] problems which arise from poor housing, from unemployment, from stark poverty.”

Although MCA and FNS nurse-midwifery services shared a similarly indigent patient population, a similar approach to birth, and a similar commitment to nurse-midwives as one solution to the nation’s maternal and infant health problems, the services had several important differences.
While FNS served entire families, Lobenstine Clinic served pregnant women only.79 Lobenstine operated its prenatal and postpartum clinics out of a comparatively small space: “the first floor of . . . [a] three-story basement and brownstone former residence.”80 The clinic staff was also more particular than FNS about the pregnant women they served; they turned away patients with “any abnormal condition” because they had the option of sending those patients to local maternity hospitals, with which they had cooperating agreements. Furthermore, MCA worked closely with a variety of New York City agencies, including social-welfare organizations, such as the Henry Street Settlement and the Metropolitan Life Insurance Company’s Visiting Nurse Service, both of which provided Lobenstine Clinic patients with postpartum nursing care.81 Although FNS worked with hospitals as far away as Lexington, Cincinnati, and Richmond, its remote location meant that it did not have the multitude of local options available to MCA.

A large difference between the MCA and FNS nurse-midwifery services was in their patients’ race and ethnicity. FNS advertised constantly that it served the “finest old American stock,” but MCA was vague about its client base. While MCA made clear that Lobenstine Clinic served indigent patients, the few publications that discussed the clinic almost never mentioned anything about patients’ racial or ethnic background. MCA probably made this choice because the clinic served mostly African Americans and Puerto Ricans, a clientele no one—sometimes not even MCA staff—wanted. In the late 1930s, Corbin reported that “the district which has been served from the 113th Street [Lobenstine] clinic is increasingly made up of Puerto Ricans and a rather low level of colored folks.” She hoped to open a second clinic in Washington Heights, located “in the center of an area of better class white people,” to “reach a better class clientele.”82 Of course, New Yorkers who knew the clinic was located in Harlem would have assumed that the patients were African American, since by the 1930s, Harlem was known as an African-American community. That MCA literature sidestepped the race and ethnicity of clinic patients indicates that MCA administrators realized that highlighting such information could have harmed MCA.

Until 1947, the clinic was located on 113th Street between 7th Avenue and Central Park West, in southernmost central Harlem. The facility served indigent patients in a district surrounding the clinic, defined as south of 142nd Street, west of 5th Avenue to the Hudson River, and north of 86th Street.83 Compared with FNS, which served 700 square miles in a sparsely populated mountain region, Lobenstine Clinic served a tiny geo-
graphic area, but one with a much greater population density. The clinic itself spanned both the African-American and Puerto Rican sections of Harlem, and the district included a large part of those sections, as well as parts of Morningside Heights and Manhattanville, Central Park West, and Washington Heights.84

Clinic statistics from 1932 to 1936 indicate that 70 percent of the patients were “colored” and 30 percent were “white.”85 As scholars have explained, the meaning of these terms constantly shifted. Corbin’s comment above—that the district from where the patients came was “increasingly made up of Puerto Ricans and a rather low level of colored folks”—suggests that “colored” meant African American, and “white” included Puerto Rican. However, it is likely that some Puerto Ricans would have been classified as “white” and some as “colored”; The WPA Guide to New York City (1939) and economist Lawrence R. Chenault’s The Puerto Rican Migrant in New York City (1938) both distinguish between “white” Puerto Ricans and “colored” Puerto Ricans.86 Conversely, Chenault noted that “the entire group [of Puerto Ricans] is sometimes referred to by Americans as ‘colored.’”87 Regardless of how they were classified, the clinic always served Puerto Rican patients, and the numbers increased over the years, as seen in clinic statistics for the 1940s and 1950s and in the increased migration of Puerto Ricans to the clinic district. Even as early as 1934, Hattie Hemschemeyer told Mary Beard, an associate director of the International Health Division at the Rockefeller Foundation, that she was pleased that the foundation sponsored a nurse-midwifery student from Spain at the Lobenstine School because “her knowledge of Spanish has been of invaluable assistance to the patients and to the staff.”88

