CHAPTER 6

Don’t Push
Struggling to Create a Political Strategy and Professional Identity

Introduction

Born in 1899 in Ottawa, Ontario, Aileen I. Hogan grew up in a middle-class family, with two older and two younger siblings. After high school, Hogan completed a secretarial course and worked for Canada’s War Department during World War I. After both of her parents died within the same year, Hogan and three of her siblings ventured off to New York City, where she found work as a medical secretary. In her late thirties, she decided to attend nursing school at the Columbia-Presbyterian School of Nursing. There, she became interested in maternity nursing. After graduation, Hogan worked as a staff nurse, and eventually head nurse, on the labor-and-delivery service at Sloane Hospital. During World War II, she went to Britain and France in a special Presbyterian Hospital unit. Although she did not work with mothers and babies during those years, Hogan learned about parent education from talking to young soldiers who were about to become fathers. When she returned to the United States after the war, she used the GI Bill to attend Teachers College, Columbia University, to get a bachelor’s degree in nursing. At Columbia, she took classes from Hattie Hemschemeyer, director of Maternity Center Association’s nurse-midwifery school. Impressed by Hemschemeyer’s lectures on nurse-midwifery’s focus on continuity of care during pregnancy, childbirth, and the postpartum period, Hogan “had to see if it worked,” so she enrolled in MCA’s program in 1947.
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Referring to her nurse-midwifery education as “a joy,” Hogan remembered that “in one way it was too ideal a situation . . . not one that could be duplicated.” As Hogan explained, a nurse-midwife graduate felt “secure in her service skills, and educational ability,” but was frustrated because she had “few opportunities to actually be in midwifery.” Although Hogan avoided this problem for a year after graduation from MCA by returning to Teachers College for a master’s degree, she certainly faced it when she became chair of maternity nursing at the Frances Payne Bolton School of Nursing at Western Reserve University (now Case Western Reserve University) in Cleveland, Ohio. Hogan found herself at “the center of surgical obstetrics, which meant heavy medication during labor, spinal anesthesia for delivery . . . delivery by high forceps as soon as the cervix was open; a baby in need of resuscitation by hot and cold baths, and usually in oxygen for the first day.” Despite an open-minded chief of obstetrics, an understanding dean, a great faculty, and wonderful students, Hogan faced one barrier after another as she tried both to implement what she had learned in nurse-midwifery school and to respond to what many parents were asking for: “a different type of maternity care.” Although Hogan created successful programs in natural childbirth, she resigned after three years, realizing that she “could not teach a health-oriented program in a surgically oriented hospital.” Once free from her problematic job, she accepted a position as a consultant for MCA and, for the next fifteen years, engaged in “fascinating, delightful, and rewarding work” creating parent-education programs with nurses all over the United States and Canada. Looking back, Hogan explained that she was “typical of the nurse-midwifery graduate of the 40s . . . using my midwifery experience as a background for teaching, spreading the gospel of midwifery.”

While working for MCA, she also got involved in the politics of nurse-midwifery. She tried working within several nursing associations to organize nurse-midwives, but kept coming up against obstacles. Years later, Hogan understood why the national nursing organizations refused to “make room for us.” “They themselves were in the process of organizing a new nursing set-up. The problems were enormous, and to them we were probably just an annoying minority group that should have had the good sense to be patient, and wait till the mother organization was set up, and ready to go.” But to Hogan and her colleagues, nurse-midwives could not afford to wait. They felt that for years, they had done good work and now needed to create coherent plans for the education and practice of nurse-midwifery so that it could have a recognized place in the American health system. By 1955, they had decided that “if there was not a place for mid-
wifery in nursing, then we'd have to establish our own place," and they formed the American College of Nurse-Midwives (ACNM).

By the year ACNM was established, nurse-midwives had been practicing in the United States for three decades, yet they remained misunderstood and were not respected. Invented to serve as a stopgap until all women had access to well-trained physicians, nurse-midwives were never expected to be at the center of American health care. However, by the 1950s, they seemed even less necessary than they had in the 1920s for several reasons. Most births now took place in hospitals, and very few hospitals had, or saw the need for, nurse-midwifery services. Obstetricians, now part of a prestigious specialty, attended the births of more American women. Shifting trends in American culture and medicine, such as a decline in immigration, the growing prestige of both physicians and hospital births, campaigns by health professionals against midwives, and changes in laws related to midwifery, had, for the most part, killed the traditional midwife. Maternal mortality was no longer the terrible problem it had been earlier in the century. So, what place would nurse-midwives have? Would they work closely with physicians or independently of them? Would they work within the mainstream health-care system or outside of it? Would they practice in hospitals or outside of them? Overall, nurse-midwives answered these questions by pursuing a strategy of accommodation; in other words, they made a conscious decision to work within the health-care establishment. However, they disagreed among themselves about exactly how accommodating they should be.

