

THE UPS, DOWNS, AND INTERLINKAGES OF NURSE- AND DIRECT-ENTRY MIDWIFERY: Status, Practice, and Education

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In this article and the one that follows, I seek to provide an anthropological overview of both the upside and the downside of recent transformations in the status, education, and practice of nurse- and direct-entry midwives. My motivation for writing stems from the many inquiries I receive from student midwives, or those thinking about becoming student midwives, concerning my opinion about which educational path they should follow and what kind of midwife they should become. For the past several years, through interviews and participant-observation, I have been studying the development of two new direct-entry certifications by members of the Midwives' Alliance of North America (MANA) and the American College of Nurse-Midwives (ACNM), and the differing educational philosophies these two certifications represent. As a result, students often ask me to explain what I have learned about the divergence between ACNM and MANA over the issues of scope of practice and appropriate educational routes. This and the following article are my attempts to make my understandings about both nurse- and direct-entry midwifery more available to such students, as well as to midwifery educators, practicing midwives, consumers, and social scientists interested in these issues.

In the course of carrying out this research, I have interviewed approximately 30 direct-entry midwifery students and 30 nurse-midwifery students about their motivations for becoming midwives and their educational experiences. In addition, I have conducted over 100 interviews with experienced nurse- and direct-entry midwives on a variety of topics, from their training to the nature of their practices to their motivations for developing direct-entry certification. At present, I am still actively conducting research and many of my interview tapes have not yet been transcribed. Since I have been asked to write this article before my research is complete, I have relied heavily on editorial assistance from a number of prominent nurse- and direct-entry midwives, all of whom are listed in the acknowledgments.

During this editorial process, it often became apparent that midwives in both organizations are extremely concerned about how they will be represented in print. It seems that both nurse- and direct-entry midwives want me to represent them as they would like to be, not necessarily as they are. The passion both groups put into their critiques of my portrayal of the downsides shows very clearly the depth of their desire to be the best midwives, the best educators, the best caregivers they can be, according to their respective values and beliefs. They want their ideal image to be presented in print, *because they strive to live up to that ideal*, and are concerned about printing anything that might threaten a profession that is still at a fragile evolutionary stage.

But I see midwifery as increasingly strong—strong in practitioner-client relationship, strong in safety, strong in evidence-based care. During my interviews with midwifery students, I was struck by the fact that almost all the students I spoke with, direct-entry and nurse-midwifery alike, felt spiritually called to practice midwifery. I take this fact as another indication of midwifery's strength—it is an ancient profession with powerful appeal to new generations. It is clear that no matter what the individual drawbacks in their training and practice styles, midwives are the best care providers for the vast majority of mothers and babies. The benefits of midwifery care have been well and thoroughly described by numerous authors (see for example Rothman 1982, Goer 1995, Arms 1997). Most recently Judith Rooks has provided thorough summaries of nearly every study done on the outcomes of midwifery care in her comprehensive *Midwifery and Childbirth in America* (1997; see also MacDorman and Singh 1998). I do not need to recapitulate these findings here. Suffice it to say that midwives' nurturant, woman-centered, evidence-based care produces excellent outcomes, generally with lower rates of intervention and lower costs than births attended by physicians.

Nevertheless, the medical monopoly in the U.S. is still firmly in control of birth: obstetricians and family practitioners attend 94% of American births. Most American women think only of calling an obstetrician when they become pregnant; many people are unfamiliar with the benefits of midwifery practice and do not know that midwives are available in almost every city. The 8700 or so midwives who attend 6% of American births¹ are culturally marginal in relation to the 35,619 obstetricians (and other doctors) who attend all the rest. Much work needs to be done to educate the public about the benefits of midwifery care. I am a firm believer that midwives themselves are the most effective public educators because they often speak out about who they are and what they do. This country needs many thousands more midwives than it has. Students are the key to midwifery's future; it is in the interests of helping them make informed choices about how to become midwives that I offer the following assessments. In these assessments, I include the both the upside and the downside as I see them, so that the students for whom I write will be as informed as possible and, whichever route they take, will understand the benefits to seek and the risks to guard against.

In what follows, I first present a general overview of the ups and downs of nurse- and direct-entry midwifery. I then describe the historical reasons for the present tensions between the ACNM and MANA, the professionalization of "lay" midwifery, the development of two new direct-entry certifications by members of these two national midwifery organizations, and the tensions generated by the exclusive establishment of one of these certifications in the state of New York. I consider the potential role of each of these new certifications in keeping open the full spectrum of midwifery care, including home birth. And I offer an evaluation of the stylistic and philosophical differences between experiential and didactic models of midwifery training, describing the trend toward the incorporation of both models in all current versions of midwifery education. In the concluding sections, I venture to express my own vision of a midwifery future in which harmony between the two national organizations prevails and unity in diversity is the dominant theme.

Please note that the following sections refer only to members of ACNM and MANA. I have not studied and cannot speak about midwives not affiliated with either organization.

