PART II

Active Labor,
1940–1960
Introduction

As an unmarried woman who received multiple advanced degrees, Kate Hyder was unusual for her era but quite typical of prominent mid-twentieth-century nurse-midwives. Born in 1905 in Hendersonville, North Carolina, Hyder received a bachelor’s degree from the North Carolina College for Women (now the University of North Carolina, Greensboro) in 1925 and a nursing degree from the Johns Hopkins School of Nursing in 1928. She stayed at Johns Hopkins Hospital to work in obstetrics for five years and then worked at the Rockefeller Institute of Medical Research for several years. At that point, Hyder was lucky enough to receive a scholarship to attend Teachers College at Columbia University. As part of her master’s program there, she studied midwifery for six months at Maternity Center Association’s Lobenstein Midwifery School (where she received her nurse-midwifery certificate in 1936), attended Teachers College during the second semester, and then worked in public-health nursing in North Carolina for two years as part of her scholarship requirements. She then returned to her education at Teachers College, where she supervised and taught nurse-midwives until completing her master’s degree in nursing in 1941.

In the years following her graduate education, Hyder held jobs in several places. With the support of Maternity Center Association (MCA), Hyder helped found a new and short-lived nurse-midwifery school for African-American nurses in New Orleans, which I will discuss in chapter 5. Following that, Hyder supervised midwives in Guatemala for a few
years, and then directed the nursing service at Chicago Maternity Center, an innovative home-delivery service that provided a team of physicians, medical students, and nurses to attend the births of poor, urban women.\(^2\) When she arrived at Yale University in 1946, Hyder took an appointment as assistant professor of the School of Nursing, as well as an administrator of nursing in the obstetric unit at the Grace–New Haven Community Hospital. There, over the next five years, Hyder, along with psychiatrist and pediatrician Edith Jackson and obstetrician Herbert Thoms, made radical changes in the hospital’s approach to childbirth and the postpartum period.

Hyder first met Jackson at a weekly Wednesday tea for staff physicians and nurses, where the doctor quickly assessed her. After exchanging brief niceties, Jackson immediately cut to the chase: “How do you feel about breastfeeding?” Hyder answered correctly: “I feel very good about it.” Jackson had already begun dreaming about her rooming-in project, a groundbreaking plan for newborns and mothers to stay together in the same rooms, making breastfeeding and bonding easier, and she hoped that Hyder would join her.

In fact, as Hyder recalled years later, she was well-prepared to advance the rooming-in concept even though she had never done anything like it in the hospital setting. As a nurse-midwife, she had managed home births where rooming-in occurred naturally and where most new mothers breastfed. She had attended home births in Harlem while a student at MCA and in North Carolina while working in public health. (As Hyder remembered, pregnant black women in North Carolina were essentially forced to give birth at home since southern hospitals only allowed them to give birth by the coal fire in the basement.) Her experiences with home births made Hyder “well-attuned” to the “pleasure” of having a new mother, her husband, and younger children together for the birth of a baby. Thus, Hyder joined Jackson’s crusade.

Rooming-in faced initial opposition from physicians, nursing supervisors, and nurses, yet between 1946 and 1952, the Grace–New Haven Community Hospital successfully established a small rooming-in unit. Hyder was an essential factor in the realization of the project, convincing nurses of its value and turning Jackson’s dreams into a workable plan. Although her nurse-midwifery background aided the project, she knew her training would not be understood or respected and she waited several years to reveal her nurse-midwife status to many of the physicians.

Hyder left Yale when the rooming-in project ended and continued her work as a professor of nursing, this time at the graduate school of Teach-
ers College. Five years later, she left New York City, saying it was “too big a place for me.” She joined the faculty of the University of Connecticut School of Nursing, from which she retired after fifteen years. In 1991, at age 86, Hyder died in Hamden, Connecticut, just a few miles from Yale.

Hyder was one of a number of nurse-midwives in the 1940s and 1950s who were moving in new directions. In the 1920s and 1930s, leaders at Frontier Nursing Service (FNS) and Maternity Center Association (MCA) had sought to improve American maternal and infant health care by enabling nurse-midwives to attend home births and supervise traditional midwives. Starting in the 1940s and escalating in the 1950s, nurse-midwives shifted their focus to hospitals, reflecting the nationwide trend toward hospital births. In hospitals, they brought their emphasis on the physical and emotional aspects of a new mother’s birth experience and they pioneered the nation’s first demonstrations in “natural childbirth,” as well as the Yale “rooming-in” project. But the majority of nurse-midwifery school graduates working in hospitals did not actually work as nurse-midwives. Rather, they found employment in obstetrics as nurses, nursing supervisors, and instructors. These women did not have any of the independence, or even semi-independence, of nurse-midwives actually practicing the profession for which they had trained. Instead they served as subordinate nurses within the hospital hierarchy.

The mid-twentieth century also saw the expansion of nurse-midwifery with the development of educational programs at some of the nation’s leading universities—Columbia, Johns Hopkins, Yale, and Downstate Medical Center, State University of New York—along with the creation of nurse-midwifery services at the hospitals affiliated with these universities. The expansion occurred because nurse-midwives wanted the opportunities and recognition that came with university affiliation, and hospitals, which had a shortage of obstetricians, needed more birth attendants in the wake of the baby boom. Additionally, a growing number of women demanded that more attention be paid to the emotional aspects of childbirth; this demand was better met by nurse-midwives than by any other type of practitioner. The expansion in educational programs translated into an increase in nurse-midwives. By 1963, approximately 750 women had graduated from American nurse-midwifery schools, a dramatic increase from approximately 225 in 1946. Affiliation with major universities represented a modicum of mainstream acceptance of nurse-midwifery as well as an opportunity for a small group of women to practice hospital-based nurse-midwifery, but it also meant that nurse-midwives had to work within the confines and follow the dictates of university-affiliated hospitals.
Moving into the Hospital

To understand why nurse-midwives moved to hospital employment, it is important to understand American childbirth in the 1940s and 1950s. As seen in table 4.1, the number of American births occurring in hospitals increased dramatically between 1935 and 1945 and continued to jump in the postwar era. Women increasingly wanted to deliver in hospitals, the growing centers of American medical care. As discussed in chapter 1, in the 1920s and 1930s, more and more white middle- and upper-class women went to the hospital to give birth, despite the fact that hospital births were more dangerous than home births. Hospital births only gradually became safer starting in the late 1930s and continuing into the 1940s and 1950s, with the introduction of new medical discoveries and techniques. The establishment of hospital blood banks, blood typing and transfusions decreased the risks associated with postpartum hemorrhage. The newly discovered oxytocin (a drug which hastened birth) counteracted anesthesia, which often slowed labor and asphyxiated the fetus. Heart monitoring machines detected fetal distress. X-ray pelvimetry led to early detection of pelvic deformities and other problems. During and after World War II, widespread availability of penicillin and sulfa drugs, which inhibit bacterial infections, dramatically decreased the danger of puerperal infections.