Lobenstine Clinic patients must have struggled on a daily basis. New York City’s African Americans and Puerto Rican immigrants faced even harder times than white Americans did in the 1930s. Fifty percent of African Americans were unemployed, double the rate for whites. Most decent paying jobs were closed to African Americans. Department stores, for example, hired African Americans as porters, maids, and elevator attendants, not as higher-paid sales clerks. Subways hired them as porters, not as better-paid motormen. Rents in Harlem, where African Americans were forced to live, remained higher than other places, and yet housing conditions in Harlem continued to decline. Health conditions also worsened, with African Americans having higher rates of tuberculosis and other diseases, as well as maternal and infant mortality rates double those of the rest of New York City.89 As black medical professionals pointed out, poor living conditions and lack of access to medical resources—including
discrimination and insufficient services at Harlem Hospital—caused poor health.\textsuperscript{90} Despite such poor conditions, African Americans continued to migrate to New York City during the Depression because opportunities were fewer and conditions were worse in the rural South.\textsuperscript{91}

In the 1930s, New York City’s Puerto Ricans also faced difficult lives. Significant numbers of Puerto Ricans migrated to New York City after 1900, with the largest numbers entering the city between 1946 and 1964. As American citizens, they moved to the continental United States for a variety of interrelated reasons, which mainland companies in search of cheap labor exploited. These included poor economic conditions in Puerto Rico caused by the decline of the sugar-crop industry (the United States had forced the industry to be the basis of the Puerto Rican economy after invading and taking over the country in 1898) and the lure of jobs on the mainland. Overpopulation in Puerto Rico was also a factor and the Puerto Rican government actively encouraged emigration.\textsuperscript{92} Before 1940, Puerto Ricans settled primarily in central and east Harlem, in the community that became known as El Barrio. They also settled in Brooklyn, and after World War II, migrated to the South Bronx.\textsuperscript{93} Prejudice caused by their race and ethnicity, as well as their limited skills, forced them into low-paying jobs. Most Puerto Rican men worked in factories as unskilled laborers or in menial jobs in service industries, especially in restaurants and hotels.\textsuperscript{94} Puerto Rican women often did piecework in the garment industry, where they received payment for each piece they completed, to supplement, and in some cases provide, the family income. While doing needlework at home, they worked long hours and earned extremely low wages, with payment sometimes delayed by the contractors.\textsuperscript{95} Like African Americans, Puerto Ricans lived in substandard housing with inadequate sanitation, and they faced poor health and a lack of access to modern medicine.\textsuperscript{96} Economist Lawrence R. Chenault found that central Harlem, which contained a large Puerto Rican population and was the location of Lobenstine Clinic, had by far the highest infant and tuberculosis mortality rates, and new cases of venereal disease, in all of New York City.\textsuperscript{97}

If these poor Puerto Rican and African-American women did not give birth with nurse-midwives through MCA’s home delivery service, where would they have been giving birth, and with whom? In the 1930s, most African-American women in New York City probably delivered their babies with physicians’ help in hospitals. According to one study, in New York City between 1917 and 1923, 98.3 percent of African-American births took place in the hospital or at home with nurses or physicians. Increased efforts by public-health agencies to push women to seek medical
care during pregnancy and childbirth in the 1920s and 1930s suggest that the percentage might have been greater by the time MCA's clinic opened in 1931. Another study confirms the medicalization of childbirth among African Americans in the urban North. In 1937, Elizabeth Tandy, senior statistician for the United States Children's Bureau, found that in northern cities, physicians attended 97.9 percent of all African-American births, and 61.8 percent occurred in hospitals. 98