The Ups and Downs of Nurse-Midwifery

Nurse-midwifery has strong roots in home birth practice and the home care of the poor during the 1920s and 1930s, when Mary Breckenridge adapted the British combination of nursing and midwifery to serve the rural poor of Appalachia through the Frontier Nursing Service, which she founded in 1925. Today nurse-midwives practice in many settings, but mostly in the hospitals where 99% of American women give birth. 96% of the births that CNMs attend take place in hospitals (Rooks 1997). They made and have stuck with a decision that the best place for midwifery is inside the health care system. They got in by being trained as nurses, which meant that midwifery could be construed as an advanced form of nursing, which put it solidly inside medicine (Roberts 1995: 121; Rooks 1997:40).² At the time, this was a very strategic move: the nurse-midwives who founded the ACNM in 1955 were (and still are, to a lesser degree) trying to legitimize midwifery in the face of powerful medical opposition and a long and relentless medical campaign to convince the public that midwives were unsafe practitioners (Donegan 1978, Donnison 1977, Leavitt 1986, Wertz and Wertz 1989.) Training midwives as nurses not only made sense in terms of the increased range of care they could offer, but also in terms of (1) convincing the public that they constituted a legitimate and trustworthy profession; and (2) convincing physicians that they should be part of the American system of obstetrical care.

Now that the members of ACNM are expanding into "direct-entry" midwifery education and certification (see box 1), they are doing so in careful alignment with nurse-midwifery. Nursing was their ticket to entry and legitimacy; although they are willing to drop a nursing degree as a requirement, they will keep all other aspects of their educational standards by creating ACNM's version of direct-entry midwifery in the image of nurse-midwifery. To succeed within medicine, as they are doing, they must mirror the standardized education of all medical professions. Their leadership believes that success within the technocracy³ requires a college degree, and that it is disempowering to women to require them to obtain an education worthy of a college degree without also requiring them to obtain the degree. That is why, starting in 1999, ACNM will require that all CNMs obtain a baccalaureate degree (in any field) either before, during, or upon completion of their midwifery education.⁴ Presently there are no undergraduate nurse-midwifery programs leading to a baccalaureate degree; thus in effect, for the immediate future, the baccalaureate will be a requirement for entry into all such programs. Nurse-midwifery programs that used to grant certificates in midwifery without requiring a baccalaureate will apparently

become post-baccalaureate programs;⁵ although the door is open for ACNM-accredited programs to choose to grant the baccalaureate degree, so far none have expressed interest in doing so (Laura Slattery, personal communication, 1998). Some in the ACNM strongly advocate that the Master's degree should be required for certification, but the ACNM Board of Directors has recently reaffirmed that the Master's is not a requirement. 70% of nurse-midwives already do have the Master's degree.

[Note to Midwifery Today: All the boxes should be off to the side; the text is continuous and should not be interrupted by the boxes]

Box 1

The Use of the Term "Direct-Entry" in the U.S.

I must stop here to explain the complexities of the term "direct-entry," which in its simplest form means that one enters directly into midwifery education, instead of first passing through the discipline of nursing. This is the definition utilized by most non-nurse midwives, many of whom chose as early as the mid-1980s to replace the term "lay" with "direct-entry"—a term already well-known in Europe—because it conveys their strong sense of themselves as professionals and carries the definite if subtle implication that nursing is at best a roundabout way to enter midwifery. Direct-entry midwifery is the norm in Europe, where most midwives do not become nurses, but rather attend formal three-year midwifery training programs in post-secondary educational programs or universities.

There appears to be some disagreement within the American nurse-midwifery community over the proper meaning of the term "direct-entry." Some nurse-midwives favor the broad definition (entering directly into any type of midwifery education). Others point to the European use of the term to mean government-accredited formal education. Still others seek to limit the use of the term in the U.S. to mean very specifically that one enters midwifery education not through nursing but through an ACNM-accredited university-affiliated midwifery training program (which will require completion of basic science prerequisites and a university degree). Many "direct-entry" midwives see this as a costly and indirect route.

It is essential to understand that we are dealing with two radically different educational paradigms, even though they are called the same thing. There are important ramifications of this semantic confusion: because both groups are using the same label, some members of each feel that the other is coopting their process, not to mention their terminology.

Another problem that confounds the use of the term "direct-entry" is the fact that some ACNM members believe that all who call themselves direct-entry midwives should at a minimum meet the criteria laid out in the international definition of a midwife (see box 2); many direct-entry midwives do not meet these criteria. A few in the ACNM have attempted to resolve this problem by suggesting that all American midwives who do not meet the international definition should be called TBAs (traditional birth attendants)—an idea that MANA midwives find not only inaccurate but also insulting in the extreme. In developing countries, generally speaking, TBAs, while often highly respected in their own communities, have far less formal Western-style training and lower overall social status than "midwives" who meet the international definition. The evidence-based knowledge and skills of NARM-certified CPMs (see below), including those who are apprentice-trained, are very different from those of most traditional midwives; to lump them together in the same category would be extremely misleading. In addition, most MANA midwives believe that even TBAs shouldn't be called TBAs, as this is a somewhat derogatory label that often obscures their locally valued roles as community midwives.

Box 2

The International Definition of a Midwife

A midwife is a person who, having been regularly admitted to a midwifery educational program duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility, and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance, and the execution of emergency measures in the absence of medical help.