By World War II, hospitals and physicians were gaining increased prestige and authority. World War II strengthened the notion that the hospital was a place of science, with the latest technologies, diagnostic, preventive, and curative medicine, and specialized physician scientists. The wartime Office of Scientific Research and Development and its Committee on Medical Research funded and coordinated the development and production of penicillin in the United States, by connecting universities, universities,

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<tr>
<th>Year</th>
<th>Percentage of American Births in Hospitals</th>
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<td>1935</td>
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<td>1945</td>
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Table 4.1 Percentage of American Births in Hospitals, 1935–1960
government laboratories, and the pharmaceutical, chemical, and distilling industries. Widespread production and disbursement of penicillin effectively curbed infections caused by war wounds. Such nationally coordinated medical research to develop and produce penicillin was not unique; the war years saw an increased emphasis on scientific research in all aspects of pharmacology and medical practice. The need for hospital services to treat infectious disease decreased as a result of sulfa drugs and penicillin, but increased for chronic illnesses, such as heart disease, cancer, and strokes. Hospitals increasingly became places for the upper and middle classes to seek treatments and cures (often without success) for chronic disease, in hopes of prolonging life. General hospital admissions grew by nearly 32 percent between 1941 and 1946, and by 26 percent between 1946 and 1952. In the postwar years, hospitals grew further as a result of the Hospital Survey and Reconstruction Act (known as the Hill-Burton Act for its two sponsoring senators, Lister Hill and Harold Burton), signed by Harry Truman in 1946. Hill-Burton provided federal assistance to states for the renovation or construction of hospitals and health centers, reinforcing the belief that the more hospital services Americans had access to, the better off they would be. The program resulted in a massive growth of public hospitals, especially in rural areas and small towns that lacked voluntary or proprietary hospitals. The bill, both indirectly and directly, dramatically increased hospital services to the indigent.

As access to private health insurance increased from the 1930s through the postwar period so did use of hospital services. Prior to the 1930s, very few Americans had private health insurance. This changed with the development of two provider-controlled health plans, or insurance controlled by hospitals and physicians: Blue Cross, hospital insurance, in 1929, and the less popular Blue Shield, medical (or physician) insurance, in the late 1930s. Whereas Blue Cross resulted from rising costs of hospital care and the inability of patients to cover these fees, Blue Shield evolved in response to physicians’ desire to prevent adoption of government-controlled health insurance. The postwar period saw the expansion of employer-provided private health insurance as a way to recruit and retain employees. This expansion also occurred because labor unions won the right to bargain collectively for health benefits and because commercial insurance companies grew rapidly. In 1946, one-third of Americans had some kind of private hospital insurance, the most common type of insurance; 50 percent had coverage by 1950, and 75 percent by 1960. Thus, during the postwar era, more Americans, especially the middle class, gained access to the new technologies and therapeutics found in modern hospitals.
During World War II, the federal Emergency Maternity and Infant Care (EMIC) program, which was created to pay for the births of service-men’s babies, also encouraged hospital deliveries. This wartime service provided maternity care for over 1,203,500 military wives, and medical, nursing, and hospital care for their infants through age one.\(^13\) The federal government funded EMIC, and state and local health departments administered it. The program did not require either physicians or wives to participate, and the patients could choose which physicians to use.\(^14\) The EMIC program paid fifty dollars for prenatal, intranatal, and postnatal care to general practitioners, less than the going rate in large cities but more than in some smaller cities and rural areas; the program paid more to obstetricians.\(^15\) EMIC enabled many women to deliver in hospitals, who otherwise could not have afforded to do so. A wartime anthropological study of maternity care in a rural New Mexican community found: “With World War II came the EMIC program providing many Spanish-American mothers with their first experience of a hospital delivery. For many it proved a happy one and carried with it prestige, making a subsequent delivery at the hospital imperative, even without the aid of federal funds.”\(^16\) Thus hospitals drew in parturient women, through wartime government funding of maternity care, the expansion of hospitals and health insurance, and women’s own desires for safety and access to the best of medical science.\(^17\)

At the same time hospitals were attracting women, creating a need for more personnel in hospital obstetrics, the number and use of practicing traditional midwives declined, reducing the need for nurse-midwives as supervisors and trainers. The number of midwives in the rural South decreased after 1950 due to several factors: state efforts to promote professional rather than lay attendance at birth, African-American migration to urban areas, and African-American women’s lessening desire to use traditional midwives when public hospitals and welfare were available.\(^18\)

The war caused a shortage of health-care personnel, “with doctors and nurses being plucked from our civilian ranks like petals off a daisy,” explained Hazel Corbin, MCA’s director.\(^19\) Corbin’s colleague, Hattie Hem schemeyer, director of MCA’s Lobenstein Midwifery School, discussed the specific problem of wartime obstetrics in a 1942 issue of the *American Journal of Nursing*, stating that “most of [the] obstetricians were located in and around big cities, and the war has made an already poor distribution of medical service even worse.” Hem schemeyer concluded: “the idea that every mother should have her personal obstetrician doesn’t hold water when we look at the figures.”\(^20\) After the war, the United States con-
continued to experience a shortage of health-care providers, created by hospital expansion, the growth of chronic care, and increases in Americans’ visits to providers due to economic prosperity and popular and medical optimism about cures for disease. Expanding technologies and services especially prompted the need for more nurses. This factor also contributed to nurse-midwives’ move to the hospital.

Some obstetricians wanted nurse-midwives to work in hospitals, both to help patients have what they viewed as better birthing experiences and to allow obstetricians to pursue other interests. Recording the previous year’s accomplishments and coming year’s goals, the MCA’s Medical Advisory Board’s annual report for 1958 recommended increased use of nurse-midwives as part of the hospital “obstetric team” to make possible the provision of “educational and emotionally supportive facets of maternity care which are acknowledged to be desirable but are for the most part unobtainable for lack of qualified personnel.” According to the Board, “with the steadily rising birth rate, there are not, and will not in the foreseeable future be enough obstetricians to provide continuous, comprehensive maternity care to the expectant mothers of this country, particularly those cared for on overtaxed ward services.” Male obstetricians’ “combined work load of private practice and hospital duties often makes it impossible to give each patient the time and continuous personal attention conducive to the best possible results, in terms of mental and physical health, on both an immediate and a long term basis.” The Board argued that female nurse-midwives could provide that attention, thus “reducing the obstetrician’s work load” and “releas[ing] him for the teaching and clinical research needed to ensure a continued improvement in maternity care.”

The postwar baby boom also contributed to a need for more hospital personnel. During the Depression and the war, many Americans had postponed marriage and childbearing. This changed dramatically in the postwar years with the “baby boom,” which reached its height in 1957. Between 1945 and 1960, the United States population increased by around forty million, or 30 percent, creating enormous strains on hospital obstetrics departments.

Finally, women’s frustrations with the hospital birthing experiences helped create a place for nurse-midwives. Seeking safety and the benefits of scientific progress, increasing numbers of women during the war and postwar years had given birth in the hospital. Yet, many of these women found hospital births alienating. Removed from their homes, parturient women missed the traditional support systems their family members and friends provided, and they often disliked analgesics and forceps, which
hospitals commonly used. Women felt safer delivering their babies in hospitals, but missed the “tender loving care” that was such an integral part of delivering at home. According to Hazel Corbin, the “mechanization of maternity care” left women feeling like sick patients, rather than healthy laboring women; alone, without the support of family and the comforts of home; and as though “things were done to her, not with her.”

For laboring women, physicians, and nurses themselves, obstetric nurses were part of the problem. As historian of childbirth Judith Walzer Leavitt has explained, patients often blamed obstetric nurses for what they saw as impersonal, unpleasant birthing experiences. Mothers found nurses more focused on hospital routines and efficient procedures than on their individual needs. The tension may have stemmed from the fact that physicians and hospital administrators demanded that different nurses care for an individual woman in labor, delivery, and the postpartum period rather than the same nurse staying with a laboring woman throughout the process. Hospitals also dictated that nurses serve as physicians’ assistants and follow doctors’ orders, even though they might have made different decisions about a woman’s care had they been acting independently as did the nurse-midwives who worked for such services as FNS with little supervision and much success. Finally, hospitals demanded that nurses focus on procedures laboring women often dreaded and which were unnecessary from a medical standpoint, such as giving enemas or shaving pubic hair, rather than on simply spending time with their patients providing moral support in addition to physical care.