It would be easy to conclude that nurse-midwives sold out, or that internal disagreements weakened their resolve, but those conclusions would ignore the very difficult climate in which nurse-midwives functioned and the different paths they chose to take. Nurse-midwives had to cope with a health-care system and with other medical professionals that often rejected them and what they represented. Political scientist James C. Scott has argued that underdogs—and in the health care hierarchy, nurse-midwives were underdogs—have rarely made direct political attacks on their superiors because doing so would be “dangerous, if not suicidal.” If we apply Scott’s theory here, we see that American nurse-midwives could not simply have rejected the mainstream medical establishment. They needed physicians and nurses as allies in order to survive; they needed physician backup for their home delivery and hospital services, and they had to work with doctors and nurses in hospitals. Nurse-midwives would have committed professional suicide had they directly confronted physicians, nurses, or hospitals. Moreover, many of them had no desire to reject
American medicine; indeed, nurse-midwives defined themselves in part as not like traditional midwives, but as modern professionals and collaborators with physicians. Thus, they tried to make inroads into American obstetrics by subtle, rather than direct, methods of resistance—through calculated forms of accommodation—by using the “weapons of the weak,” as Scott called them. But nurse-midwives had different approaches to accommodation, as seen in two sets of documents from the mid-1950s: 1) the rank-and-file’s range of responses to a proposed definition of “nurse-midwife,” and 2) the leadership’s arguments about the formation of a national nurse-midwifery organization. Given that most mid-twentieth-century health professionals—and Americans—associated midwives and women with a past best forgotten, nurse-midwives fought an uphill battle as they tried to find a place for themselves in the American health-care system and to change the American way of birth.

The Profession in the 1950s: Misunderstood, Unrecognized, and Rejected

To understand why nurse-midwives disagreed about the best ways to carve out a piece of the health care pie, it is important to consider where nurse-midwives worked, and what others thought about them. By the mid-1950s, most worked in hospitals or government bureaucracies where either administrators or institutional policy (or both) dictated to a great degree what they did and how they did it. Although all nurse-midwives practiced direct clinical midwifery—providing prenatal and postpartum care, and managing births—while in school, few did so after graduation. In one survey, 20 percent practiced clinical midwifery, mostly providing prenatal and postpartum care only, and 7 percent managed labor and delivery. A small number continued what nurse-midwives had traditionally done, staffing home-delivery nurse-midwifery services in select locations, as discussed in chapter 5. In the mid- to late 1950s, other pioneers, discussed in chapter 4, worked at a handful of major university medical centers, where they staffed hospital nurse-midwifery services and offered an unusual, and more personalized, option for postwar maternity patients in hospitals. But few hospitals had nurse-midwifery services, and as more women wanted to give birth in hospitals, there seemed to be little need or desire for home-delivery nurse-midwifery services. Therefore, most nurse-midwives did
not practice direct clinical midwifery but instead worked as maternity nurses or supervisors, as Aileen I. Hogan did at Case Western, or as administrators of maternal and child health programs where they often taught and supervised traditional African-American and Latina midwives.

Wherever they worked, nurse-midwives felt misunderstood and unappreciated. These feelings became clear when a group of leading nurse-midwives in 1954 questioned all known nurse-midwives as part of their efforts to organize a national nurse-midwifery organization. In response to the question, “In what ways do you think . . . [a national nurse-midwifery] organization could help you?” nurse-midwives frequently answered by saying that an organization might help other health care professionals and the public to know and understand what nurse-midwives did. One Frontier Nursing Service (FNS) graduate wrote that she hoped a national nurse-midwifery organization could “bring . . . the practice of nurse-midwifery to the attention of the American public, particularly doctors.” Another thought such an organization might “help to give nurse-midwifery the recognition it deserves.” Another nurse-midwife believed a national organization could “help me translate to other professional personnel the value and work of nurse-midwives.” Yet another nurse-midwife hoped an organization could “help clarify the meaning of nurse midwifery to the public.”

Two nurse-midwives, writing from the South, expressed particular frustrations with the views held of nurse-midwives in their region. Virginia Lamb Chrestman from Baton Rouge, Louisiana, believed that only “maybe [a national nurse-midwifery organization] could help change the attitude of people in the South about nurse midwives.” Jane McAllaster Burr explained that she “would like to see Nurse-Midwives be recognized to be more than Grannies,” but doubted that a national nurse-midwifery organization could help her “out here” because Oklahoma did not recognize midwives to begin with.

