History of the Department of Obstetrics and Gynecology
Written by the esteemed Dr. Robert MacKenzie

1925-1973

Archival materials kindly provided by
Ms. Shirley Wilton and Ms. Lois M. Borden

1924 – 1973
A Story of a Twentieth Century Medical Center

1924 -  Dr. MacKenzie graduated from Columbia P&S and worked with Dr. Abbe at St. Luke’s for 3 years
1927 -  He began work as a surgeon and family doctor in NJ
1930 -  The American Board of Obstetrics and Gynecology was founded. In 1933 he became the third Ob/Gyn Dr. in the state of New Jersey.
1934 -  He became FACS, Fellow of the American College of Surgeons
1935 -  Member of the new, New York Obstetrical Society
1940 -  Member of the American College of Obstetricians and Gynecologists. Later, 1963-1969, he would serve two terms on the ACOG Board of Governors.
1926 – 54  He was on the staff of Monmouth Hospital, Long Branch, NJ, and developed the training of young doctors preparing for Ob/Gyn certification.
1955 – 62  on the staff in the Jersey Shore (Fitkin) Hospital he established their Ob/Gyn department.
1963 – 73  His hospital retirement was required at age 65, and he continued his office and care of patients for ten years. His final retirement at age 75 was celebrated in 1973.

Dr. MacKenzie’s career is illustrative of the development in the 20th century of Obstetrical and gynecological specialization in medical care for women. As a graduated surgeon, he was able to successfully establish the hospitals’ departments of Ob/Gyn care in what is now the Jersey Shore University Medical Hospital in Neptune, and the Monmouth Memorial Hospital in Long Branch.

Upon retirement in 1973, he was given the following plaque from his fellow doctors at the Jersey Shore Hospital -------- [na]
[Conditions and changes were not defined by time span but it is convenient and fairly accurate to divide description according to decades].

1925 – 1935

During this period maternity work was desired by few doctors but accepted by most including surgeons. (Only five physicians strictly limited their practice: Dr. Campbell of Long Branch and Dr. Fisher of Asbury Park were specialists in Eye Ear Nose & Throat, Dr. Herrman was a radiologist, Dr. Nichols a pediatrician caring in those days mostly for sick babies, Dr. Moffett an orthopedic surgeon dividing his time between New York and this area). Most “confinements” were in places of residence or “maternity homes”. Cesarean operations were done only by general surgeons until at “Monmouth”, after several years, exception was made for me. During most of these years management of labor and delivery was unrestricted in both hospitals. One popular doctor believed in shortening labor by manual dilation of the cervix and Medium A forceps. Results would not pass today’s critical inspection. The need for isolation of beds for obstetrical patients and limited access to the delivery room area was made clear when puerperal sepsis claimed several lives at the Fitkin Hospital soon after it opened in 1932. Public concern about deaths associated with pregnancy (the rate of maternal mortality was then 6 per 1000 deliveries) was aroused by report of a statistical study in New York City and critical articles in several magazines. The Medical Society of the State of New Jersey had appointed a “Maternal Welfare Committee” in 1933. As a part of its work each maternal death was investigated and preventable factor evaluated. The Journal of the Medical Society published each month a “Lesson from a Death Certificate”. There was, from the first, an appreciation that satisfactory obstetrical result must include a healthy neonate. The Committee’s name was altered to add “Child Welfare”.