Due to widespread criticism of obstetric nursing, and nurse-midwives’ disagreement with obstetric nurses’ approach to maternity care, nurse-midwives, and their supporters, carefully distinguished their work from traditional obstetric nursing. Nurse-midwives made clear that they attended to patients from the first sign of labor through the postpartum period, taking time to stay with one patient continuously, to help family members adjust to the new arrival, and to provide support for the family and mother in dealing with the parturient woman’s normal but occasionally alarming emotional upheavals. Especially in the late 1940s and early 1950s, nurse-midwives emphasized that they, as opposed to typical obstetric nurses, focused on the psychological and emotional aspects of childbirth. As one MCA-trained nurse-midwife working in a major medical center explained, “midwifery education does not just develop the nurse as clinician, skilful in observation and judgment of the laboring woman’s physical progress. It makes it possible for her to see childbirth in its total context of family life and human values.” While obstetric nurses had to
offer routinized, or what Corbin called “mechanized” care, nurse-midwives “raise[d] nursing care in labor to a creative art, always changing to meet the demands of the individuals in the specific situation.” Similarly, an MCA publication explained, “Great progress, as expressed in mortality rates, was undoubtedly made in American obstetrics in the past thirty years. In the stress on primary objectives of safety, however, too little attention was paid to the social and emotional aspects of childbearing and their influence on family life. The nurse-midwife is helping to restore the emphasis on patient-centered care and total health of mother and child.”

The publication argued that the nurse-midwife could “supply something valuable which had previously been lacking in hospital maternity care, and which the obstetricians did not have the time, nor the unprepared nurse the specialized education, to provide.” By 1952, Corbin claimed nurse-midwives, “though few in number,” were the “torch bearers,” changing maternity care from “the ‘obstetrical factory’” and the “delivery room where every professional is an impersonal, masked automaton,” to personal care emphasizing the individual needs of mothers, fathers, and newborns. Corbin wrote numerous articles in nursing journals decrying the lack of attention paid to women’s emotional needs and hoping to change nurses’ and physicians’ attitudes toward pregnant, laboring, and postpartum women. She and other MCA staff and students believed nurse-midwives could help women reclaim support and control over their births.

Despite nurse-midwives’ claims about their differences from obstetric nurses, most nurse-midwifery school graduates who worked in hospitals in the 1940s and 1950s were invisible because they were not practicing nurse-midwives. Instead, they worked as obstetric nurses, obstetric nursing supervisors, or instructors of obstetric nursing. While these women applied their nurse-midwifery experience to their hospital-based nursing jobs, their patients, fellow health-care personnel, and the public rarely knew that the women staffing these positions had trained as nurse-midwives. In fact, it is difficult to find information about the typical hospital nurse-midwives of this era because most of the records do not differentiate between them and nurses who did not have nurse-midwifery training.

Available records suggest that nurse-midwifery school graduates who worked in hospitals found their nurse-midwifery background provided them with broader experience in maternity care than they had received in nursing school; this experience gave them much-needed skills and confidence for their work in hospital maternity wards and nursing schools. For example, Barbara Sklar Laster, a 1948 graduate of MCA’s Lobenstine
Midwifery School, said that in her job as an obstetric and general duty nurse at Detroit’s Deaconess Hospital, “I worked nights by myself in [the] labor and delivery ward for 1 yr. Midwifery taught me to do rectals, determine progress and detect abnormalities in labor.” Mildred Disbrow, a 1950 graduate of FNS’s nurse-midwifery school, found her nurse-midwifery experience very helpful in her position as supervisor of obstetric nursing at a Pittsburgh-area hospital. Because the institution had no medical interns or residents, the “supervisor assumed much responsibility for labor management.” Disbrow also noted that her nurse-midwifery training augmented her teaching when she became a professor of obstetric nursing at the University of Pittsburgh. It helped her “in teaching total care since as a midwife one stays with [the patient] in her home throughout labor” and in taking a “better public health approach” with maternity patients.

However, a nurse-midwifery background could also lead to frustration for women working in hospitals, since what they had come to see both as an ideal birthing experience and an ideal professional experience were often impossible to achieve in the postwar hospital setting. Hospital nurses were not in charge of new mothers from pregnancy through the postpartum period and thus could not practice their sustained, holistic approach to the prenatal, labor-and-delivery, and postpartum stages of pregnancy. Additionally, they sometimes encountered barriers while trying to use their education. As nurses and nursing instructors, they were expected to live up to and teach the traditional nursing ideals of subservience; yet they often felt such conservativism in the hospital setting did patients a disservice.

For example, Aileen I. Hogan, who followed graduation from Lobenstine School in 1947 with a three-year stint as chair of maternity nursing at the Frances Payne Bolton School of Nursing at Western Reserve University (now Case Western Reserve University) in Cleveland, said that while her nurse-midwifery experience provided essential “background and authority in teaching,” it was “also quite frustrating” for her to be “10 years ahead of current practice” and not be allowed to implement her training and experience with hospital patients. Like Hazel Corbin and other nurse-midwives, Hogan criticized maternity nursing, believing that many hospital maternity nurses were not well rounded and well trained like nurse-midwives and that they did not provide new mothers with “a sense of continuity of care.” Despite Hogan’s criticisms, she and other hospital nurse-midwives who worked as nurses or nursing instructors must have continued (whether by choice or dictate) at least some and perhaps many of the hospital routines that depersonalized maternity patients. And while
Hogan ultimately departed the hospital setting, too frustrated with the barriers she encountered, those who stayed may have internalized some of the more rigid maternity nursing values even as they tried to change them. At the very least, they would have had to adhere to traditional nursing practices as a way to maintain their employment in hospitals that required such obedience to protocol.

**Pioneers in Natural Childbirth**

One small group of nurse-midwifery graduates who worked in hospitals made a significant contribution to hospital births by pioneering “natural childbirth” in the United States. In 1947, MCA brought British obstetrician Grantly Dick-Read (1890–1959), who invented the concept and practice of natural childbirth in 1933, to the United States for the first time. According to Read, modern women had been conditioned from childhood to fear childbirth, but could be taught to undo that conditioning through education and relaxation techniques. Once a woman was fully aware of what would happen to her, she could eliminate her fear—and thereby her pain—along with the need for pain-relieving medications. Beginning later the same year Read arrived, MCA nurse-midwives instructed patients in preparation for natural childbirth, offering classes to first-time mothers who registered at MCA for home delivery and eventually to interested mothers who had attended MCA mothers’ classes and planned to give birth at local hospitals. Graduates from Lobenstine School also staffed natural childbirth demonstrations in New Haven and New York City hospitals in the late 1940s and early 1950s. With extensive attention from the media, including articles titled “I Watched My Baby Born” and “Natural Childbirth: Young Mother Has Her Baby with No Fear, Little Pain,” MCA staff and MCA graduates set up the nation’s first “natural childbirth” classes, initiating a trend that would become significant in the 1970s and remains so in the present.

Historians explain that natural childbirth’s popularity among American women was related to decreases in maternal mortality that had become widespread by the mid-twentieth century. Women felt, and indeed were, safer in childbirth than ever before; thus, they and their health-care providers could concentrate on more psychological aspects of birth. This new focus led to “natural childbirth,” which offered an alternative to increasingly mechanized, anesthetized, and impersonal hospital births.
MCA nurse-midwives began to offer their patients prenatal education in natural childbirth for two reasons. First, nurse-midwives’ long-standing values and beliefs fit well with the requirements of the natural childbirth method. Since the 1920s, nurse-midwifery organizations had espoused the normality of pregnancy and labor and valued an investment of time and close personal relationships with patients. Second, the natural childbirth method appealed to nurse-midwives because it gave them a definite role in hospital obstetrics. Although nurse-midwives still attended the births of many poor women in their homes, their role as home-birth attendant and supervisor of “granny” midwives had diminished. They created a new niche for themselves: improving obstetric nursing in the hospital. Part of their improvement plan included introducing the new method of natural childbirth. Genuinely believing in the benefits of natural childbirth, nurse-midwives thought their special skills and training would enable them to be experts in and teachers of the method.