The answers nurse-midwives throughout the United States gave to the question, “What comments do you have on the suggested definition of nurse-midwifery?” provided nurse-midwives an opportunity to air their exasperation with common misperceptions about their occupation. One nurse-midwife said that “I have only one suggestion. It is not about the definition but that nurse midwifery not be made so much fun of but publicized more.” Similarly, another nurse-midwife, originally from England, suggested: “I feel that with more publicity, the general public, would not look upon [us] . . . as ‘odd.’ I feel that more should be made known in the U.S. to the nursing and medical profession as to what a nurse-midwife really is. . . . [In my] recent experience in a maternity hospital, I felt that all
but one doctor out of five felt the [nurse-midwife] was a real asset.”

Another nurse-midwife complained about physicians’ lack of knowledge about her profession: “I think Doctors in general should be informed what a nurse midwife is. They have no idea that a nurse midwife even knows how to tie a cord.”

In fact, the young profession had faced problems with terminology and publicity for a long time. As far back as the 1910s, before nurse-midwives practiced in the United States, health-care providers debated what this new type of birth attendant should be called. In 1914, physician Frederick J. Taussig, the first American to use the term “nurse-midwife,” anticipated the problems that would surround it. He suggested that nurses might object to the new term, fearing that “the public may identify such nurses with the objectionable type of women engaged in midwifery here in America.”

In 1927, Mary Breckinridge, founder and director of FNS, explained that she liked the term “nurse-midwife,” because it incorporated “midwife,” which she saw as an ancient, important calling, still highly regarded in European countries. She noted that in continental Europe, midwives “kept abreast of modern developments” and therefore their position remained “dignified and assured,” and that English women had standardized and improved midwifery, creating the Central Midwives Board in 1902. Although midwife was “a name in disrepute” in the United States, Breckinridge and her FNS staff chose to call themselves “nurse-midwives” because local people used the term midwife and “any other, such as ‘obstetrical nurse,’ would only confuse them.”

In 1943, a nurse-midwife working in rural Georgia wrote to a colleague about the confusion surrounding their occupation’s name. She hoped a professional organization of nurse-midwives would “find a different name which implies interest in the whole maternal and infant cycle, rather than the present name which indicates someone interested in the delivery alone. . . . And besides the ‘grannies’ have forever received the name ‘midwife’ for use—at least in the South.”

In the mid-1950s, nurse-midwives were still arguing over what they should be called. In 1953, Nicholson J. Eastman, professor of obstetrics at the Johns Hopkins School of Medicine and director of Johns Hopkins’ experimental nurse-midwife training program at its obstetric clinic, insisted that nurse-midwives be called obstetrical assistants because this term “more nearly connotes than any other the main function which we would envisage for such nurses, namely, the rendering of skilled assistance to obstetricians.” He elaborated: “In vast rural areas of this country and in understaffed hospitals, this skilled assistance may also include the conduct of normal deliveries but never without the supervision and control, in

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absentia, of a readily available obstetrician.” Sister Theophane sympathized with Eastman’s professional position, but reaffirmed the need for the term “nurse-midwife.” In a letter to the dean of Catholic University’s School of Nursing Education, she wrote: “In principle, I believe he [Eastman] is not opposed to calling us nurse-midwives but he thinks it expedient or diplomatic to use a name his confreres are more apt to accept. We cannot let the obstetricians supervise and control our practice. They could accept or throw us out at their wish. [Nurse-midwifery] has to be a self-governing body.” At an American Nurses Association Convention in 1954, nurse-midwives “generally agreed that the title ‘nurse-midwife’ is the only one that is understood on an international level and that this title was preferable to any other so far proposed.” They also agreed that “any prejudice that is a hang-over from granny-midwife days and ways could be out-lived with a moderate amount of determination on the part of nurse-midwives.” Yet they were wrong; even in twenty-first-century America, that prejudice still exists.