Traditional midwives attending births at home provided another option for African-American and Puerto Rican women, but this option was disappearing over the first three decades of the twentieth century. Across the nation, midwife-attended births decreased from 50 percent in 1900 to 15 percent in 1930, as a result of several factors. Obstetricians convinced fellow physicians and the public that midwives had set obstetrics back by decades and that reform-minded women were demanding better obstetrical care. Other factors contributing to the decline of the traditional midwife included a decreasing birth rate and a significant drop in the number of immigrant midwives following the passage of strict federal immigration quotas in 1924. In the urban North, midwife-attended births decreased even more dramatically than they did nationwide. By 1932, midwives attended only 8 to 10 percent of births in New York City. Many of those midwives were European immigrants who attended births by women in their own ethnic communities, not black women. 99 While black midwives continued to practice in the South, many changed jobs when they migrated North; this was, in part, because northern urban black women sought professional help during childbirth. Like their white counterparts, black women in northern cities received information from public-health agencies arguing that physicians provided the best childbirth care. Plus, as the number of children they bore decreased, they wanted what they saw as the best for their fewer deliveries. 100 However, some available literature suggests that a significant minority of northern urban African-American women continued to use midwives. One source indicates that as late as 1937 midwives attended the births of one-third of black babies in northern cities. 101 Several studies discuss the popularity of the folk healing system among northern urban blacks, including those who lived in Harlem. Black Harlemites often turned to faith healers, spiritualists, and elderly “grannies” because of a long-time belief in a mixture of African, spiritualist, and agrarian traditions. They turned away from physicians because of discriminatory practices in hospitals, lack of money, and disinterest in obtaining professional medical care. Given African-American Harlemites’ devotion to folk healing practices, it
would not be surprising that they also used traditional healers to help them to deliver their babies. Traditional healers offered special medicines made of dried cobwebs, rabbit brains, and “cockroach rum,” as well as such folk recommendations as placing a fried egg on a woman's belly to speed labor or tying a bag of lice around a baby’s neck to end teething pains. Many probably combined traditional practices with care from health professionals for their deliveries.

We know much less about birth attendants and the locations of childbirth among Puerto Rican Harlemites. Most went to health department clinics to receive health care in the 1930s. At these clinics, they had access to well-baby care, dental hygiene programs, diagnosis of venereal diseases, and chest examinations for tuberculosis. Staff at these clinics would have advised strongly that women seek physicians to attend their babies' births. However, language and cultural barriers, as well as negative attitudes of Anglo health professionals toward Puerto Rican patients, may have militated against patients accepting the advice of clinic staff. As one Puerto Rican writer noted, many Puerto Ricans “complain of much waiting at clinics, the abrupt or discourteous manner of the physician or nurse, the superior attitude of the North American, [and] routine treatment, which they deeply resent (being treated as they put it, ‘like a machine’).” In addition, clinics often lacked the resources to deal with patient needs. Thus, Puerto Ricans and African Americans in Harlem who wanted professional medical assistance during childbirth faced many barriers, including high costs, discrimination, professionals’ insensitivity, and inadequate services and resources. MCA provided poor families in Harlem with another option—one where the price was right and the services readily available.

The Lobenstine Midwifery Clinic’s Approach to Birth

Among the many services MCA provided was frequent prenatal care; the level of attention to the gestational period stood in stark contrast to the infrequent, or nonexistent, prenatal care provided by general practitioners and traditional midwives, who attended the majority of American births prior to World War II. Rose McNaught and her fellow MCA nurse-midwives, just like the women at FNS, encouraged patients to register early in their pregnancies at the Lobenstine Midwifery Clinic. A patient’s first visit involved a thorough examination by the resident physician. If the physician found no abnormalities, nurse-midwife staff and students cared
for the pregnant woman during the rest of her pregnancy, labor and delivery, and postpartum period. If the first visit uncovered an “even minor abnormality or suggested later difficulties,” the physician arranged for an obstetrical consultation. From 1933 to 1952, patients averaged 7.7 prenatal visits to MCA’s clinic, and nurse-midwives, nurse-midwifery students, and clinic physicians made an average of 2.3 visits to pregnant women in their homes. In normal pregnancies, nurse-midwives performed the majority of the prenatal work until the last month of pregnancy. They checked blood pressure, examined urine, and looked for metabolic problems, instructed pregnant women in “healthful living,” offering prospective mothers information on diet, dress, easier ways to perform housekeeping, and information on the normal course of labor.\footnote{105}

As compared to FNS, MCA maternity patients had easier access to physicians because of MCA’s urban location and design. From the beginning, MCA referred patients with medically complex conditions to hospitals, a realistic decision given MCA’s location in New York City.\footnote{106} In addition, as Hattie Hemschemeyer, Lobenstein School’s director, explained, MCA had to take into account “the traditional pattern of doctor-nurse relationship so firmly established in this country,” in a way that FNS, a nurse-midwifery service in an isolated region with very few physicians, did not.\footnote{107}

Unlike most schools for health practitioners, MCA trained its nurse-midwives to examine all aspects of the patient’s environment affecting “the health and happiness and peace of mind of each expectant mother and father,” including substandard housing, unemployment, poverty, overwork, lack of proper nutrition, and lack of sunshine.\footnote{108} McNaught said that during the Depression, instead of collecting money from her patients at MCA, she and her colleagues often gave them money so they could eat.\footnote{109}

Along with regular appointments with patients, MCA nurse-midwives’ broad prenatal care program included education for mothers and pregnant women. As discussed earlier in the chapter, MCA was a national leader in teaching patients about prenatal care by the time it opened its nurse-midwifery clinic and school, and the nurse-midwives continued MCA’s strong prenatal care tradition in their instruction of antepartal clinic patients.