MCA nurse-midwives based their instruction on Read’s *Childbirth without Fear* (1944) and on *Training for Childbirth* (1945) by Minnie Randall, a British nurse and physical therapist. In fall 1947, Helen Heardman, a British physical therapist who had worked with Read and other British obstetricians, came to MCA and helped reshape MCA’s approach toward natural childbirth. Because Read’s book dealt mostly with theory and not with specific ways to help patients, Heardman focused on practice. She taught MCA nurse-midwives exercises and relaxation techniques for women in the prenatal period and in labor and delivery. Beginning in fall 1948, MCA opened its natural childbirth classes to all women registered for home delivery through its nurse-midwifery service, and to those attending mothers’ classes at MCA who were interested in or whose obstetricians had requested that they prepare for natural childbirth. MCA provided a series of six classes, lasting one-and-one-half hours each, for nurse-midwives to explain the principles of natural childbirth, including “the hard work required of the mother during labor,” “the persistent effort she must make during pregnancy to acquire patience, self-control, and ability to relax and carry through to the end,” and “the satisfactions of being awake to participate in the baby’s birth progress and hear its first cry as soon as it is born.” They also taught breathing and relaxation exercises.

Pregnant women wore loose clothing so they could participate fully in the exercises, designed to help women “utilize breathing in the relaxation of their bodies and minds” and “strengthen the muscles which are active in labor, to increase their elasticity, improve their tone, and use them purposefully.” Women were to practice these exercises at home, preferably...
with their husbands, and sometimes even their children. MCA titled the last class, “Rehearsal for Labor,” in which pregnant women learned about the sensations and procedures they would experience throughout the course of labor. In this last class, women practiced the breathing and exercises in the actual positions hospitals expected them to assume during the first and second stages of labor. Advocates of natural childbirth believed women must understand the natural childbirth method thoroughly to have a satisfying birth, for “upon completion of these classes, a report of each mother’s participation and performance is sent to the doctor who requested her attendance at the series.”

Natural childbirth provided MCA nurse-midwives entrée to hospital obstetrics as nurse-midwives. The nurse-midwives created a raison d’être for themselves, arguing they “filled a gap in existing maternity services, helping the hospital and obstetrician to provide more complete and satisfying care to expectant mothers and their families.” MCA staff believed that nursing education, even graduate education in nursing, did not prepare nurses well to care for maternity patients. As an MCA publication explained, “A few leaders in obstetric nursing education recognized how inadequate the available preparation was to provide either satisfying service to the mother or professional gratification to the nurse. Those who had first-hand experience with nurse-midwifery and the use of nurse-midwives in public health work realized that here was a possible answer to some of the major problems in obstetric nursing education and patient care.”

In the late 1940s and early 1950s, MCA participated in two hospital demonstrations of natural childbirth, one at Grace–New Haven Community Hospital and the other at Columbia-Presbyterian Medical Center. From 1948 to 1949, MCA, in cooperation with Yale University’s Schools of Medicine and Nursing and Grace–New Haven Community Hospital, participated in a widely reported demonstration of the principles of natural childbirth run by Herbert Thoms (1889–1972), chief of obstetrics and gynecology at Yale University.

This first demonstration took place outside New York City, in part because of MCA’s inability to get enough obstetricians at a New York hospital to start a demonstration. Eight nurse-midwives, all graduates of the Lobenstine School, served in the Connecticut hospital, two at a time for six months each, financed by MCA. Two physicians, also subsidized by MCA, worked with them. MCA nurse-midwives instructed patients in this experiment in six prenatal classes, offering one lecture and two exercise classes during the early stages of pregnancy, and another lecture and two more
exercise classes on labor and delivery in the last month of pregnancy. The 
last class included a tour of the labor and delivery rooms in the hospital.49

Yale’s natural childbirth demonstration coincided with its pioneering 
Rooming-In Research Project run by psychiatrist and pediatrician Edith 
Jackson and nurse-midwife Kate Hyder. Many women who used natural 
childbirth also tried rooming-in and breastfeeding. At first, most Yale 
physicians and nurses opposed rooming-in. As Hyder explained, the 
obstetricians opposed it because they “didn’t think the mothers needed to 
know anything more than what they told them,” and the nurses were afraid 
of change. Typically, obstetric nurses knew about mothers but not babies 
and nursery nurses knew about babies but not mothers. The rooming-in 
project required that nurses perform tasks that they had not been trained 
to do—work with mothers and newborns together, and the nursing super-
visors feared that the project might necessitate the use of more nurses dur-
ing a terrible nursing shortage.50

Despite resistance to rooming-in, Hyder and the physicians opened a 
small unit from 1946 to 1952. As Grace–New Haven Community Hospi-
tal’s director during this era suggested, Hyder may have been the key to the 
project’s success. She succeeded in convincing the nursing supervisor and 
the nurses in maternity and nursery services—all of whom were originally 
opposed to this seemingly radical idea—of its advantages. Hyder com-
pleted a time study showing that one nurse spent less time caring for four 
mothers and babies together than did separate obstetric and nursery nurses 
working in the more typical manner. She also began the rooming-in unit 
with a graduate nurse and Yale nursing students who supported the idea, 
so that the unit’s first employees were people unused to traditional hospi-
tal routines and therefore not afraid of change.51

In addition, Hyder served as a bridge between Jackson’s rooming-in 
ideals and the reality of hospital routines. For example, Jackson wanted the 
mother to nurse her baby whenever the baby needed to be fed, even if a 
nurse had just brought the mother a tray of food. But Hyder explained to 
Jackson that this could not work because if the mother did not eat right 
then, the tray would be taken away because no staff member was available 
to reheat it. So Hyder came up with that she saw as a solution: “the nurse 
on the ward would come and pick up the baby and pat it and try to placate 
it until [the mother] had finished eating.” Hyder believed that this was the 
way “to keep the mother happy but liv[e] within the routine of the hospi-
tal.”52 She was more realist than revolutionary, making an unorthodox pro-
ject work within conservative hospital routines and among staff afraid of 
change, while subtly refusing to push for Jackson’s true goal: total priority
placed on the breastfeeding relationship between mother and newborn.

Unlike the MCA-Yale demonstration, MCA’s second attempt to promote natural childbirth did not coincide with a rooming-in project. From 1951 to 1952, MCA sponsored a natural childbirth demonstration in conjunction with Columbia-Presbyterian Medical Center at the Sloane Hospital for Women. An MCA nurse-midwife, who had spent six months at the Grace-New Haven project, conducted the study. She acquainted herself with the staff, procedures, and attitudes toward parents at the hospital, finding that many nurses had already attended MCA for instruction on preparing mothers for natural childbirth, and welcomed the opportunity for other nurses to receive this preparation. The MCA-Columbia-Presbyterian program for preparation in childbirth began with a series of six classes for mothers, each lasting an hour and a half. Later in the study, mothers and fathers received instruction together. The nurse-midwife in charge analyzed the deliveries of three different groups: randomly selected registrants in the prenatal clinic who were asked if they wanted to attend natural childbirth classes and did so; randomly selected registrants in the prenatal clinic who expressed initial interest but chose not to attend the classes because they could not find child care for their other children, were unable to speak English, or lost interest; and women who explicitly sought instruction in natural childbirth. The medical and nursing staff always offered medication “whenever the patient showed any sign of stress or increasing discomfort.” They found that patients who attended the classes required fewer analgesics and smaller dosages than those who did not attend the classes, although the majority of patients in all groups used some Demerol, Seconal, and/or scopolamine.