She has an important task in health counseling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynecology, family planning and child care. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service. (World Health Organization 1996)

What nurse-midwives have gained from these strategies is multiple: legal status in all 50 states (and the District of Columbia), insurance reimbursement and malpractice coverage, participation in some managed care programs, a degree of respect within the medical community and in the wider society, the ability to offer the benefits of midwifery care in hospitals where the vast majority of women give birth, and the credentials and skills to carry out and publish much-needed research on midwifery practice. Because they are integrated into the health care system, CNMs can find employment throughout that system. Most are employed by hospitals, physicians, or HMOs; some choose to enter midwife-run private practices. CNMs in private practice tend to know all the women in their practices and derive a great deal of satisfaction from their work, but often suffer from burnout and find it difficult to also “have a life.” At such a point they can fluidly choose to enter larger practices where they may have less patient involvement but more time for themselves and their families (Cecilia Wachdorf, personal communication). In between these two extremes are many nurse-midwives working in large practices who struggle to maintain a balance between the risk of burnout and their desire to offer personalized care with some degree of continuity (Lisa Kane Low, personal communication, 1998). Many CNMs make in excess of \$60,000 per year; their salaries range between \$25,000 and \$85,000, with a mean of \$55,000 (Bauer 1998:4). (The mean salary for obstetricians is \$212,000). Some CNMs are able to work pre-set hours with a reasonable number of days off, and accrue vacation and leave time and retirement benefits.

Nurse-midwives primarily care for women around their reproductive functions, dealing mainly with pregnancy and birth, family planning, health screening, and management of common gynecological conditions. Although officially CNM practice is centered around the care of low-risk women, in fact many CNMs give high-quality, nurturant, and collaborative care under extremely difficult conditions in inner city hospitals to high-risk indigent women who otherwise would receive the dregs of our inadequate medical system. Their new core competencies (1997) expand their scope of practice into more general women's primary health care, should they wish to offer it.

Because most CNMs attend births in hospitals, they become part of hospital culture, learning it from the inside. Thus they are often able to generate significant cultural change. In hospitals across the country, CNMs have introduced alternative policies and techniques such as allowing women to eat or drink during labor, to get up and walk, to labor in water, and to room in with their babies after birth. CNMs have designed and opened in-hospital alternative birth centers, successfully lobbied for LDRPs (a single room for labor, delivery, recovery, and the postpartum period), and offered breastfeeding education and support. Obstetricians and nurses who observe the benefits of CNM care are often inspired to change both their attitudes toward birth and the way they treat birthing women. Most CNMs find their work intrinsically rewarding: they thrive on the intimate connections they develop with their clients, often on the spot during labor or birth, on a client's positive response to their nurturing, empowering care, and on their ability to sometimes hold a holistic space in which a woman can freely birth the way she chooses, in spite of the medicalizing constraints of the hospital environment. CNMs have also been instrumental in developing out-of-hospital freestanding birth centers where they can regularly offer holistic midwifery care; a few of them (probably less than 3%⁶) attend births in homes.

Some states give CNMs clear legal prescriptive authority; in others, they are usually able to prescribe under a more limited arrangement such as standing physician orders. Within the parameters of nurse-midwifery, CNMs have plentiful opportunities to learn new skills: for two examples, in order to give their clients more continuity of care, many CNMs are learning and performing diagnostic ultrasound, and some are training to first-assist when their clients undergo Cesarean sections. Some CNMs also incorporate alternative and complementary methods such as herbal, nutritional, or homeopathic therapies. CNMs can advance professionally into directorships of programs, education or research positions, or can move into the growing field of public health. And their numbers are growing at a rapid rate, as is the percentage of births they attend. When I first started my midwifery research in 1994, there were 4993 members of the ACNM; as of June 1998, there are 7717 members (including students).

Paralleling the above gains are a particular set of losses. Although high salaries and team practices facilitate raising a family, they do not guarantee job security—virtually all CNMs are vulnerable to managed care cutbacks and physicians' resistance to competition. Participation in managed care often subjects CNMs to pressure to care for more women in less time with fewer resources. Because a standard for all CNMs is that they must practice in collaboration with physicians,⁷ they can be prevented from practicing if the physician withdraws

from that collaboration, or the hospital decides to deny them privileges. For example, a number of CNMs have invested heavily to open birth centers, only to be forced to close them when they lose their collaborating physician and cannot find another. Their opportunities to attend home births are similarly limited (see below). There is also the reality of the debt load associated with a university-based degree, which can go as high as \$70,000 (some CNMs have government-funded scholarship assistance).

And although many nurse-midwifery educators make concerted efforts to train their students in a midwifery, not a medical, model of care, nurse-midwifery training is inevitably medicalized to some extent because it is primarily hospital-based. In effect CNMs are taught a duality of models and must learn to creatively balance them both (Cecilia Wachdorf, personal communication). Yet they must strive to create this balance inside a system that is heavily weighted toward the medical, not the midwifery, side. Once in practice, nurse-midwives must maintain good working and social relationships with physicians and nurses, usually must follow the policies of the hospitals in which they attend births, whether or not they agree with them, and must struggle to be included in HMOs and other managed care programs.

Many CNMs have told me how easily this inevitable medicalization slips into over-medicalization. I recently spent a day with a group of about 70 nurse-midwives in upstate New York. I asked how many of them feel that they are offering truly woman-centered, holistic midwifery care in the hospitals where they practice. Only about five hands went up, engendering a lively discussion about how these five manage to do it when the others want to but cannot for fear of losing their jobs.