In the mid-1950s, nurse-midwives faced rejection even by people who, at least theoretically, should have been their allies. From the beginning, nurse-midwives had faced resistance from nurses, but the resistance became more formalized during the 1950s. When a group of nurse-midwives discussed organizing themselves in 1954, they first approached national nursing associations, hoping they could “set standards for education,” “standardize practice to some extent,” “define functions,” and “provide for official status and legislations as well as a tool for official publicity.” Sister Theophane Shoemaker, chair of the Committee on Organization and director of Catholic Maternity Institute (CMI), explained why the committee wanted to organize within a national nursing organization. First, the survival of nurse-midwifery depended on it. Second, nurse-midwives would be perceived as more professional if they were part of “a well organized and recognized group,” in other words, by becoming a subsection of a national nursing organization. Finally, anticipating future debates, Sister Theophane said that nurse-midwives might leave nursing if not more closely associated with the profession: “It is a pity to allow the few hundreds of nurse-midwives who are now actively engaged in their professional capacity and the larger and ever increasing number to follow, to be torn away from nursing. And if we do not organize and become unified in our thinking, this is what will happen, I am afraid.” Thus, Sister Theophane implied that nurse-midwifery needed nursing—to provide political backing and safety in numbers—and that nursing would also benefit from increasing their members by adding nurse-midwives, as
well as through exposure to nurse-midwives’ different perspectives on health care.\textsuperscript{24}

In addition, nurse-midwives had previous successful experience organizing within a national nursing organization. From 1944 to 1952, the National Organization for Public Health Nursing (NOPHN) included a nurse-midwifery section, comprising nurse-midwives, nurses, and physicians.\textsuperscript{25} Once the NOPHN dissolved in 1952, nurse-midwifery leaders tried to find a new home for the nurse-midwifery section in either the National League for Nursing (NLN) or the American Nurses Association (ANA), both prestigious organizations interested in nursing credentials and professionalization.\textsuperscript{26} The NLN and ANA responded with tentative suggestions about forming groups to study nurse-midwives’ function. This response frustrated nurse-midwifery leaders, who decided to form a separate nurse-midwifery organization, believing the bureaucratic, cumbersome approach of the NLN and ANA would not allow nurse-midwives to accomplish their purposes.\textsuperscript{27} As Sister Theophane explained, the officers of the national nursing organizations rejected nurse-midwives because they “believed nurse-midwifery was equivalent to medical practice and thought it impossible to encompass us within a nursing organization.”\textsuperscript{28} In other words, they thought that nurse-midwives were too independent to be considered “real” nurses, and therefore, might disrupt the nursing organizations’ all-important relationships with physicians.

**Different Approaches to Accommodation**

**Example 1: The Rank-and-File Debate the Meaning of Nurse-Midwifery**

Feeling misunderstood, unrecognized, and rejected, nurse-midwives in the mid-1950s debated among themselves: What is a nurse-midwife? What does she do? Where does she fit into the health care system? In 1954, a group of leading American nurse-midwives in attendance at that year’s American Nurses Association annual meeting formed a Committee on Organization to develop a formal way to bring nurse-midwives together and set standards for their education and practice. The committee struggled to develop an official definition of “nurse-midwife” and agreed upon the following:
Part II: Active Labor, 1940–1960

The Nurse-Midwife combines the knowledge and skills of professional nursing and midwifery, enabling her, in addition to the usual nursing functions, to assume full responsibility for the education and care of mothers throughout the maternity cycle so long as progress is normal. With this combined background of preparation, she is prepared by education and experience to meet the needs of the mother and her baby for skilled care and emotional security as well as to contribute in a constructive way to the changing pattern of maternity care and education.29

Although this definition seems simple, it created controversy among nurse-midwives. The Committee on Organization sent out approximately 400 questionnaires to nurse-midwives trained in the United States and working all over the world to gauge whether they agreed with this definition, the extent to which their education prepared them for their job responsibilities, and whether and how a professional organization could help them. The 156 responses they received to these questionnaires provide an excellent opportunity to understand rank-and-file nurse-midwives’ concerns about their role and status; the complicated, sometimes ambiguous, relationships among nurse-midwives, physicians, and nurses; and the differences in nurse-midwives’ approaches to defining and carving out their place in the American health-care system.30

To respondents, the most controversial part of the committee’s definition of “nurse-midwife” was the explanation that nurse-midwives “assume full responsibility for the education and care of mothers throughout the maternity cycle so long as progress is normal.” A number of nurse-midwives expressed concern that the definition did not mention that nurse-midwives worked under a physician’s supervision. In a strong critique, Helen Marie Fedde, who trained and worked at FNS and then served as nurse supervisor at an Oklahoma hospital, wrote: “I would suggest the insertion of the clause ‘under the direction of a qualified physician’ after the word ‘assume.’ In all we have ever learned or taught we have felt that the nurse who will take any such responsibility without definite and planned medical direction will hurt the cause of midwifery far more than she will help it.” In an attached letter to the head of the Committee on Organization, Fedde continued her line of thought: “The minute we set ourselves up as experts we are lost. In the United States we will always be directly responsible to a doctor and no matter how high-flown our name or how rigid our requirements we will never be more than nurses—nurses
with a special skill."

