

Autonomy in Midwifery: Definition, Education, Regulation

by Robbie Davis-Floyd

This article appears in *Midwifery Today* 46, Spring, 1996.
Both *Midwifery Today* and the author give permission for it to be replicated for educational purposes.

One day a few years ago I stood at the edge of a corn field in central Mexico watching a farmer tilling his land. When he was ready to take a break, we sat down together in the shade of a tree and talked for a while about his past. He told me that he had trained as a schoolteacher, and had taught high school in various towns for several years. When I asked him why he switched to farming, he replied, "*Porque aqui nadie me manda*" ("Because here, no one tells me what to do.") In other words, as a farmer working his own land, he was autonomous.

The American Heritage Dictionary in my computer defines an autonomous individual as one who is

1. Not controlled by others or by outside forces; independent.
2. Independent in mind or judgment; self-directed.
- 3.a. Independent of the laws of another state or government; self-governing.
- b. Of or relating to a self-governing entity.
- c. Self-governing with respect to local or internal affairs.

This definition raises several important issues that I want to address here. As it makes clear, there are two components to autonomy--action and thought. I suggest that the most critical of these is thought. Midwives who are autonomous in thought, even if they work in a system that defines them as subordinate, are often able to bend or manipulate the system in order, most of the time, to give truly woman-centered care. But it is difficult to learn to think autonomously if your training is designed to make you think dependently. While it is true that classroom instruction in hospital-based nurse-midwifery is increasingly designed to foster independence of thought and action, many midwives find that once they are on the hospital floor, such independence is difficult to maintain in the face of supervisors who criticize them for spending too much time with patients and send them to clean out closets instead, or who insist that they follow hospital protocols and routines to the letter. A CNM I know, a dear friend of mine, once told me that after she graduated from nurse-midwifery school "you couldn't get me near a birth without three fetal monitors and five anesthesiologists standing by." In other words, she did not learn autonomous midwifery; she was trained to be dependent on the system. Many hospital-based midwives gain little experience in handling emergencies on their own; when a serious one arises, they have but to push a button or call for help, and others will come and take over.

For these and other reasons, hospital-based midwives sometimes look to their direct-entry sisters for models of autonomy in midwifery. Let me tell you Samantha McCormick's story.

Samantha's three years as an obstetrical nurse in a high-risk hospital in New York left her terrified of birth, and she told me that her year in Columbia University's nurse-midwifery program did not do enough to allay those fears. In an effort to develop confidence in herself and in the birth process, she interned at a nurse-midwifery program in Cooperstown, New York renowned for its holistic approach. After two months there, she still did not feel confident, so she decided to apprentice with Shari Daniels, a direct-entry midwife who used to run a midwifery program in El Paso, Texas and who now takes groups of midwives to do births at Victoria Jubilee Hospital in Kingston, Jamaica. Her apprenticeship with Shari finally gave Samantha the trust in birth and the courage to handle emergencies in the self-reliant home birth midwifery way for which she had been searching.

Obviously there is tremendous value in the autonomy that American direct-entry midwives who work in birth centers, at home, and in hospitals overseas have achieved. Yet no midwife is an island. The independence and self-reliance of many American DEMs who work outside the system have their

own intrinsic limitations. Sometimes a midwife needs to be part of a team, to have a viable system of backup and transport in place that she can call on when her own judgment tells her it is necessary. As a member of this team, she can accompany her patient to the hospital and continue to give care. There is nothing autonomous about being stopped at the hospital door. Thus true autonomy of practice requires not only independence of thought but also good collaborative working relationships with other practitioners.

It is absolutely absurd, after all the data that has been accumulating for twenty years, for physicians, hospitals, and insurance companies to impede the establishment of such relationships, as too many of them continue to do. Thus the other issue most linked with midwifery autonomy in my mind is the education not of midwives but of physicians, health care administrators, and insurance representatives about the worth of midwifery care. I have found that it is the practitioners who have had little or no exposure to midwifery practice who still hold fast to the damaging stereotype that midwives who work outside the hospital are ignorant and unsafe. Such practitioners tend to learn about midwifery the fastest when they are exposed to the midwives they so deeply mistrust. Watching such midwives work, getting to know them, even having a friendly conversation with them can be a mind-opening experience for the stereotype-bound. So, given the current ratio of 35,000 practicing obstetricians to around 7000 practicing midwives, instead of a highway to keep clean, perhaps every midwife should pick five OBs to educate!

The last issue raised by the above definition is self-governance. American midwifery, which should be independent and self-regulating, is too often controlled by hospital administrators, physicians, and medical or nursing boards. Because midwifery care is so different in so many ways from standard medical or nursing care, it is near-impossible for physicians and nurses to generate regulations that facilitate, instead of impede, the practice of midwifery, as good regulations should do. The ACNM's move into direct-entry education and certification is in part an attempt at achieving greater autonomy for their profession, as this move may ultimately result in the removal of ACNM-style midwifery from regulation by nursing boards and the establishment of new, independent midwifery boards in many states. It would be a shame if this self-regulation, which is going to take a tremendous amount of work to achieve, were to be accompanied by a concomitant loss of autonomy by the MANA-style direct-entry midwives who, while working for their own legislation, may nevertheless come to be regulated in some states under the same midwifery boards as their ACNM-certified sisters. In such a case, whose model of midwifery practice and education would be used to set the standards in each state? As CNMs and DEMs struggle toward a viable autonomy--one that allows both independence of thought and action and some degree of incorporation within the health care system--it is my hope that they will meet the challenges posed by their diversity in ways that incorporate that diversity's full range.