Over-medicalization is the shadow side of nurse-midwifery education and practice, but it is very hard to generalize about. Some CNMs practice holistically, but humanistic caring and compassion are more constant features of nurse-midwifery care than the non-medicalized holistic approach.⁸ Some CNMs, most especially those involved with high-risk patients, become extremely dependent on medical technologies and diagnostic techniques; some become as interventive as any OB. Others who try to resist the overuse of these technologies that characterizes the medical approach to birth may end up succumbing to hospital pressure and not practicing the kind of midwifery they would like to practice. Frustration and burnout can often result. Many CNMs I have interviewed point out with sadness that the women they attend often insist on ultrasounds and epidurals. As I learned in my earlier research (Davis-Floyd 1992), it is a fact that the majority of American women feel safer when birth is medically controlled. Most women want a combination of high technology with humanistic care in which their opinions are considered and their decisions are respected. Nurse-midwives are able to offer this combination; several studies have shown that most women are satisfied with their nurse-midwifery care.

But not all. The promise of a woman-centered advocate is a compelling one for many nurse-midwifery clients who wish to avoid unnecessary intervention; if that promise is eclipsed by medicalization, it can be an unhappy surprise. Recently a number of letters and personal accounts from new mothers protesting their CNM care have come to my attention. These women counted on their CNMs to protect them from unnecessary intervention, but instead ended up with labor induction and/or augmentation, frequent or continuous use of the electronic fetal monitor, withholding of food and drink, too-hasty episiotomies, etc. When CNMs perform such interventions unnecessarily, which of course physicians are notorious for doing, consumers point to the over-medicalization of CNM practice and training. On a panel discussion at the 1997 MANA conference in Seattle, ACNM President Joyce Roberts seemed to accept this criticism as a necessary price to pay for higher gain:

You ask, what is the risk of this formalized education? You say it is over-medicalized. I would say it need not be, but I would also add that the risk of not having it is not being able to practice in all the domains that the WHO definition says midwives practice in. [See box 2.] One has to weigh the risks of protecting themselves from over-medicalization and the realities of our health care system today, or take the consequences of limiting your practice to a very narrow domain.⁹

Such limitation has indeed been the choice of many MANA midwives. Although they are increasingly moving into the mainstream in a number of states, in general most have in the past consciously chosen to stay outside the dominant medical culture. This has resulted in a greater degree of marginalization, which many consider a worthy price to pay for maintaining autonomy, avoiding over-medicalization, and holding open the home birth option. Nurse-midwives, who must practice with physician collaboration and under insurance restrictions, usually cannot provide home birth services. Very few CNMs attend home births (see endnote 6), whereas MANA's 1400

members primarily attend home births. The following section will discuss the upside and the downside of direct-entry midwifery as practiced by the members of MANA.

The Ups and Downs of Direct-Entry Midwifery¹⁰

In the U.S., home births account for less than 1% of all births—a figure that has not changed nationally in over a decade (Rooks 1997). That percentage is higher in Oregon (around 6%) and rising in Florida, Washington and other states where midwifery is legal, but on a national level it is still minuscule. While many decry this low figure, Ina May Gaskin, the current President of MANA, points out that this low percentage of home births

can be seen as an accomplishment, given the highly financed, highly organized efforts that American physicians over the course of this century have made towards stamping out home birth altogether. We have not only maintained that steady rate, but we have begun to experience what happens when a struggle such as this takes place over a generation....Given the opposition the medical profession has directed against midwifery, we in MANA believe that it has been an accomplishment for us to have survived at all! As more studies are carried out on the safety and efficacy of DEM practice, we believe that the percentage of home births will rise, not fall, during the years to come. We see the six-fold increase in home births in Oregon, where midwifery has long been legal, as significant. We are still in the stage of being a 'best-kept secret' when it comes to mainstream culture. (Personal communication, 1998)

Direct-entry midwives are legal, regulated, and licensed, registered, or certified in 14 states (Alaska, Arkansas, Arizona, California, Colorado, Florida, Louisiana, Montana, New Hampshire, New Mexico, Oregon, South Carolina, Texas, Washington); legal through judicial interpretation or statutory inference, or a-legal (not legally defined but not specifically prohibited from practice) in 19 states; effectively prohibited in 8 states where licensure is required but unavailable; and illegal in 9 states and the District of Columbia.¹¹ They can obtain insurance reimbursement from private companies in most states where they are licensed, and Medicaid (and sometimes managed care) reimbursement in Arkansas, Arizona, Oregon, Florida, Washington, New Mexico, South Carolina, and Vermont. (In many other states licensed midwives are fighting for Medicaid and managed care reimbursement, with varied results. In most states, home birth attended by direct-entry midwives is still an out-of-pocket expense.) They often work alone or in practices with one or two primary midwives,¹² and are almost always on call. For some, burnout is the result of this constant availability; others find this a viable way of life.

They are rewarded for their dedication by the excellent outcomes and untrammelled beauty of the out-of-hospital births they attend, by the empowerment their clients experience through having given birth on their own, and by the strengthening of the family that often results when birth takes place at home. Other rewards include the awareness that their work is helping to preserve home birth as a viable option for American women¹³ and that they are keeping holistic, independent midwifery alive and are furthering the preservation and development of its unique body of knowledge—a knowledge based on the wide variations in truly normal birth, which can only take place outside of the artificial constraints of the hospital environment (see below). Many direct-entry midwives appreciate the flexibility they enjoy as independent practitioners: should they desire more time off, they can cut down on the number of clients they take on. In areas where interest in home birth is steady or growing, they can choose to accept more clients until they build their practice to the level they desire. Thus their incomes vary widely: those who attend only a few births a year may make only a few thousand dollars, while some direct-entry midwives make upwards of \$60,000 per year.