Others who critiqued this part of the definition held a different opinion about the role physicians should play vis-à-vis nurse-midwives. Some saw the physician’s role as a consultant to or supervisor of the nurse-midwife; these nurse-midwives saw the physician as more responsible for patient care than the committee had outlined, but perhaps less responsible than Fedde’s preferred wording. Emma Lois Shaffer, for example, noted that “a medical examination and consultation during pregnancy seems important when possible.” Sara Elizabeth Fetter asked whether “medical approval or in cooperation with the medical group” should be included in the definition. Rachel Pierce Schottin argued that the definition needed to state more explicitly that the nurse-midwife cooperated with a physician who took over the case if progress was abnormal. Reva Rubin wanted the definition to explain that although nurse-midwives had “full responsibility” for the care of mother and baby, they were “under medical orders in terms of care.” By this, Rubin probably meant that the nurse-midwife followed physician-established medical routines, not that physicians were present to give orders to nurse-midwives.

A few nurse-midwives who felt the definition should include the physician gave him/her only the task of performing an initial physical exam. For example, Peggy Helen Brown suggested that “each midwife assumes responsibility of the patient, after the latter has had a full examination by a doctor” Anne Fox agreed. Sister M. Elizabeth Dunbaden Hosford suggested that nurse-midwives wanted to mention physicians’ involvement in their patients’ care to avoid potential public relations problems. “Should not mention be made,” she wondered, “that the assumption of care of normal mothers and babies is under medical guidance—for instance, the initial physical examination would still be a medical responsibility—we know what is meant, but would allied professions and the lay public?” Nurse-midwives struggled to overcome the perception that they worked alone—and outside of the medical mainstream.

Still others complained that the committee’s definition stopped short of explaining the real responsibility of nurse-midwives for their patients. They suggested the nurse-midwife was responsible for recognizing abnormal developments during gestation and labor, as well as the normal. Some made no mention of physicians taking over in abnormal situations, while one added that the nurse-midwife would help “secure adequate care in such cases.” Writing from India, Eunice LaRue noted that although the definition was “Good for U.S.A. . . . Those of other countries must also handle abnormal cases.”
Part II: Active Labor, 1940–1960

The responses from rank-and-file nurse-midwives to the Committee on Organization’s questionnaire provide one lens through which to understand the different degrees nurse-midwives believed they should accommodate physicians and hospitals. They show that while some nurse-midwives highlighted their independence and almost complete responsibility for their patients’ care, others emphasized their subordinate status, arguing that “we will never be more than nurses—nurses with a special skill.”

Example 2: The Leadership Debate How Much Nurse-Midwives Should Challenge the Medical Establishment

A second set of documents, showcasing internal disagreements among the nurse-midwifery leadership about the best way to organize, provides another useful lens through which to view nurse-midwives’ range of political strategies. Rejected by nursing, nurse-midwives were left on their own to form standards and a professional organization. They then had to decide how to proceed. The leaders of the three existing services and schools, Frontier Nursing Service, Maternity Center Association, and Catholic Maternity Institute, shared a passionate belief in the good work nurse-midwives did to help women and children, along with a desire to see the profession of nurse-midwifery expand. However, each had her own idea about how that should happen. FNS’s Mary Breckinridge wanted to take one path, one that was cautious and avoided any possible conflict with physicians, yet which seemed to encourage nurse-midwives’ autonomy. CMI’s Sister Theophane Shoemaker and MCA’s Hattie Hemschemeier, however, wanted to take another path, one that advocated gaining acceptance for nurse-midwifery as rapidly as possible and which focused on teaching and administration in public-health agencies and hospitals, rather than on more autonomous work in isolated settings.

FNS leaders had formed their own nurse-midwifery organization, the Kentucky State Association of Midwives, in 1929, a few years after the founding of FNS. The association’s purpose was “to raise the standard of midwives and nurse-midwives, who are or have been or may hereafter be engaged in the active practice of midwifery, to a standard not lower than the official standards required by first class European countries in 1929.” In 1939, all but one of the forty-four nurse-midwives in the association were or had been on staff at FNS, and as an FNS article admitted, “no great task has been required of its members” since the association’s inception.
In the early 1940s, the association was enrolling more members, many from outside Kentucky. By 1943, membership had jumped to eighty-one, 20 percent of whom had no association with FNS. Increasing diversity led leaders in 1941 to change the name to the American Association of Nurse-Midwives (AANM) to reflect this more national composition of the organization’s membership.