MCA nurse-midwives also educated mothers all over the world directly and indirectly through their numerous publications, maternity exhibits, and maternity institutes for public-health nurses. By 1935, half of the twenty thousand public-health nurses employed in the United States had attended a training session given by an MCA nurse.\footnote{110} By the same year, MCA had distributed 50,000 copies of its Routines for Maternity
Nursing and Briefs for Mothers’ Club Talks, and set up a Hall of Science exhibit at the 1933 Chicago World’s Fair entitled “Face Motherhood Informed—Remove All Questions.” Many parents ordered The Maternity Handbook for Pregnant Mothers and Expectant Fathers, written in 1932 by MCA’s Anne A. Stevens, which presented in simple terms the major points of safe maternity care, “mak[ing] available [to] fathers and mothers everywhere the benefits of the Association’s experience.” In 1939, MCA published Birth Atlas, a short, beautifully illustrated book that reproduced twenty-four life-size sculptures of fertilization, fetal growth, stages of labor, and return of the uterus to normal size and position, perhaps the most famous publication produced by MCA. Renowned obstetrician Robert Latou Dickinson designed the models that Abram Belskie sculpted. MCA nurse-midwives—and thousands of public-health nurses, maternity nurses, and physicians—have used Birth Atlas to teach their patients, from 1940 to the present.

In addition to their pioneering work in prenatal care and education, Rose McNaught and her colleagues were pioneers in labor and delivery. Like their counterparts at FNS, they generally delivered babies on their own without the interventions typical of obstetricians of this era. In the first 1081 deliveries of the Lobenstine Clinic patients (1932–1936), 84.1 percent had normal labor, with complications occurring in 15.9 percent.
However, only 7.5 percent, or eighty-one women, had complications severe enough to require hospitalization. MCA attributed the “low incidence of hospitalization . . . to the discriminating selection of patients and to the generous amount of time spent by the medical staff in the clinic and in the home. When a complication necessitating hospitalization occurred, the physician responded promptly to the midwife’s call and made plans for the immediate admission of the mother.” Nurse-midwives used sedatives, including ether, potassium bromide with chloral hydrate, Demoral, and Seconal, “when indicated.” Labors were short—the average was six hours and forty-five minutes—and nurse-midwives attended the patients for a large part of that time, an average of four-and-one-half hours. Long-time MCA clinic obstetrician Marion D. Laird suggested the short labors “may be due to the confidence engendered in the patient and her family by the satisfying personal contact in this small service.”

MCA’s urban location and proximity to physicians and hospitals meant that compared with FNS its nurse-midwives had less autonomy and its patients more contact with physicians during labor and delivery. In fact, physicians played a larger role in MCA patients’ births, despite the fact that MCA’s nurse-midwifery home-birth service, the Lobenstine Clinic, carefully chose which patients it would accept. Unlike FNS, MCA’s nurse-midwifery service declined to serve a number of pregnant women who wanted to deliver there. Between 1932 and 1936, the service refused a little over one-quarter of the women (379 out of 1460) who applied for their care because they lived outside the clinic district, applied almost at term, had unclean homes, were found not to be pregnant, or had complications that made a home delivery inadvisable. But MCA nurse-midwives still delivered babies under less-than-ideal conditions, often in primitive tenement homes. In fact, as Rose McNaught recalled years later, when she introduced newly graduated physician Marion Laird to home deliveries, Laird “nearly collapsed the first time she went out with me and saw what we had to do on a home delivery in some of those houses—so poor and dirty.” Still nurse-midwives assured patients that “no matter how lacking in modern facilities these homes are, when the time comes for the baby’s arrival, the room in which he will be born is made clean and orderly by the nurse-midwife.” If a laboring woman needed hospitalization, the Lobenstine Clinic had an “excellent working agreement” with two New York hospitals, Sloane Hospital for Women and the Lying-In Hospital at Cornell, where patients “could be rushed right in and taken right to the labor floor with no questions asked.” In the 1930s, while attending patients in labor, nurse-midwives reported by telephone to the medical
director who gave orders, as necessary, for “examination, medication, or treatments.” Physicians visited approximately one in four MCA patients in labor. When physicians checked in on patients giving birth at home, they judged whether they or the nurse-midwife should complete the delivery. MCA staff quickly found they used “twice as much medical service as we had originally estimated to be necessary. Out of every hundred mothers who were registered for care, one in seventeen needed to be hospitalized for definite medical reasons at some time during the maternity cycle.” Hospitalization resulted from prenatal and postpartum complications as well as from labor-related problems or the need for perineal stitches.