In short, direct-entry midwives (DEMs) face the challenges and reap the benefits of being self-employed entrepreneurs. Like some MDs, they run independent practices; their earning ability is not constrained by salaries but rather depends on their level of energy and their ability to attract clients (which itself is constrained by cultural attitudes toward home birth). In states where they are licensed and regulated, they often serve as the sole proprietors of thriving businesses (at a time when many MDs are being forced to trade in their economically advantageous positions as independent practitioners for the rigid payment schedules of HMOs). Many DEMs make a good living, many do not, but all of them love their work. Most DEMs would not trade the challenges, tribulations, and rewards of their entrepreneurial practices for the constraints of working in a hospital setting.¹⁴ Wanting to be where the majority of women are, some DEMs do desire to become qualified for hospital practice and go on to become CNMs; they usually retain their ideological commitment to MANA and to out-of-hospital birth (Ventre, Spindel, and Bowland 1995).

In states where they are licensed, direct-entry midwives are gaining increasing respect from the physicians in their areas. In part this seems due both to their proactive creation of educational standards and protocols, their participation on licensing boards and agencies (for a midwife, the professional is always political), and to the documentation of their good outcomes that played a part in their obtaining licensure. In such places, DEMs are usually welcome to remain in the hospital with the clients they transport. But in other states where they are shut out of the system and are little understood, they may be actively persecuted by the legal and medical establishments. The possibility of prosecution may limit their ability to carry appropriate technologies. And even when they transport in a timely and appropriate manner, they may be banned at the hospital door and blamed by hospital personnel for “botched home births.” Many medical practitioners, and some nurse-midwives, have serious concerns about the safety of direct-entry practice; they point to the fact that there are some DEMs in practice with truly inadequate training.¹⁵ Thus when a DEM makes a mistake, no matter what her individual knowledge and skills, most people in the medical community are only too ready to assume that she is “ignorant” and “incompetent,” and go on to assume that incompetence and lack of education characterize all midwives of her ilk—an irrational application of a damaging stereotype that has no basis in fact. Most direct-entry home birth midwives have excellent midwifery educations, are highly skilled clinically, and are increasingly choosing to demonstrate their education and their competence through meeting the standards for CPM certification.

Box 3

My Usage of the Term “Lay”

Out of their self-made level of expertise, during the 1980s members of MANA began to reject the term “lay” midwife in favor of terms that better characterized their status; these included “empirical,” independent,” “traditional,” and later the more professional term “direct-entry” (see Box 1). But the general public and many in the health care professions have not caught up with these changes, and still refer to all DEMs as lay midwives. In this article I use the term “lay” only in the following cases: (1) when I am talking about nurse-midwives who still call direct-entry midwives “lay”; (2) when I am talking about licensed direct-entry midwives who call unlicensed direct-entry midwives “lay” (as in Washington state and elsewhere); (3) when I am talking about nurse-midwives who used to be, and used to call themselves, “lay midwives”; and (4) when I am talking about a historical period in which MANA members referred to themselves as “lay.” It should be noted that, in spite of the pejorative use of this term by some groups, having been a lay midwife at the beginnings of the midwifery renaissance is a strong source of pride for many midwives, even though they no longer use the term.

The Professionalization of Lay Midwifery

In 1981, Sister Angela Murdaugh, the new President of ACNM, sat in the ACNM Open Forum taking notes on a yellow pad. The topic on the floor was “lay midwifery” (see box 3), and the overall message that Sister Angela wrote down was that the membership of the ACNM wanted to be “in dialogue with lay midwives.” In response to that message, she called a meeting of lay midwives and nurse-midwives who had started out as lay midwives at the ACNM headquarters in Washington D.C. in late October of 1981. At that meeting she urged the lay midwives to organize themselves and create formal principles of practice—a suggestion for which she later took a great deal of heat from some members of ACNM, who bitterly resented the “division of midwifery” into two separate organizations, hoping instead to convince the lay midwives to enter the ACNM fold. It was at that initial meeting that the idea of MANA was born.

The actual creation and naming of MANA took place in a hotel room during the 1982 ACNM convention in Lexington, Virginia, where a visionary group of lay and nurse-midwives gathered to charter an organization with an international scope (North America includes Canada and Mexico) that would give them and their sisters a sense of group identity and common cause. (For more detail, see Schlinger 1992:14-27). Why did they choose to form a new organization instead of becoming nurse-midwives and joining with ACNM? My observation is that it is because they believe deeply in the value of preserving their independent midwifery model of education and care in order to effectively serve the women who choose out-of-hospital birth, and they did not and do not believe that this task can safely be left to the ACNM. MANA vice-president Anne Frye further explains (personal communication 1998):

Thirty years ago, non-nurse midwifery rejuvenated itself via a network of women with no prior experience who began to attend births as a direct result of community demand. At that time, nurse-midwifery was a little known profession with very few CNMs in practice compared to today--many of these early truly lay midwives did not even know there was an option, and many who did know rejected the idea that nursing had anything to offer midwifery. However, as

the movement grew and these original “lay” midwives became more sophisticated in their understanding of the details of medical training and practice, they saw quite clearly that what they were seeing at home births often did not reflect what they were reading about and seeing in hospital birth. Understanding that they were developing a different knowledge system, over time they sought to develop educational methods and programs that would perpetuate that system, and to avoid incorporation into the more medicalized nurse-midwifery approach.