In this period, the nineteen thirties, changes were many and a shift in my own plans was one. Although enjoying family practice I decided to specialize in the care of women. My training at the New York Lying-In Hospital had been valuable but short. I sought additional instruction in visits to universities where new ideas and techniques were being developed. After observing in Boston the famous Dr. Phaneuf I saw the advantage of a lower segment incision in most cases of Cesarean section and began to employ this technique. In Buffalo I was impressed by the remarkable skill of the notorious Dr. Potter who performed routine (elective) internal podalic version and breech extraction for his patients at term. But this venturesome interference did not appeal. By contrast in Cleveland Dr. Arthur Bill’s 180 degrees forceps rotation of the fetal head impacted in mid-pelvis with occiput posterior seemed a fine maneuver. I routinely used this procedure with good result when faced with such a problem in subsequent years. The Kjelland forceps then popular at Margaret Hague Hospital and elsewhere but was not a satisfactory instrument in my hands. Helpful also was a visit to Northwestern University in Evanston, Ill., where Dr. William Danforth, Sr. received me graciously and showed the uterine packer he had devised. This instrument was purchased and used in a number of emergency situations. Special gauze packing material is essential to a good result, especially in the event of inversion of the postpartum uterus. I had only to go to nearby Philadelphia to see Dr. Pieper apply his forceps designed to assist extraction of the after-coming head. Having this valuable tool increased my confidence in management of breech presentation. I was careful; however, to make sure that conformation of the bony pelvis was normal in these cases and I learned quickly
that Cesarean was indicated if membranes ruptured with an undilated cervix in primipara. Although this is in no sense a scientific paper, it seems not improper to mention my encouragement of trial labor in many cases where hysterectomy had been performed by me. There must be, of course assurance of favorable fetal size and position and no contraction of the birth canal. Preference for vaginal delivery by the patient was also a condition. No rupture of the uterine scar occurred in these cases.

Finally and with apology for reporting personal matters, meaningful developments seem to deserve mention. In 1933 I was examined and won certification by the American Board of Obstetrics and Gynecology. In 1934 the American College of Surgeons admitted me to Fellowship and in 1935 the New York Obstetrical Society elected me a member.


During this period the obstetrical departments both at Monmouth Memorial Hospital, as it was then called, and the Fitkin Hospital were better organized with improved facilities and staffing. All attending doctors were not specialists by formal training nor was their work limited to care or women. But all were conscientious and cooperative. There were weekly meetings with review of unusual cases and a monthly statistical report with occasional commentary by a consultant from New York or Philadelphia. General practitioners doing obstetrics were urged to attend these conferences. There were rules governing conduct of labor and delivery; only outlet application of forceps was permitted non-staff members. Consultation was compulsory when labor failed to progress and if other complication arose. A patient with history of Cesarean delivery could not be cared for by a non-staff doctor. The burden of operative work was mine. At Fitkin the able Dr. Kenneth Brown was co-chief of the Obs Service but lacked surgical training. I was called when Cesarean operation seemed the best way to terminate pregnancy. I trusted his judgment completely and we had a most pleasant relationship.

Dr. William Shanik and Dr. William Heatley opened offices and quickly proved helpful. Dr. Shanik particularly was well qualified for full responsibility. In 1942 the departure of both of these men to serve with U.S. armed forces seriously weakened our staff. Dr. Mildred Luca had come along in ’41 but could hardly fill the gap. Advantages of hospitalization were by this time appreciated and less than 5% of births were planned at home. The so-called maternity homes with their inadequate equipment were out of business.

In the years before the war, as Dr. Shanik will recall, the two of us participated in a government program designed to ensure better care for Army and Navy dependents. EMIC funds rewarded us for lectures urging regular prenatal examination, nutrition, weight control, etc. EMIC also paid fifty dollars, if I recall correctly, for complete pregnancy care. With wartime needs depleting all civilian medical services, assistance with anaesthesia was a real problem. In 1944 I managed to take advantage of a course in conduct anaesthesia given at the Philadelphia Lying-In Hospital by the highly regarded Robert A. Hingson. Then in the U.S. Public Health Service, Dr. Hingson was mainly known for his work in and advocacy of continuous caudal anaesthesia. He did not decry intrathecal anaesthesia and it seemed to me that this was the more practical for my use because of the number of patients whose progress in labor must be supervised simultaneously. I employed procaine, pontocaine and the heavier Nupercaine with results that with few exceptions were satisfactory to me and to the patients. I am positive that I caused no nerve injury and no infection. It is possible that poor judgment in timing “spinal” may have contributed to anoxia and poor condition of a few infants. With experience, the danger
of this was more fully appreciated and measures taken to up the mother’s oxygen intake and prevent lowering her blood pressure. Also I found less use for this method of pain relief in women who had one or more previous vaginal deliveries.