The nurse-midwife and obstetrician who coauthored the study concluded that natural childbirth aided both the family and the hospital, strengthening parents’ ties to one another and helping them “develop a family feeling about the baby.” It also brought together various specialists within the hospital, creating less anxiety and “more intelligent cooperation” of patients with physicians. Significantly, many of the prepared patients were probably middle-class. The non-English speakers and those who could not find baby-sitting made up a large percentage of those choosing not to attend the natural childbirth classes. At the end of the two-year demonstration, the nurse-midwife became a full-time member of the nursing faculty at Sloane Hospital for Women, “ensuring continuation of the program.”

MCA solicited letters from women who took natural childbirth classes at MCA demonstration sites from around 1947 to 1951. Unlike many of
nurse-midwives’ earlier clientele, who were poor and often from racial or ethnic minorities, most of these letter writers were middle class, and most likely white. The letters, which are an invaluable source for patients’ perspectives, reveal that natural childbirth provided choices to women who were unhappy with the existing childbirth options. The majority of the women who wrote to MCA about their natural childbirth expressed satisfaction with the method, saying that it gave them a sense of security and control, support during labor and delivery, an immediate connection with their newborns, and reduction or elimination of fear.

A physician’s daughter explained that after reading Childbirth without Fear, she wanted to deliver as a “Read patient.” Delivering without anesthesia or analgesia, she reported, “I honestly had no pain at all and have never been through such a miraculous experience in all my life. I watched the entire process in the anaesthetist’s mirror.” She followed her natural childbirth with a stay in the rooming-in unit where her baby slept in a crib next to her. A nurse whose husband was a medical student also sang the praises of natural childbirth because she enjoyed “the privilege of being aware and of seeing what was taking place.” Like the physician’s daughter, the nurse followed her birth with rooming-in, “complet[ing] an unbelievably enjoyable hospital experience.” The wife of a Yale student who delivered naturally and roomed-in with her infant emphasized three aspects of her birth experience that she especially enjoyed. First, she had one nurse throughout her labor, giving her “a sense of security to have someone know just what was happening and of the progress I was making. She explained what was occurring and what could be expected.” Second, she was reassured by the use of the word “contractions,” rather than “pains.” Third, she found “the mirror over the delivery table . . . very reassuring. It meant I could see exactly what was happening and all fear was removed.” The natural childbirth method appealed to these women because it offered them an alternative to the typical postwar childbirth experience, providing them with awareness during and immediately after the birth, emotional support, immediate bonding with their baby, and the promise of decreased pain.

Ironically, nurse-midwives who were still delivering babies at home or supervising traditional midwives knew more about natural childbirth—if “natural” is defined as “present in or produced in nature”—than those employed at the Yale or Sloane natural childbirth demonstrations. At home, birth tended to involve less technology and fewer interventions; in other words, there was less “science” and more “nature.” At hospitals, pioneering nurse-midwives and physicians involved in natural childbirth tried
in some ways to recreate what had been typical in other settings, cultures, and eras.

Although nurse-midwives taught natural childbirth at relatively few hospitals in the late 1940s and early 1950s and although other health professionals soon became involved in establishing natural childbirth classes, avant-garde nurse-midwives set the stage for a rethinking of childbirth practices in U.S. hospitals. In the 1970s, the feminist, women’s health, and consumer movements combined to produce a new interest in natural childbirth. Increasing numbers of women demanded their right to be fully awake and aware during delivery and condemned what they saw as misogynistic medical practices controlling a fundamentally important and defining event in their lives as women. Today, shifting norms and values have caused a change; women are no longer given an amnesiac whereby they forget the childbirth experience as was typical in the mid-twentieth century. Now, most of the drugs given to women during labor, such as epidurals, allow them to participate consciously in the birth of their babies. Some women want their births to involve as few interventions as possible and actively seek out health practitioners who will support them in their approach.

Hospital Demonstrations and New University Programs

In the mid- to late 1950s, nurse-midwives accelerated their move into the hospital by creating nurse-midwifery educational programs at three major university medical centers, Columbia, Johns Hopkins, and Yale, all of which had large teaching hospitals associated with them. The heads of obstetrics and gynecology departments at the large hospitals associated with these university medical centers welcomed the opportunity for nurse-midwives to attend the skyrocketing numbers of baby boom births, which obstetric residents were unable to handle on their own. Additionally, in 1958, MCA closed its home-delivery service due to women’s decreased interest in home birth, and simultaneously moved its School of Nurse-Midwifery to Downstate Medical Center, State University of New York in Brooklyn, New York, using Kings County Hospital for students’ clinical experience. The nurse-midwives working at these four university medical centers were unique: unlike other nurse-midwives working in hospitals in this era, these women actually worked in hospital nurse-midwifery services and practiced hospital-based nurse-midwifery.
MCA heavily influenced the four new programs. Columbia, Johns Hopkins, and Downstate Medical Center were directly affiliated with MCA, and their nurse-midwifery directors were graduates of the Lobenstine School. Although not directly affiliated, Yale’s program had several important connections to the association, including the Yale-MCA natural childbirth program that laid the groundwork for the school, and Ernestine Wiedenbach, the administrator of Yale’s nurse-midwifery program, who was a Lobenstine alumna and had worked at MCA. Given MCA’s influence, it is no surprise that the four programs were interconnected. Nurse-midwifery students at one institution often gained additional clinical experience at one or all of the other three institutions.

The four programs had a number of similarities. Columbia, Johns Hopkins, and Yale had conducted earlier demonstrations with nurse-midwives, either natural childbirth programs or pilot nurse-midwifery services, before opening schools of nurse-midwifery and placing students in their affiliated hospitals. Nurse-midwives worried about convincing not only fellow health professionals but also expectant mothers of their value, given that by this time most American mothers expected physician management of pregnancy and birth. Thus the programs claimed that the earlier demonstrations proved the efficacy using nurse-midwife students and staff to work with normal cases, and that the nurse-midwives convinced their necessary audiences of this success. The programs trained students to stay with mothers throughout labor—which was atypical for nurses and physicians in this period (and even today)—and to emphasize emotional aspects of childbirth. They all received extensive support from chiefs of obstetrics and gynecology in their institutions. In particular, Nicholson Eastman from Johns Hopkins and Louis Hellman from Downstate Medical Center were nurse-midwife enthusiasts, believing that nurse-midwives provided excellent, personalized care and that they were essential to resolving the huge shortages in obstetric personnel.

Nurse-midwives and physicians working at these major medical centers challenged hospital routines in childbirth and assumptions about the necessity for predominantly male physician management of childbirth. They reflected frustrations with current trends in hospital-based, obstetrician-managed childbirth, and they showed that the “male medical model” of medicine and science did not go unchallenged in the mid-twentieth century. These nurse-midwives and physicians worked within the system to challenge existing norms, which meant that their challenge was fundamentally conservative. They worked and led departments at the top medical and nursing schools in the United States, they certainly
believed in the value of obstetricians managing birth, and they had to make compromises in order for nurse-midwives to be accepted. But perhaps working within the system made the challenges offered by nurse-midwives and physicians associated with the new nurse-midwifery programs especially subversive. They challenged the rules, written and unwritten, in the very institutions that influenced larger trends in American medicine.