When the Committee on Organization met in 1954 to consider the best way to organize nurse-midwives, FNS leaders suggested that the AANM be reorganized to attract a wider variety of members. Sister Theophane agreed that if nurse-midwives could not organize within a national nursing organization, the next best option was to build on the AANM. However, despite an initial display of goodwill among the leaders of FNS, MCA, and CMI, the Committee on Organization ultimately rejected the AANM proposal because of ideological differences between FNS, on the one hand, and MCA and CMI, on the other.

Personality differences also hindered the two camps’ ability to work together. Although FNS leaders initially suggested building the AANM into the national organization, they later gave a “cool reception” to the idea, at least according to the members of the Committee on Organization. One committee member, Ruth Boswell, an alumna of the FNS Frontier Graduate School of Midwifery, expressed her frustration with the people at her alma mater: “people at Wendover [the town in which FNS headquarters and Mary Breckinridge resided] . . . are a tight little group and you have to be a certain kind of person to fit in. I can truthfully say that I have no nostalgic feelings for the place. The work there was hard, it was not easy for me to pay ‘court,’ having never been exposed to the European traditions [many of FNS nurse-midwives were British], nor was it easy for me to espouse what I felt was the hypocritical attitude then prevalent among the more religiously-inclined and the missionaries in the group.” Conversely, Breckinridge was frustrated at what she saw as false compliments by MCA and CMI leaders to get FNS help in forming a national nurse-midwifery organization. Louis Hellman, director and professor of obstetrics and gynecology at Kings County Hospital in Brooklyn, who established midwifery instruction at his hospital in the late 1950s and had great respect for Mary Breckinridge’s work, nonetheless noted later in life that Breckinridge “thought that [the] only [midwifery] education and midwifery [practice] in the United States happened in Wendover, Kentucky.”

Race played yet another divisive role in the FNS and the MCA/CMI camps. AANM’s rejection of African Americans as members, during at
least some of its history, was a major reason why MCA and CMI leaders ultimately decided that the AANM would not be a suitable national nurse-midwifery organization with which to align. In 1944, MCA invited local nurse-midwives to discuss the question: “Will a national organization of nurse-midwives help us to do a better job?” Although they answered in the affirmative, the MCA nurse-midwives decided they could not join the AANM because it did not allow African-American members, and thus the eight African-American graduates of MCA’s school could not join the association.

In the early 1940s, extensive discussion occurred among members of the AANM about whether African Americans should be included in the association. Year after year, the AANM decided against African-American membership, yet leaders continued to discuss the issue and sometimes modified the association’s policies. This repeated discussion of African-American nurse-midwives, forty-one potential members (less than 20 percent of the entire profession at that time), suggests that race remained a contentious issue for the AANM, and whiteness was central to the AANM’s conception of the nurse-midwife.

Breckinridge’s racial attitudes very likely affected AANM policies on African Americans. Breckinridge spoke with kindness about the slaves her family finally freed and with whom she was raised, but she would never dine with an African American. Helen Browne, FNS assistant director before Breckinridge died and director afterward, who was British, did not understand Breckinridge’s racist attitudes and always wanted to accept applications from African-American nurses. But as late as the 1960s, FNS never did so, although it accepted African, not African-American, obstetricians as its guests.

Personality and racial differences undoubtedly divided the FNS and MCA/CMI camps. However, the most conflicts among the two arose over strategies for how best to create a strong organization of nurse-midwives and approaches toward nurse-midwifery education and practice. Breckinridge and other leaders of FNS approached organization more cautiously than Sister Theophane and Hemschemeyer, emphasizing nurse-midwives’ work in isolated, rural areas rather than hospitals, and encouraging measured organizational development and support from physicians and laypeople. Breckinridge wished to keep the AANM as the national association because it had an “old tradition which is beyond price for a young and experimental branch of nursing.” She also wanted to keep the AANM...
articles of incorporation because they caused “no bad feeling” with other professional organizations, such as the American Medical Association or American Nurses Association. In particular, the article of incorporation stating that nurse-midwives worked “with special reference to rugged, difficult and economically poor areas,” helped nurse-midwives’ relationships with these organizations because working in such areas was “non-controversial.” Breckinridge believed “slow growth” was the best strategy to organizing nurse-midwives, because “the profession is still young in this country and could so easily incur opposition which would retard its growth by many years.”