Emerging from the grassroots to serve an out-of-hospital clientele, for nearly four decades these women who started out in the late ‘60s and early ‘70s as “lay midwives” have educated themselves, attended births, trained apprentices, codified their unique body of knowledge in books and articles (see for examples Bruner 1998, Frye 1996, Davis 1997, Gaskin 1990), joined together to write appropriate standards for their out-of-hospital practices, lobbied for workable legislation, developed educational programs and state certification processes, and thrived in spite of the ill wishes and often active persecution of the medical establishment. They have organized themselves into a movement powerful beyond its small numbers because of the widespread public support it enjoys from the dedicated and numerous members of the alternative childbirth movement.

The Creation of the Certified Professional Midwife (CPM)

When I was asked to speak at my first MANA conference in El Paso in 1991, there was an ongoing debate over the word “professional,” which many of the midwives present were refusing to use because of its exclusionary connotations. Nevertheless, it was clear that they were evolving themselves as professional midwives with a codified and cohesive body of knowledge and skills. During the Carnegie-sponsored Interorganizational Work Group (IWG) meetings between ACNM and MANA that took place in the early 1990s, delegations from both organizations worked to pinpoint their similarities, and looked (ultimately unsuccessfully) for ways of resolving their differences (see Rooks, Gaskin, this volume). The ACNM delegates pointed out that non-nurse midwives lacked standards and methods for measuring competence. Anyone could hang out a shingle, call herself a midwife, and join MANA.

Responding not only to such critiques from the outside, but also to problems within the home birth community occasionally generated by midwives who did not practice appropriately, many MANA members felt a strong need for a means of standardizing midwifery education to ensure that home birth midwives would share a common and established base of knowledge and skills, and for clear mechanisms for peer review and professional discipline¹⁶ (Pam Weaver, personal communication 1998). At the same time, MANA members were increasingly recognizing a need for a mechanism for proving the professional competency they had been developing that would help them interface with the medical system. These midwives, whom the ACNM still characterized as “lay,” were feeling, acting, and running businesses like professionals, and they perceived the potential value of a credential that would validate their knowledge of midwifery. (Those who had been the victims of medical persecution report being “forced” to this conclusion.)

The strong desire for such a credential on the part of many members of MANA was paralleled by great concern that the uniqueness of direct-entry midwifery as they had been developing it would become co-opted in the process of trying to achieve standardization and enter the mainstream. It was the powerful vision of one of the MANA representatives to the IWG, Sharon Wells, that it would be possible and indeed was the ideal time to create a certification process that preserved MANA’s “Midwifery Model of Care,” and that the preservation of this midwifery model--as developed by the midwives who founded MANA and as expressed in writing for the first time by sociologist Barbara Katz Rothman in 1982--would ultimately depend on the existence of this certification.

The concern felt by many MANA members about the possible dangers of cooption led to the gradual step-by-step development of certification, with great care being taken at each step to address these concerns. During the 1980s midwives in Oregon, California, Massachusetts, Colorado, New Mexico, and New Hampshire had created and implemented their own certification processes in their respective states. The creation of national certification, which had been in the air since MANA’s inception, had been a topic of much discussion at the 1985 MANA business and open forum meetings (Elizabeth Davis, personal communication, 1998). In the late 1980s, these discussions crystallized into MANA’s formation of an Interim Registry Board (which later evolved into the North American Registry of Midwives (NARM)), whose charter was to develop an examination to test knowledge. The original intention was to develop a national registry of those who had passed this written examination. Over 400 midwives were eventually listed on this voluntary registry.

Once it existed, the NARM written exam was quickly picked up by midwifery associations and state agencies which had been needing such an exam but did not wish to develop it themselves. Perceiving the potential benefits, many in MANA intensified their call for a professional credential through which they could demonstrate not only their knowledge but also their experience, abilities, and skills. This demand, in combination with the professionalizing impetus of the many state certifications, and the critiques stemming from the IWG meetings, the medical community, and even the home birth midwifery community about the lack of standards for independent direct-entry midwifery, spurred the members of MANA and NARM to expand NARM into a full-fledged testing and certifying agency, designing, developing, and implementing the credential, the Certified Professional Midwife (CPM). (For a detailed description of this process, see Houghton and Windom 1996b and Rooks 1997: 248-252.)

In 1991, the Midwifery Education and Accreditation Council (MEAC) was founded by the National Coalition of Midwifery Educators, a group of MANA midwives who had created or participated in direct-entry midwifery programs in the U.S. over the previous ten years. MEAC is responsible for the evaluation and accreditation of direct-entry educational programs; it has accredited or pre-accredited ten such programs to date. MEAC's stated mission is to improve the quality of direct-entry midwifery education, as well as support innovative and diverse midwifery education programs, including apprenticeship. (Structurally speaking, MEAC is the equivalent of ACNM's Division of Accreditation (DOA), and NARM is the equivalent of the ACNM Certification Council (ACC)). See Figure 1.

Figure 1.



It is important to note that the ACNM is a professional organization: you must hold ACC (or ACNM¹⁷) certification as a CNM or a CM to be a full voting member¹⁸, and you must graduate from a DOA-accredited program and pass the ACC exam to receive that certification. In contrast, MANA is not a professional organization in the same sense, but rather an inclusive umbrella group that welcomes all midwives as members, certified or not. You do not have to be a member of MANA to receive CPM certification, nor do you have to graduate from a MEAC-accredited program. Anyone who declares herself to be a midwife can be a full voting member of MANA. Generally speaking, ACNM, whose membership is exclusive, has represented the profession of nurse-midwifery, whereas MANA, whose membership is inclusive, has represented the independent midwifery movement (a social phenomenon, not a profession) (Betty Anne Davis, personal communication). Nevertheless, MANA is professionalizing, and it remains to be seen whether, as more and more members of MANA choose to become CPMs, MANA itself may (or may not!) evolve into a professional organization that requires CPM certification for voting membership.