Columbia

In 1955, Columbia University’s School of Nursing established a nurse-midwifery program, in cooperation with MCA, Columbia’s School of Public Health and Administrative Medicine, and the Presbyterian Hospital in New York City. This program was administered by two MCA nurse-midwives and one registered nurse. Students took either an eight-month course to receive a certificate in nurse-midwifery or a twelve-month course to receive simultaneously a master of science in nursing and a certificate in nurse-midwifery. Master’s students majored in public health or hospital nursing. Students received clinical experience at Sloane Hospital for
Women (which was part of the Columbia-Presbyterian Medical Center), as well as at MCA before it closed its home-delivery service in 1958, and at Kings County Hospital once MCA transferred its work to that location.64

Columbia laid the groundwork for its nurse-midwifery educational program in two ways. First, as discussed earlier, it conducted a demonstration in natural childbirth classes. After the demonstration ended in 1953, Margaret Hogan, Lobenstine alumna and coordinator of the Sloane demonstration, became a full-time faculty member at Columbia’s School of Nursing. Then, “with the cooperation of the medical and administrative staffs,” she worked with two nurse-midwives from MCA to develop a nurse-midwifery program and advanced maternity nursing at Columbia.65

Second, in January 1954, Columbia tried a pilot nurse-midwifery service at Sloane. Nurse-midwives staffed prenatal clinics for women whose pregnancies were expected to be normal and who received approval from an attending or resident obstetrician. Obstetricians saw the expectant mothers in the sixth and ninth months of pregnancy and if any abnormalities appeared. Deemed a success, “these [prenatal] clinics fitted in well with the hospital's clinic and educational program.” The “medical results were comparable to those in the rest of the service,” and “not one mother refused” the program once it was explained—in fact, “many who were passive at the start evinced interest and satisfaction as their care progressed.” Later that year, MCA registered twelve expectant mothers to deliver at Sloane with a nurse-midwife. However, “instead of allowing the nurse-midwife to assume full responsibility under the supervision of the medical staff as long as progress remained normal, the resident assumed full responsibility, wrote all of the orders, and scrubbed in with the nurse-midwife for delivery.” By spring 1955, though, the obstetricians must have decided that they trusted the nurse-midwives because they allowed the nurse-midwives to deliver the babies of ten of the twelve mothers registered.66

In September 1955, after slowly paving the way, the Columbia-MCA program began granting master's degrees in maternity nursing and certificates in nurse-midwifery. According to its 1957–1958 course catalogue, students learned to be “specialist[s] on the obstetric team,” managing all phases of pregnancy and childbirth, “with medical guidance,” in normal cases, and providing and supervising care of newborns. Students provided “not only expert obstetric care, but [also] education of the expectant parents for their role, preparation of the mother for the labor experience, skilled attendance and emotional support throughout labor, and integration of maternity care with good family living.” Program sponsors believed

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that nurses needed nurse-midwifery education if they intended to perform certain jobs, such as teachers of expectant parents, consultants in maternal and child health, supervisors of public-health nurses or hospital maternity departments, obstetrics instructors in nursing schools, instructors and directors of nurse-midwifery schools, and supervisors and teachers of traditional midwives. The master’s program, which some students took in conjunction with the nurse-midwifery certificate, required students to take a wide array of classes to gain a broader knowledge of the administration of hospitals or public-health agencies. Located in one of the nation’s premier nursing schools, this program was innovative because it taught student nurse-midwives in a university setting and provided them with practical experience at a major urban hospital.

Johns Hopkins

In 1956, MCA helped establish another university-affiliated program at Johns Hopkins University, administered in partnership with the Department of Obstetrics of the Johns Hopkins University School of Medicine and Johns Hopkins Hospital. This program’s international focus made it unique. For the first three-and-one-half years, the Johns Hopkins Hospital received funding from the China Medical Board of New York “to train as many foreign students as possible, as well as American nurses planning to serve abroad,” to work in maternal and child health in underdeveloped countries. After that time, the hospital received funding from the United States Children’s Bureau. By April 1961, forty-six of the first eighty students who had completed the Hopkins program worked outside the United States, mostly in Africa.

Like Columbia, Hopkins conducted a pilot program with nurse-midwives prior to establishing a nurse-midwifery school. In this program, nurse-midwives were called “obstetric assistants.” Although the title seemed to link them tightly with obstetricians, they were no more or less independent than nurse-midwives in other programs. At the prenatal clinic, the obstetrics professor was always present, but the obstetric assistants “assumed complete responsibility” for the prenatal care of mothers whose pregnancies and deliveries were expected to be normal. The obstetric assistants also handled deliveries of these patients, with “medical consultation and supervision . . . available as needed,” and they took responsibility for postpartum care as well. The pilot program worked; after the first six months, only two of 114 mothers refused to register with the obstetric assistants.
After this success, Hopkins founded a nurse-midwifery educational certificate program under the direction of Nicholson Eastman, chief of obstetrics at Johns Hopkins Hospital, Sara Fetter, Loberstine alumna and director of the Hopkins nurse-midwifery program, and Hattie Hemschmeyer, associate director of MCA. All Hopkins students took courses and received clinical experience at both MCA and Hopkins—with four months spent in New York City and four months in Baltimore; thus in the early years they learned about both home and hospital deliveries, until MCA discontinued its home-delivery service. Students took courses in medical issues—Normal Obstetrics, Problems and Complications in Obstetrics, and Anesthesia and Analgesia. They also learned to work with parents—Preparation for Group Work with Parents and Marriage Counseling, and in different employment settings—Midwifery in Developing Countries, Administration for Nurse-Midwifery Education, Introduction to Public Health, and Maternal and Child Health Service.

At Johns Hopkins Hospital, a team of three, which included the director of the nurse-midwifery program, a nurse-midwife instructor, and the assistant resident, met every month to decide which expectant mothers should be transferred to the nurse-midwifery service for their maternity care. Patients were then given an option between the nurse-midwifery service and the medical service (conducted by obstetricians and medical residents), with the fees being the same for both. At the nurse-midwifery service, nurse-midwife students, under the supervision of a nurse-midwife instructor, managed all aspects of prenatal care; patients saw the assistant resident if complications developed (and were transferred to the medical service for the remainder of the pregnancy, if necessary). Once a patient in the nurse-midwifery service went into labor, she was admitted to the labor-and-delivery suite, met by the nurse-midwife student, and then examined by the assistant resident and the nurse-midwife student. The nurse-midwife student, “under the supervision of the nurse-midwife instructor and with medical guidance available from the assistant resident,” managed the labor and delivery, staying with the patient the entire time. Nurse-midwife students then visited their postpartum patients and newborns at least twice each day until they were discharged on the third or fourth day after delivery, and then several visits once the mother and baby left the hospital. At the six-week postpartum visit, the nurse-midwife student examined the patient, and the obstetrician reviewed what she did with her. Thus, Johns Hopkins nurse-midwives managed most of the prenatal, labor-and-delivery, and postpartum care of their patients, using
medical guidance and intervention only when necessary.

Yale

In 1956, Yale University’s School of Nursing established a master’s of science in nursing program in maternal and newborn health nursing, with an optional elective in nurse-midwifery. Although not affiliated with MCA, this program was directed by MCA alumna Ernestine Wiedenbach, who was known as the “relaxation lady” by doubting physicians. Fellow MCA staff had paved the way for the Yale nurse-midwifery program with the natural childbirth demonstration, “convinc[ing] the medical directors associated with Yale that nurses with specialized knowledge of obstetrics could improve hospital maternity care and contribute to the education of nurses and physicians.”75 After working at the natural childbirth demonstration, Wiedenbach joined the Yale School of Nursing faculty in 1952. When the School of Nursing decided to include graduate programs, Wiedenbach, influenced by her “friend, counselor and advisor” Hazel Corbin, promoted a specialized master’s program in nurse-midwifery.76

Yale’s maternity nursing program focused on the psychosocial aspects of birth management. Its curriculum “provide[d] an opportunity for the nurse to broaden her understanding of people and of relationships through the social and behavioral sciences and to deepen her knowledge of her chosen clinical area through the nursing, medical and public health sciences.” Courses included a Patient Centered Seminar, Psychodynamics, Marriage and the Family, and The Nature of Culture. Students received experience in the maternity out-patient department, labor-and-delivery unit, and rooming-in unit of the Yale–New Haven Medical Center.77