Breckinridge also wanted to continue to include lay members interested in nurse-midwifery in their organization, while MCA and CMI leaders wanted to restrict a national organization to nurse-midwives. Finally, Breckinridge felt strongly that the AANM should not have high dues because many members earned small salaries; nor should it have too many committees because members generally had little free time to serve on them.

Breckinridge’s ideas about organizing nurse-midwives frustrated Sister Theophane and Hemschemeyer. They worried that Breckinridge did not want an “alive, progressive, dynamic, and growing” organization. The CMI and MCA leaders hoped for an organization to promote educational standardization and coordination and to act as an “official mouthpiece,” as well as a forum to share ideas, all of which would require committees and sizable dues. Sister Theophane indicated to FNS leaders that she held out hope for expanding the AANM, but to the Committee on Organization, she admitted that she had given up on this FNS-based organization.

A second major ideological division between Breckinridge, and Sister Theophane and Hemschemeyer, stemmed from their different approaches to nurse-midwifery education. FNS trained its students to practice midwifery, while MCA and CMI trained their students to serve as teachers and administrators for traditional midwives and obstetric nurses. To some extent, nurse-midwifery leaders from FNS and from MCA and CMI accepted their different emphases, but each camp believed it knew the best way to serve patients and the profession. From the FNS camp, Helen Marie Fedde, an FNS graduate and dean of the school for two years, explained:
The F.N.S. is bound to differ somewhat from both MCA and CMI in outlook and in aim. I cannot think that that is bad. Most of our students are taught with the primary purpose of preparing them as fully as possible for the actual practice of nurse-midwifery in remotely isolated areas of this country or on the mission field. I feel that in any consideration of functions or of educational standards that this basic purpose should be kept firmly in mind. The training for administration, in my opinion, will always be secondary to this.\(^{58}\)

From the MCA and CMI camp, Hemschemeyer agreed that nurse-midwives needed regular contact with patients, but felt “midwives should become more articulate about their work and devote more of their time and energies to administration, teaching, and interpretation.”\(^{59}\) She believed her suggestions would elevate the professional status of the nurse-midwife.

An even more dramatic ideological conflict concerned two MCA/CMI and FNS approaches to nurse-midwifery practice. As CMI director and MCA-educated Sister Theophane explained, first, a student trained at MCA only accepted normal patients “delegated to her by the obstetrician” after completion of a physical examination. Second, “the nurse-midwife [trained at the Lobenstine School] would not be a private practitioner as was the principle of work in Kentucky.” Nurse-midwives trained at MCA, Sister Theophane concluded, prepared primarily to supervise and teach, and could only work where medical services were available, while FNS graduates prepared to practice and had less contact with and supervision by physicians.\(^{60}\) MCA and CMI leaders thus believed, somewhat incorrectly, that FNS promoted nurse-midwives as autonomous health professionals.

Both the FNS and CMI/MCA approaches to nurse-midwifery possessed some radical and some conservative elements; in limited ways each approach undermined the modern American notion that male physicians would dictate patient care and, more specifically, childbirth. The FNS approach directly challenged medically supervised births, but reached relatively few people because FNS focused on its eastern Kentucky demonstration site, and trained students primarily to be direct practitioners.\(^{61}\) Also, its approach did not seem to accept the reality of childbirth in the mid-twentieth century: most women wanted to deliver their babies in the hospital. The MCA/CMI approach was in some ways more threatening because it reached more people. These institutions trained students to teach nurse-midwifery to nurses and traditional midwives, who would
then teach their patients. In addition, as discussed in chapter 4, MCA helped expand nurse-midwifery to new places (university hospitals) and in new directions (university education). However, MCA and CMI’s strategy emphasized the need for obstetrician involvement in nurse-midwives’ work, thus offering a less direct challenge to obstetricians.62

The Formation of the American College of Nurse-Midwifery

The leaders of MCA and CMI ultimately succeeded, both in their approach to nurse-midwifery and in the creation of a new national nurse-midwifery organization. On November 7, 1955, in Santa Fe, New Mexico, five nurse-midwives signed papers to incorporate the American College of Nurse-Midwifery (ACNM). A few days later, the ACNM held its first convention in Kansas City, just before the American Public Health Association convention so that nurse-midwives could attend both; Aileen Hogan and Hannah Mitchell, whose stories I told at the beginning of this chapter and in chapter 5, respectively, participated in this first gathering.63 The following month, the ACNM published its first journal, Bulletin of the American College of Nurse-Midwifery, a continuation of the short-lived broadsheet, The Nurse-Midwife Bulletin (May 1954–October 1955).64 By 1955, nurse-midwives had created both a national professional organization and a professional journal.