Births attended by MCA nurse-midwives involved referral to and therefore intervention by physicians more often than those attended by FNS nurse-midwives. However, all women who initially saw a nurse-midwife, whether in an urban or rural location, had fewer interventions in their births and were less likely to deliver in a hospital compared with women attended only by obstetricians. In the 1920s and 1930s, an obstetrician-attended birth almost always occurred in the hospital and involved routine interventions like forceps and heavy drugs.

In addition to thorough prenatal care and innovative labor-and-delivery care, McNaught and the other MCA nurse-midwives also provided extensive postnatal care. They visited patients in the home every afternoon, and nurses from Henry Street Settlement House—sent by MCA—visited patients every morning, for the first twelve days after delivery. MCA also asked patients to return to the clinic for medical examinations at the end of one and three months after giving birth, sending any postpartum patients with abnormalities to Sloane Hospital for Women.

While many physicians promoted the safety of artificial food, sometimes arguing that it was better than breast milk, and while breastfeeding was on the decline among American mothers, MCA literature assumed that mothers would nurse their babies. For example, the association’s handbook for pregnant mothers and expectant fathers explained how to prepare breasts for breastfeeding, and concluded that formula feeding was like thievery:

Of course ‘mother’s milk’ really is ‘baby’s milk.’ It belongs to the baby. Nature has made it for him, it is his best food and it is no use at all to the mother. It is stealing from a baby not to let him have his mother’s milk, unless the doctor says that nursing will hurt the mother or that her milk is not good for the baby. Nursing is the easiest, cleanest and safest way to feed a baby. Breast fed babies are sick less often than
bottle fed babies. Bottle feeding is a great help—really a life-saver—when there is some good reason why a baby should not nurse. It is always a makeshift for the baby’s best food. No mother who is trying to do her best for her baby would use it if she could help it.123

Another MCA handbook, for public-health nurses in obstetrics who led classes for expectant parents, “assumed that every mother intends to nurse her baby”; it told nurses to explain to mothers that breastfeeding causes the uterus to contract after birth and to “urge breast feeding” in special classes for fathers. This guide did suggest that nurses demonstrate how to make formula just in case a baby needed supplementary feedings or a mother could not breastfeed, but the demonstration showed that formula making was very cumbersome. In fact, the guide advised: “After this demonstration, it is well to comment on what is very obvious that the mother who can breast-feed her baby and not bother with formula is indeed fortunate.”124 Thus, at a time that many physicians discouraged breastfeeding, MCA nurse-midwives actively encouraged it.

As at FNS, MCA’s comprehensive prenatal, labor-and-delivery, and postpartum care program made a difference in its patients’ lives. Table 3.2 shows very low maternal mortality rates for Lobenstine Clinic patients, compared with the population of New York City and the nation as a whole. As with FNS, these rates are particularly impressive given that Lobenstine Clinic patients were generally poor, African American or Puerto Rican, and often lived in substandard housing, had poor health, and worked long hours in difficult jobs. As scholars have pointed out, race and ethnicity did not cause a higher risk of maternal death; rather the high percentage of these women who were poor, overworked, and unhealthy put them at risk.