In line with the concerns of many MANA members, the board members of NARM and MEAC and their many volunteer supporters were determined that the new CPM credential and all MEAC-accredited educational programs would not coopt direct-entry midwifery by medicalizing its standards, but rather would fully reflect the "Midwifery Model of Care" (see box 4) to which MANA and its affiliates lay claim—independent, woman-centered, holistic, out-of-hospital midwifery. To ensure success in this endeavor, NARM designed and carried out a full-scale survey of practicing home birth midwives to determine what these practicing midwives considered to be appropriate entry-level requirements. The survey, known as the *1995 NARM Job Analysis*, was sent to 3000 midwives, 800 of whom sent in properly completed surveys (one-third of them were CNMs). This high return rate is remarkable, especially given the fact that these detailed surveys took up to twelve hours to fill out. The responses showed a high degree of consensus among all respondents, indicating strong agreement within the homebirth midwifery community about the knowledge and skills that should be required for safe entry-level out-of-hospital practice. On the basis of these responses, NARM designed its written and skills examinations, ensuring that CPM requirements are based on actual home birth midwifery practice. In celebration of this accomplishment, and speaking for all those who participated in the development of CPM certification, during a 1997 panel discussion direct-entry midwives Pam Weaver and Elizabeth Davis exclaimed, "We did it! We actually managed

to develop a certification that encompasses everything we hold dear!" The first CPM, Abby Kinne of Ohio, received her certificate on Nov. 10, 1994.

Box 4
The Midwifery Model of Care

The Midwifery Model of Care is based on the fact that pregnancy and birth are normal life events. The Midwifery Model of Care includes: monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle; providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support; minimizing technological interventions; and identifying and referring women who require obstetrical attention. The application of this woman-centered model has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

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CPM certification is competency-based; where you gained your knowledge, skills, and experience is not the issue—that you have them is what counts. In keeping with MANA's values NARM has been as inclusive as possible, honoring multiple routes of entry into midwifery, including self-study, apprenticeship, private midwifery schools, and university-affiliated programs, including those accredited by the ACNM.¹⁹

Thus the major criticism that ACNM educators level at NARM certification is that it is not tied to a required formal educational process that utilizes only standardized, accredited programs. Here we find the crux of the philosophical differences around educational issues that divide these two organizations. MANA members do not accept the argument that formal, standardized education is necessary to provide safe and competent practitioners. Citing recent trends in adult education in other fields, they stand behind their value on competency-based education. CPM certification has built into it what is known in adult education as a portfolio process (a portfolio is the formal documentation of a person's education through life experience). This documentation must be extensive and must demonstrate that the candidate meets NARM midwifery experience requirements (performance of 75 prenatal exams, attendance at 20 births as an active participant and 20 more as primary caregiver, etc.) as listed in the NARM publication *How to Become a CPM*. Knowledge is tested through the NARM Written Exam. Skills are verified in two ways: the candidate's educational supervisor or mentor must attest that she has achieved proficiency on each area listed on the *Skills, Knowledge, and Abilities Essential for Competent Practice Verification Form* provided in the CPM application packet, and the candidate must take a hands-on skills exam.

Because most midwives who took the early forms of the NARM written exam passed, the exam was criticized by CNMs and others as being too easy, a mere mechanism for "grandmothering in" all practicing midwives without any real testing of their abilities. It was not widely understood that the pilot project in which these early forms of the exam were tested was for experienced midwives only, who would be expected to pass. The fact that few did fail the early, less sophisticated versions of the NARM exam seemed to some leaders in the ACNM to justify their pre-existing view that they should not leave direct-entry certification up to MANA and NARM. But over the ensuing three years, NARM hired an outside testing agency and created sophisticated, psychometrically valid, rigorous written and hands-on skills exams, which have proven to be effective screening mechanisms.

In 1997, the consumer group Citizens for Midwifery contracted with two specialists in competency-based education and testing at Ohio State University, Deborah Bingham Catri and Robert A. Mahlman, to carry out independent evaluations of the NARM process, including its exams. They each presented expert testimony to the Direct Entry Midwifery Study Council (established by Ohio statute), copies of which are available through Citizens for Midwifery. Catri testified about competency-based education, and concluded from her analysis that the CPM process is in fact competency-based. Mahlman, a testing expert, reviewed the testing aspects of the certification process to determine if the examination and its development meet industry standards for high quality certification

tests; he found that the quality was as good or better than comparable programs and that the procedures followed were based on established standards for this kind of testing. (Their testimonies are unpublished, but copies of the full texts as well as summaries are available from Citizens for Midwifery (1-888-CfM-4880) or may be downloaded from the Internet at www.mana.org or www.cfmidwifery.org.)