The first executive board of the ACNM was composed of seven women; four, including president Hattie Hemschemeyer and president-elect Sister M. Theophane Shoemaker, were MCA alumnae, two were FNS alumnae, while the seventh had completed her midwifery education in Britain and later worked at both FNS and CMI. FNS leaders and staff did not join the new organization.65

The ACNM focused on gaining recognition for nurse-midwives and regulating the entry of nurse-midwives into practice. In 1956, as part of this focus, the organization formed a committee charged with formalizing the profession’s philosophy and practice, as well as nurse-midwives’ functions, standards, and qualifications. The committee, reinvented several times with different members, did not get its recommendations approved by ACNM membership until 1966. The membership disagreed about how to avoid alienating their obstetrician supporters and how to recognize the
many different kinds of roles that nurse-midwives played—from direct clinical practitioners in midwifery to obstetric nurses to maternity consultants in federal, state, and local departments of health.

The first configuration of this committee, in existence from 1956 to 1960, moved away from the Committee on Organization's emphasis on nurse-midwifery as an independent profession and toward nurse-midwifery as a clinical specialty within nursing under medical guidance. A later configuration of the committee stressed medical supervision, but suggested that once nurse-midwives received approval from physicians for their plans, they took care of patients on their own unless complications occurred. This approach to nurse-midwifery alarmed even diehard obstetrician supporters like Louis Hellman, who was concerned that nurse-midwives would become independent practitioners and that the ACNM as an organization was trying to be too independent. Thus, the committee's final list of nurse-midwifery functions, published and approved in 1966, stated clearly that nurse-midwives worked under the direction and supervision of physicians. It also acknowledged the realities of the profession in the 1950s and 1960s, stipulating that nurse-midwives who worked as traditional nurses, as many did, had to work within the rules of practice dictated by nursing, while those who practiced clinical midwifery had additional functions, including the administration of analgesics and anesthesia, performing episiotomies, and delivering babies. In 1966, the same year the committee got approval on its list of nurse-midwifery functions, the ACNM started reviewing and approving nurse-midwifery educational programs, although it was not recognized as the accrediting agency for these programs by the U.S. Department of Education until 1984.66

ACNM, the MCA- and CMI-based organization, and AANM, the FNS-based organization, finally worked out their differences, merging in 1968 under the American College of Nurse-Midwives name. It is not a coincidence that the ACNM first proposed the merger just months after Breckinridge died in 1965. In 1967, when the AANM was folding into ACNM, FNS leaders wanted to ensure that their organization's history and bylaws were not lost in the process. As late as 1969, competition or conflict arose between FNS and the newly merged ACNM. In that year, Vera Keane, the president of ACNM and an MCA graduate, criticized then FNS director Helen Browne for discussing only FNS, rather than the broader topic of nurse-midwives, in a Today Show interview on midwifery with Barbara Walters.67 Regardless, by this point, with many nurse-midwives working in hospitals and as nurses, rather than in direct clinical
midwifery practice, ACNM leaned in favor of major accommodations with physicians and nurses in order to survive and expand their profession.

Conclusion

In the mid-1950s, as nurse-midwives tried to renegotiate their place in American health care, they faced a series of problems: defining their profession, getting outsiders to understand who they were and what they did, and winning support for their fairly radical views about childbirth. To negotiate the rocky path to public respectability and professional acceptance these obstacles created, nurse-midwives chose the political strategy of accommodation. Given the climate in which they worked, they had little choice. Increasingly, mid-twentieth-century nurse-midwives, such as Aileen Hogan at Western Reserve (now Case Western), were not autonomous. With the exception of the home-delivery services at FNS and CMI, most nurse-midwives worked in hospital or government settings where they had to report to superiors who often had little understanding of their education or capabilities, who sometimes disagreed with their approach to childbirth, and who usually resisted nurses or women being in charge.

Despite their nearly universal decision to accommodate physicians, nurse-midwives disagreed about the degree to which they should work within the health-care establishment, as seen in debates among both the rank-and-file and leadership and in the newly formed American College of Nurse-Midwifery. To what extent would physicians actually be involved in nurse-midwives’ work? To what extent would nurse-midwives work autonomously on the frontiers of health care or under the watchful eye of physicians and nurses in the center of health care? To what extent would nurse-midwives push physicians and nurses to allow them to regulate and control their own profession? The ACNM helped nurse-midwives move toward the center of the health-care establishment and gain some control over their profession, but in the process nurse-midwives compromised by agreeing to work under the direction of physicians. By definition, their strategy of accommodation, a “weapon of the weak,” had its limitations.