However, Yale was unable at first to grant nurse-midwifery certificates to master’s students who wanted them. The place where the students gained clinical experience, the University Service of the Grace–New Haven Community Hospital, did not allow them to develop the independent thinking skills nurse-midwives needed. With few mothers registered for the service, and medical students and first-year residents seeking similar field experience, the nursing students gained “meaningful experience in maternity nursing,” including “counseling and conducting a complete visit with a mother in clinic, testing her blood and urine, teaching classes in preparation for childbirth and parenthood, supporting mothers-in-labor, delivering them with guidance from the resident obstetrician, and meeting needs for . . . mothers and their newborn presented during their
postpartum—postnatal stays in the hospital.” This experience, according to Wiedenbach, was “an introduction to skills implicit in nurse-midwifery,” but not “an experience in nurse-midwifery practice per se” because “it was too medically dominated.” Wiedenbach explained,

The nurse-midwife instructor and her student, for instance, could not, because of medical policy, act on their evaluation of a mother’s normal obstetric progress or need, without first obtaining the approval of the resident obstetrician. The policy required that he make his own evaluation of every situation and his decision was final. In relation to nursing, this policy was appropriate. The fact, however, that responsibility for management of a mother’s normal labor could not be delegated to the nurse-midwife instructor and her student, impeded the student’s ability to develop judgment essential for the practice of nurse-midwifery.

Beginning in 1958, Yale provided interested maternity nursing students an opportunity to get a certificate in nurse-midwifery by providing summer field experience at other institutions, including Johns Hopkins, Sloane Hospital for Women, Kings County Hospital, and Chicago Maternity Center. According to Wiedenbach, nurse-midwifery training gave the master’s level maternity nurse new skills, deeper knowledge about childbirth, and the ability to take fuller responsibility for the health of mothers and children. By 1961, nine of the thirteen students who had received a master’s of science in nursing and a nurse-midwifery certificate held faculty positions in schools of nursing, three worked in nurse-midwifery services, and one directed patient care in a hospital.

Wiedenbach was determined that student nurse-midwives should learn to take full responsibility for expectant mothers and women in labor and delivery. However, Yale did not allow students or nurses to oversee completely the birthing process. Changing such policies would have threatened female nurses’ “second-class citizen” status in the hospital hierarchy, a role that dictated nurses should not take charge of childbirth—a medical procedure, and therefore one that only physicians should perform. When Yale refused to alter its policies to fit the needs of nurse-midwives’ hands-on training, Wiedenbach sometimes asked students to leave the institution and work elsewhere in order to gain the experience she believed necessary to a nurse-midwife’s education.
By helping establish several hospital-based university-affiliated nurse-midwifery programs, MCA was finally participating in (and one might argue even facilitating) the long-term American trend wherein childbirth was moving out of the home and into the hospital. However, this trend and MCA’s ultimate participation in it had a detrimental effect on the organization’s ability to train nurse-midwives, no matter where they would eventually practice, because nurse-midwives were rarely allowed to deliver babies in the hospital setting. In 1958, MCA closed its home-delivery service and set up a nurse-midwifery service in Kings County Hospital in affiliation with Downstate Medical Center, State University of New York. Since 1931, MCA had operated a successful home-delivery service staffed by nurse-midwives, but by the late 1950s, fewer patients used the service. In the year it closed the home-delivery service, only .5 percent of births in New York City occurred at home. As MCA director Hazel Corbin explained: “By this time there were very few home deliveries. Most of them wanted to go to the hospitals, and they had insurance of one kind or another. Their husbands had insurance, the unions had insurance. The thought of going into the hospital and having a rest for a week or two weeks sounded wonderful to them. And so there wasn’t an adequate number of women [giving birth at home] to provide experience for a school.”

MCA also faced another problem: obstetricians did not like the fact that some middle- and upper-class women, who were seeking an alternative to routinized hospital births, had recently begun using the home delivery service, and they feared that nurse-midwives were entering their turf. At the same time MCA was losing patients and, in suspicious obstetricians’ view, attracting the “wrong kind” of patients (in other words, patients obstetricians wanted for themselves), Kings County experienced an obstetrician shortage, which led to substandard care for patients.

Louis Hellman, chief of obstetrics at the hospital, offered Corbin a potential solution to the problems both MCA and Kings County faced: move MCA’s nurse-midwifery service and school to Kings County. Beginning in 1957, several conferences between MCA and nursing and medical representatives from Kings County explored the possibility of this merger. After many conversations, the two institutions hammered out policies and plans for the new nurse-midwifery education program and
service. MCA agreed to fund both the school and the service, which it did until 1974. With the finances settled, the focus of conversations among the two institutions’ administrators often centered on one contentious question: What exactly should medical supervision of nurse-midwives entail? For prenatal care, MCA and Kings County decided to continue a practice used at MCA’s home-delivery service: physicians took a pregnant woman’s prenatal history and conducted a physical examination on her first visit. Then, if a physician determined that the woman was expected to have a normal pregnancy, she or he assigned the woman to the nurse-midwifery service. Nurse-midwifery students managed labors and deliveries, and then held postpartum teaching rounds with their nurse-midwifery instructors’ supervision. However, compared with MCA’s original home-delivery service, the MCA–Kings County service included much more physician management in the labor-and-delivery and postpartum periods because physicians were always nearby in the hospital maternity ward.

Before MCA’s nurse-midwifery service moved to Kings County, nurse-midwives expressed concerns about what the hospital environment would do to “patient-centered maternity care”—something nurse-midwives felt they had created in the home-delivery service. Their concerns were well founded. Since physicians were present at all times in the hospital (and thus did not need to be summoned on horseback or on a late-night city street), they were more able to intervene in childbirth, even when nurse-midwives were given responsibility for the process. Additionally, Kings County nurse-midwives did not provide the continuity of care that they had at MCA. They did not cover the hospital labor floors every hour of every day, and therefore could not always be attentive to patients’ needs. Furthermore, many of the patients nurse-midwives delivered had not received prenatal care through the nurse-midwifery service. However, according to a Kings County nurse-midwifery instructor, the service provided a much more personalized kind of care than the regular medical service. Certainly, staff physicians and residents quickly realized and accepted that nurse-midwives offered something different. The hospital environment also allowed Kings County nurse-midwives to expand their practice to include performing and stitching episiotomies, repairing lacerations, and by the mid-1960s, inserting intrauterine devices. In addition, nurse-midwifery students gained broader clinical experience because they worked with many more patients than they had in the small, declining home-delivery service. The expansion of nurse-midwives’ services and increased number of patients they served benefited both nurse-midwives and physicians: nurse-midwives developed expertise in new areas and the
students were able to train with more patients; physicians were freed to focus on less routine practices and procedures, and they carefully supervised and controlled nurse-midwives on their turf—the hospital.90

More than any of the other university programs, the Kings County nurse-midwifery program represented the end of one era and the beginning of another. MCA moved its service to Kings County Hospital because it had no other choice. For most Americans—and certainly most residents of New York City, home birth represented a thing of the past. Reflecting this trend, MCA’s nurse-midwives stopped delivering babies at home and entered large mainstream hospitals where they faced both new restrictions and new opportunities.

Obstetrician Allies

Nurse-midwives’ move to the hospital could not have succeeded without the support of prominent obstetricians. Of course, back in the 1920s and 1930s, obstetricians like Lobenstine, Watson, and Kosmak had been essential partners in the creation of MCA’s educational program and service, and obstetricians played an important supporting role in the founding of FNS. In the 1950s, the two most influential and vocal obstetrician proponents of nurse-midwifery were Nicholson Eastman at Johns Hopkins and Louis Hellman at Downstate Medical Center, Kings County Hospital.