Aided by the ideal working conditions which spinal afforded I took the opportunity to perform immediate postpartum vaginal reconstruction in numerous cases. There was one month in which I had on my list eight patients who had lost their first baby after severe traumatic delivery. More than one of these had some degree of fecal incontinence. Correction of this problem along with a happy outcome of pregnancy brought great joy.

During this decade antibiotics were not known. Sepsis was a specter. No area of the hospital was air conditioned. In hot weather, nurses used cold cloths to wipe a surgeon’s perspiring brow. I recall one woman’s death from peritonitis following Cesarean delivery. It was August. The infection was probably uterine in source but I suspect that sweat dropped in the field in the field of operation.

In cases of neglected labor and long ruptured membranes, endometritis could be assumed even when the patient’s temperature was not elevated. The Porro procedure, exteriorizing the uterus after hysterotomy, or hysterectomy could be followed in such cases. I knew of good results, just reported, of Cesarean operations, using modification of extra-peritoneal technique devised in Austria by Latzko many years earlier. One reporter, Dr. Henry Burns of New York, came to Long Branch and assisted me in one case. With this experience I was able in 1938 to be of service to an officer’s wife who had suffered active labor for two days at the medical facility at Fort Monmouth. Examining her there in consultation, delivery through the pelvis seemed impossible. After transportation of the patient to Monmouth by ambulance a ten pound baby was extracted in good condition through paramedian laparotomy incision without entering the peritoneal cavity. Post-operative course was uncomplicated though I think the wound drained profusely.

Sometime later there was an even more dramatic utilization of this difficult surgery. The only daughter of one of Monmouth’s senior surgeons labored long and vainly to deliver her first child. When I was invited to consider the problem there was no engagement of the presenting part, the amniotic sac had ruptured, numerous vaginal examinations had been made and exhaustion was imminent. Extraperitoneal section was accomplished as the anxious father watched. Fortunately there was no injury to bladder or ureter and both mother and baby left the hospital in good condition.

It may seem digression but it seems pertinent to note my interest this long ago in what was then called “birth control,” now more properly “responsible reproduction.” My attention was first directed to the dangers of excess multiparity while on duty as a medical student in New York’s slums. In those years and in the Long Branch community of the decade now discussed it wasn’t unusual to have the Gravity X11 or XV come in with hemorrhage or malpresentation or ruptured uterus. It was obvious that for these women conception control by methods then available could not be expected. Voluntary sterilization seemed right for them and many accepted tubal ligation performed a day or two after vaginal delivery. There were no legal constraints to this procedure but there was controversy and some criticism. In many hospitals sterilization of either females or males was not permitted. I persuaded our Monmouth Memorial Hospital Medical Board to approve P.P. sterilization with restriction to patients over 30 who had requested this 24 hours before the operation and had acquiescence signed by spouse. If healthy, there must have been three children. No specification as to offspring was necessary where serious and documented health impairment existed. In 1944, questionnaire to approximately 40
women who had undergone this procedure brought unanimous and favorable answer. I reported our experiences and regulations in a paper read before District III American College of Obstetricians and Gynecologists. The response was enthusiastic and I had numerous requests for reprints.

1945 – 1955

These are the years I like best to recall. My private practice was at its peak: 648 deliveries in the year 1947. More important was the smooth functioning of the department at Monmouth. Much credit is due to the nurses: Mrs. Nelson and Mrs. Barwick in supervisory capacity, Mrs. Anna Boyd and Miss Bernice Wilson in the labor and delivery rooms, Mrs. Johns and Mrs. Thorne in the nursery and Miss Margaret Conk on Borden III at night. Never were individuals more conscientious or more skillful. The attending staff was strengthened by the return of Dr. Shanik and reinforced when Dr. S. S. Adler left the army, forsaking New York and his Polyclinic Hospital for work in the Red Bank, Long Branch area. I well recall the paper Dr. Adler, still in uniform at the time, read before one of the general staff meetings. He described indications for use of penicillin in Obstetrics. We welcomed Dr. Feferici in 1954.