<table>
<thead>
<tr>
<th>Maternity Center Association</th>
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<tbody>
<tr>
<td>(1081 deliveries, 1 maternal death)</td>
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<tr>
<td>New York City</td>
<td>104</td>
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<td>United States:</td>
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<tr>
<td>Total population</td>
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<tr>
<td>White population</td>
<td>51.2–58.1</td>
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<tr>
<td>Non-white population</td>
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Table 3.2 Maternity Center Association and Comparison Groups: Maternal Mortality Rate (per 10,000 births), 1932–1936125
Like FNS, MCA compiled statistics so that it could prove to the nation that its program of maternal and infant care was successful. Prior to its founding the nurse-midwifery school and clinic, MCA hired well-regarded statistician and Metropolitan Life Insurance Company vice president Louis I. Dublin, whom Mary Breckinridge had also employed for FNS. Dublin analyzed records from 1919 to 1921 for 8,743 patients receiving prenatal care from MCA nurses and postpartum care from Henry Street Settlement House, and he and MCA director Hazel Corbin compiled statistics on an MCA demonstration project between 1922 and 1929 that showcased the association’s maternity work in a square mile in Manhattan. Once MCA opened its nurse-midwifery clinic, it did statistical analysis in-house. Laird, medical director of MCA’s nurse-midwifery service from 1931 to 1947, analyzed statistics on mortality and morbidity for patients cared for by MCA nurse-midwives between 1932 and 1936. Obviously, the fact that MCA’s nurse-midwifery service staff analyzed the data themselves could call into question the findings. However, there is no reason to believe that the data are false. MCA statistical evidence did show some maternal morbidity and mortality, and as a pioneer in nurse-midwifery, MCA had every reason not to want to hurt its reputation by developing faulty data.

Conclusion

MCA’s Lobenstine Midwifery School trained nurse-midwives who then went on to perform much-needed work as supervisors of traditional midwives and nurses throughout the United States, and the Lobenstine Midwifery Clinic provided maternity services to a poor, minority population in need of better care. One could imagine that MCA administrators and supporters would have wished to promote the organization’s excellent, pioneering work in nurse-midwifery, especially given its skill at using media. From its beginning, MCA used the media to carry out its goal of “popular education”—to convince women that they needed to know more about pregnancy and childbirth to make maternity safer. Using connections to New York City’s elite, MCA pushed its agenda in pamphlets, books, billboards, radio talk shows, and even World’s Fair exhibits. But while its annual reports explained the nurse-midwifery training offered at the Lobenstine School, MCA did not publicize this in its mass-media materials. MCA helped invent a new professional, the nurse-midwife, yet chose
not to advertise her. More than that, MCA's media campaign pushed prospective mothers and fathers toward obstetricians, rather than promoting the new alternative to obstetricians MCA had helped create. Ultimately, MCA made the promotion of nurse-midwifery a lower priority than pushing women to seek early prenatal care.

Why did MCA make this choice? With the deep antagonism of most physicians toward anything “midwife” and the trend toward hospitalization of childbirth, it was politically safer not to promote the nurse-midwife and the Lobenstine Clinic's home-delivery service. Yet MCA had not shied away from controversy; its media materials discussed pregnancy and childbirth in an age when doing so was seen as “bad taste” and at times “obscene.” In the 1930s, some newspapers prohibited the use of the word “pregnancy,” and the New York State Board of Regents banned the film, *The Birth of a Baby*, produced with assistance from MCA, as “indecent, immoral, and tending to corrupt public morals.” MCA was a progressive organization dedicated to breaking down barriers to maternal health care. But MCA had several priorities. The nurse-midwifery service and school, although among MCA concerns, were so novel and radical that the organization decided not to use valuable media capital promoting them.

Like FNS's Mary Breckinridge, MCA physicians and nurses had to make compromises in establishing their pioneering nurse-midwifery school and clinic. They always had to be concerned about the attitudes of New York City's physicians and nurses. Physicians feared that nurse-midwives would be competitors and that they would lower the reputation of obstetrics. Nurses worried about stepping on physicians' toes and acting too much like physicians (read: independent practitioners) and not enough like nurses (read: assistants). In addition, they were concerned that the association of nurse-midwives with traditional midwives would lower nurses' reputation. Many physicians and nurses believed that midwives—whether traditional midwives or educated nurse-midwives—should no longer exist. After years of work and criticism from opponents, MCA leaders carefully crafted the new school and clinic so that they would offend the fewest people. They opened their school in the largest city in the United States to train women who would work only in the most remote areas of the country. Those women gained experience by providing maternity care for poor women of color—patients whom other health care providers did not want to serve.