Eastman was chief obstetrician at Johns Hopkins Hospital when Hopkins’s nurse-midwifery program began. He believed that nurse-midwives provided “superior” maternity care, arguing that nurse-midwives could improve American maternal health care and lift a burden from overworked physicians. According to Eastman, small rural hospitals needed nurse-midwives because uneducated nurses’ aides handled many deliveries (despite the fact that physicians, mostly general practitioners, signed the birth certificates), and large urban hospitals needed well-trained women to assist in birth. Eastman always emphasized, however, that he thought nurse-midwives should serve as assistants to obstetricians, as part of an “obstetric team.”91

Even before Hopkins had a nurse-midwifery program, Eastman had been a supporter of nurse-midwifery. In 1952, he praised a Maryland State Health Department film, Nurse-Midwifery—Education and Practice, which depicted a nurse-midwife working for a county health department.
He found “especially noteworthy . . . the joyful attitude toward childbearing which permeates the whole picture. This happy atmosphere, which stems from the approach of the nurse-midwives, provides spiritual and emotional support for the mother and in so doing illustrates one of the advantages of home delivery and midwifery care. To any young woman who is choosing a vocation, or to any nurse who is considering postgraduate training, this film will tell a heartwarming and inspiring story.”

After Hopkins piloted a nurse-midwifery service under Eastman’s supervision, he praised nurse-midwives even further:

Having observed rather closely the work of our Obstetric Assistants [the term Eastman used for nurse-midwives] for almost a year, and having imposed upon them a good many times to follow private patients in labor along with me, I have almost wondered sometimes if they did not mesmerize these mothers. The secret of their success with parturient women is, of course, the constant, sympathetic and encouraging attention they give, plus the hundred and one little things they do, such as positioning, pressure on the small of the back, and the like. I have watched all this with my own eyes and am convinced that the meticulous type of care they give is the answer to the greatest weakness in American obstetrics, namely, lack of emotional support both in pregnancy and labor.

Eastman continued, arguing that “by training, temperament and outlook” nurse-midwives are “singularly fitted” to offer “a unique, personalized form of attention throughout pregnancy, labor and the puerperium.” Eastman’s critiques of American obstetrics and praise for nurse-midwives, although common today, were revolutionary at the time.

Eastman’s motivation for using nurse-midwives was practical. He believed that nurse-midwives were necessary to meet the huge and growing shortage of obstetric personnel in a time of rising birth rates. “Who is going to deliver all these babies and provide the desired teaching and emotional support for mothers during pregnancy, labor and the puerperium? . . . Will not obstetricians need all the skilled assistance they can get over the next decade?” According to Eastman, nurse-midwives brought something special to hospital birth—a willingness to spend time with their patients and to offer them personalized care in a way that obstetricians, by training, temperament, and outlook, could not. Most importantly, obstetricians needed them in the wake of a physician shortage.

Louis Hellman was just as enthusiastic as Eastman in his support of
nurse-midwifery. Hellman was chair of the Department of Obstetrics and Gynecology at Downstate Medical Center, Kings County Hospital, and later held positions on President John F. Kennedy’s panel on mental retardation and as the Deputy Assistant Secretary for Population Affairs in the Public Health Service. In a 1964 article in the Saturday Evening Post—“Let’s Use Midwives—To Save Babies”—Hellman passionately argued for widespread use of nurse-midwives. His concerns about the state of American maternity care sounded like those from earlier in the century. Hellman began his article:

The state of maternity care in the United States is astonishingly inferior—and getting worse. In our affluent society, with its vast medical centers, the average layman may think he can take it for granted that such an elemental procedure as birth would be carried out with the highest medical standards. The truth is that in many cases there are no medical standards because there is no medical care.

He explained, as had Eastman, that there were not enough physicians to care for pregnant women. He also pointed to the uneven distribution of obstetricians, who rarely practiced in places where the poor were concentrated—the centers of cities and rural areas. Hellman went on to say that many patients ended up preferring nurse-midwives due to the personalized care they provided. Some of Hellman’s comments, like Eastman’s, provide an echo to discussions today. Like their predecessors, many early twenty-first-century reformers are concerned about the uneven distribution of health professionals, point to patient dissatisfaction with modern obstetrical care, and suggest that nurse-midwives might solve both problems.

Like Eastman, Hellman carefully positioned nurse-midwives vis-à-vis physicians, showing the need for nurse-midwives and the ways in which obstetricians would benefit from having them. In an article in the American Journal of Obstetrics and Gynecology, Hellman pitched his support of nurse-midwives to his obstetrician audience from his very first statements: “One cannot gainsay the common sense fact that the mothers of America would be better off if each at the time of labor and delivery were continuously attended by a board-certified obstetrician. A brief glance at the logistics of the situation will show that this goal is not now attainable and that the future holds no hope for its achievement.” Hellman added though that logistics were not the only problem; in fact, many women were unsatisfied with obstetric practices. He argued that the nurse-midwife could “extend the hand of the obstetrician immeasurably,” so that the obstetrician “could
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well double his activities with no loss of personalized or meticulous care of his patients.” Hellman also asserted that nurse-midwives “would encourage better and more thoughtful personalized care.”

While many physicians continued to be threatened by nurse-midwives in the 1950s, Hellman and Eastman advocated nurse-midwifery as solutions to two problems: a physician shortage and depersonalized maternity care. They, of course, had an enormous impact on the nurse-midwifery programs associated with their institutions: Downstate Medical Center, Kings County Hospital, and Johns Hopkins. They also tried to convince their peers and the public that nurse-midwives were both needed and valuable.

Conclusion

In 1960, Hattie Hemschemeyer pointed out a great advantage to nurse-midwives’ new hospital homes. In hospitals, nurse-midwives worked closely with physicians, who would then understand their value, and this understanding would lead eventually to “the establishment and wider distribution of the services of the nurse-midwife in other hospitals and institutions.” But she also acknowledged the great trade-off that came with working in hospitals: some of nurse-midwives’ “cherished convictions” would have to be altered to fit into mid-twentieth century hospital obstetrics.

Hemschemeyer was right about both the advantages and disadvantages of nurse-midwives’ entrance into hospitals. However, their role in hospitals developed more slowly than she had anticipated. Nurse-midwives who worked at the hospitals affiliated with Columbia, Johns Hopkins, Yale, and Downstate Medical Center did the actual work of nurse-midwives, providing, in most cases, prenatal, labor-and-delivery, and postpartum care to their patients. But other hospitals did not give nurse-midwives the chance to practice nurse-midwifery, nor did they give nurse-midwives any degree of autonomy. Instead, these hospitals employed nurse-midwives to be in more subordinate positions as maternity nurses and maternity nursing supervisors. In their nursing roles, they responded to the widespread criticism of obstetric nursing and the bureaucratization of medical institutions by offering obstetric patients personalized care, within the limits the hospital setting imposed, and taught the new “natural childbirth” method. But they did not manage their patients’ maternity care, or come anywhere close to doing so. In addition, the number of nurse-midwives in any hospital was small, so they had little impact on hospital policies and practices.
Yet the expansion of nurse-midwifery into hospitals, and especially into major medical centers associated with universities, was very important. Nurse-midwives practiced their profession in medicine’s leading institutions, and received enthusiastic support from some of the nation’s top obstetricians. While their numbers were small, their symbolic importance was large. Their presence challenged the notions that childbirth, even among elite women, required physicians, and that major hospital procedures required physicians. Nurse-midwives’ entrance into hospitals also highlights the problems inherent in mid-twentieth century American obstetrics and medicine. First, the United States did not have enough medical personnel, at least not in all places and with all races and classes of people, to meet patient needs. Second, many women expressed deep dissatisfaction with hospital maternity care, a fact of which some of the leading physicians were aware. Third, nurse-midwives had trouble pushing their way into hospitals because they subverted the health-care hierarchy, which had always placed physicians above nurses.