The outstanding development of this decade and of greatest interest to this group was the establishment of our resident training program. It was something of a triumph when in 1947 the Accreditation Committee of the Specialty Board approved Monmouth Memorial Hospital for one year of obstetrical training. Beginning in 1948 with Bill Ainslie and followed by Charley Korbonits, E.M. White Jr., Edward J. Le Genza, Richard Battaglia, Jerome Weinbaum, Joseph Rowe, Evalina Doo, Richard Gosling, and Birute Preikstas, the staff enjoyed their splendid assistance and had the satisfaction of giving these talented young doctors a needed start. Each one went on to attain experience qualifying them for specialization in Obstetrics and Gynecology. Gynecology – at least its surgical aspect – was still not recognized at Monmouth as properly the province of our department. Operative care of private patients, however, had finally been made possible for me by vote of the Medical Board over objection by Surgical Department members. After this precedent the way was open for Dr. Shanik and Dr. Adler. For Dr. Jacobus, Dr. Payne, Dr. Federici and those who came along later with American Board credentials there was no wait for O.R. privileges and no awareness, I suspect, of past obstacles overcome. There was continued opposition to having ward patients needing vaginal or pelvic surgery assigned to our department. In 1954 I resigned as Director in implied protest. In that year the more realistic Fitkin Hospital Board of Governors had set up a department of Gynecologic Surgery and asked me to take charge. The Department of Obstetrics and Gynecology was structured in 1964.

1955 – 1975

Following my departure from the active staff, Dr. Shanik was the director of the Obstetrical Department and carried on capably for a number of years. Dr. Adler was next to take over the reins. It was not until 1964, however, that the “powers that be” established the combined services of Obstetrics and Gynecology. I think Dr. William Vaun, Director of Medical Education influenced the Board of Governors to see the light in this matter. Dr. Federici had the honor to be the first chief of the new department. In 1970 the current program of resident training was accredited. It has steadily expanded as you know.
There have been additional developments of significance. High risk pregnancies are selected for special management. Improved diagnostic methods are available to detect complications and monitor the health of the fetus before and during labor. Perinatology has become a specialty. The intensive care nursery has the latest equipment. Whether all of this will affect appreciably better results is still, I think, questionable.

In 1947, the number of patients delivered at this institution was 1860. The fetal loss (stillbirths and neonatal deaths) was 3.5%. The Cesarean rate was 2.9%. In 1955 there were 1770 women delivered. The fetal loss was 3.2%. Cesareans were performed in 3.2% of cases. Twenty years later (1975) 2200 patients had babies with fewer disappointments; only 1.8% were stillborn or died within the first month of life. The Cesarean rate was up to 12%, still modest by today’s standards. The annual statistical report has also burgeoned from 1 to 8 pages.

There is no way to measure the satisfaction of parents with their care during the months of pregnancy and the hospital experience. I suspect that rapport between patient and obstetrician may be less as other personnel participate. It may be advantageous to have the perinatologist consult when condition of the fetus is in doubt and take over a premature or weak infant. But the obstetrician’s responsibility should not be less. His management of the birth process and the immediate care of the neonate has great importance. It is the obstetrician’s duty, certainly, to meet the emotional need of his patient through the long months of anxious expectancy, during labor, and in the puerperium.

Mothers attempting breast feeding need detailed advice and encouragement which they too seldom receive. Perineal soreness, hemorrhoidal discomfort, engorged breasts, bladder symptoms call for sympathy if nothing else. Though song and story depict motherhood as a joyous time, it is not always thus. Depression of spirit can be caused by lack of confidence in the parental role, uncertainty about relations with her husband or just hurt feelings about loss of the center stage. The obstetrician’s guidance is really needed: the office checkup should not be the only postpartum service.
## Obstetrical Statistics from the notes of Dr. MacKenzie

**December, 1975**

### MONTH YEAR - TO - DATE

<table>
<thead>
<tr>
<th>A. SERVE</th>
<th>B. SERVE</th>
<th>A. SERV</th>
<th>B. SERV</th>
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</thead>
<tbody>
<tr>
<td>A. PATIENTS DISCHARGED</td>
<td>283</td>
<td>127</td>
<td>1,304</td>
</tr>
<tr>
<td>1. DISCHARGED UNDELIVERED</td>
<td>77</td>
<td>12</td>
<td>164</td>
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<tr>
<td>2. DELIVERED IN HOSPITAL</td>
<td>206</td>
<td>115</td>
<td>1,163</td>
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<tr>
<td>3. DELIVERED OUTSIDE HOSPITAL</td>
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<td>0</td>
<td>3</td>
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<tr>
<td>B. TOTAL PATIENTS DELIVERED</td>
<td>206</td>
<td>115</td>
<td>1,166</td>
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<tr>
<td>1. OPERATIVE</td>
<td>93</td>
<td>0</td>
<td>594</td>
</tr>
<tr>
<td>2. NONOPERATIVE</td>
<td>113</td>
<td>52</td>
<td>572</td>
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<tr>
<td>3. SINGLE PREGNANCY</td>
<td>201</td>
<td>113</td>
<td>1,151</td>
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<td>4. MULTIPLE PREGNANCY</td>
<td>4</td>
<td>2</td>
<td>14</td>
</tr>
</tbody>
</table>

### C. TYPE OF DELIVERY

1. **VERTEK - VAGINAL**
   - A. SPONTANEOUS
   - B. OPERATIVE
     - 1. FORCEPS
       - A. LOW | 68 | 55 | 314 |
       - B. MID | 9 | 5 | 58 |
     - C. HIGH | 0 | 0 | 0 |
     - D. VACUUM EXTR. | 0 | 0 | 0 |
   - 2. BREECH - VAGINAL
     - A. SPONTANEOUS | 0 | 0 | 0 |
     - B. ASSISTED | 4 | 2 | 9 |
     - C. EXTRACTION | 1 | 0 | 4 |
   - 3. CESAREAN
     - A. LOW CERVICAL | 14 | 3 | 3 |
     - B. CLASSICAL | 0 | 0 | 0 |
     - C. EXTRAPERITONEAL | 0 | 0 | 0 |
     - D. WITH HYSTERECTOMY | 0 | 0 | 0 |
     - E. PRIMARY | 13 | 4 | 35 |
     - F. PERCENT PRIMARY | 8 | 3 | 5 |
     - G. REPEAT | 3 | 0 | 17 |
     - H. PERCENT REPEAT | 2 | 2 | 2 |
     - I. LAPARATOMY | 0 | 0 | 0 |
     - J. HYSTEROTOMY | 0 | 0 | 0 |
     - K. REMOVAL OF ECTOPIC | 0 | 0 | 0 |
     - L. SPONTANEOUS ABORTION | 0 | 3 | 2 |
     - M. D & C | 0 | 0 | 0 |
   - N. POSTMORTEM SECTION | 0 | 0 | 0 |

2. **VAGINAL DELIVERY FOLLOWING**
   - A. PREVIOUS C - SECTION | 0 | 0 | 1 |
   - B. MYOMECTOMY | 0 | 0 | 0 |
   - C. VERSION & EXTRACTION | 0 | 0 | 0 |

3. **DESTRUCTIVE PROCEDURES**
   - A. PRIMARY | 13 | 4 | 35 |
   - B. PERCENT PRIMARY | 8 | 3 | 5 |
   - C. REPEAT | 3 | 0 | 17 |
   - D. PERCENT REPEAT | 2 | 2 | 2 |
   - E. LAPARATOMY | 0 | 0 | 0 |
   - F. HYSTEROTOMY | 0 | 0 | 0 |
   - G. REMOVAL OF ECTOPIC | 0 | 0 | 0 |
   - H. SPONTANEOUS ABORTION | 0 | 3 | 2 |
   - I. D & C | 0 | 0 | 0 |
   - J. POSTMORTEM SECTION | 0 | 0 | 0 |

### ANESTHESIA

- A. NONE | 186 | 107 | 234 | 159 |
- B. LOCAL & OR PUDENDAL &/OR INHALATION | 24 | 404 | 173 |
Photographs of Robert MacKenzie, MD