As of June 1998, there are approximately 400 CPMs, with about 150 applications in the works and more coming in every day (Sharon Wells, personal communication). The NARM exam has been accepted as the state direct-entry licensing exam in 13 states and two Canadian provinces (Alberta and British Columbia), and the entire CPM certification process has been accepted as a route to licensure in two states (Oregon and Texas) and one Canadian province (Manitoba) and is under consideration in fifteen other states. It is important to remember that this process is very new. Contemporary comparisons between the ACNM and MANA fail to take into account the differences in the ages of these organizations. Founded in 1955, ACNM has had 43 years to work out the kinks. MANA has had just 16 years, and NARM and MEAC have been in their present form only since the early 1990s. There was a time when nurse-midwives were illegal in most states, a time when their certification exam was rudimentary, a time when they struggled to define their knowledge base and set practice standards, a time when they had to fight for legalization and licensure state by state as MANA and NARM are doing today. I recently paid a visit to Toronto, where I spoke with some of the midwives who had been instrumental in the legalization of direct-entry midwifery in Ontario. They told me they had been heavily criticized in the early stages of their process for deficiencies that they needed only time and the benefits of their learning curve to correct. One of them said, "To criticize us for not getting it perfect from Day One is like criticizing a child for having growing pains." I felt the point was well-taken, in both countries.

ACNM educators also criticize the NARM process because it is not tied to specific standards of practice. Some clarification is in order. Both NARM and the ACC are certifying agencies and as such they certify that a given midwife has demonstrated mastery of a specified body of knowledge and skills. Neither NARM nor the ACC has any legal authority to enforce compliance regarding practice standards. Licenses for both CNMs and DEMs are granted by individual states based on regulatory statutes, and the rules under which each must practice (including standards of practice) are set and legally enforced by the regulatory board of the state in which they reside and are licensed. Both MANA and the ACNM have created documents regarding practice standards, values, and ethics, which many midwives follow. Although the state sets the rules, the professional standards set by the ACNM and MANA do have the power to influence legislation and policy by serving as models; the exams created by the ACC and NARM are examples of resources these agencies can provide to states.

Whether or not CNMs, CMs, CPMs or Licensed Midwives (LMs) agree with or agree to abide by any specific standards of practice other than those determined by state law reflects their individual values and ethics. It should be noted that the practice setting (hospital, birth center, home) generally affects both the amount of scrutiny an individual midwife is subject to as well as the degree of freedom she has to provide highly individualized care. Practicing with a greater degree of freedom may be confused with a lack of practice standards when that is not the case. But greater freedom and less scrutiny do increase the importance of regular review and discussion with peers regarding practice techniques and standards (Susan Hodges, personal communication, 1998). For home birth midwives, peer review, instead of operating only as a judgmental or disciplinary process, needs to and often does serve as an effective means for ongoing evaluation of their own practices from the perspectives of their midwifery community.

The Creation of the Certified Midwife (CM)

One of the roots of ACNM's move into direct-entry certification can be traced to the development, twenty years ago, of the three-year Masters' level program at Yale University that allows a fast track through one year of nursing into two years of midwifery training. Other roots lie in the vision and determination of key figures like Dorothea Lang, a former President of ACNM and a highly respected leader in nurse-midwifery, who became a nurse-midwife in order to move the profession of midwifery away from nursing. In recent years, this vision came to be more commonly shared among ACNM members for a set of specific reasons:

- Increasing numbers of currently practicing CNMs take the role of midwife as their primary professional identity ("I am not a nurse, I am a midwife!" is a statement I have heard countless times during my interviews (see also Scoggin 1996), including many who went to nursing school only to become qualified to enter a nurse-midwifery educational program—a requirement they resented at the time, and continue to regard as

unnecessary. In addition, they resent being identified as nurses, licensed to practice under nurse practice acts, and regulated by state nursing boards. They wanted to provide a way for people who want to be midwives but don't want to be nurses to become educated in line with ACNM/DOA standards, and to be certified by the ACC.

- Physician Assistants (PAs) and some nurse-practitioners with little obstetrical training have begun to attend births in many states (Burst 1995). CNMs see this as both an infringement on their territory and as potentially dangerous for birthing women, and they recognize that someone who is already a PA should not be required to become a nurse in order to receive midwifery training.
- Increasing numbers of young women want to become midwives through ACNM-accredited routes, but regard the subordinate status of nursing as a hindrance to their desire to be independent practitioners and the years of nursing training as an unnecessarily time-consuming impediment to their midwifery careers.
- Increasing numbers of CNMs were realizing that only specific aspects of nursing knowledge are relevant to providing quality midwifery care, and that this knowledge can be obtained outside of nursing training (Rooks 1998; Lisa Kane Low, personal communication).
- Many CNMs had no confidence in MANA's and/or NARM's ability in their early stages of development to impose high educational and competency standards on direct-entry midwives. They believed that the midwives certified by NARM would be "substandard," and would endanger the midwifery profession with their substandard practice. Thus they concluded that direct-entry certification should not be left to NARM, but should be taken on by the ACC.

In 1994, ACNM members voted overwhelmingly for the ACC to create a direct-entry certification process; in 1995, they chose CM (Certified Midwife) as the name of this new type of practitioner; and in May 1997, they passed a resolution making this new CM a full-fledged voting member of the College.²⁰ Only two DOA-accredited educational routes of entry to the CM credential are or will be available: university-based programs and university-affiliated distance learning programs. These routes will not include apprenticeship programs or non-university-affiliated midwifery schools. CM entry-level requirements are based on entry-level CNM requirements; the exams taken by CMs and CNMs are exactly the same (Judith Fullerton, personal communication, 1998).²¹ All DOA-accredited direct-entry programs must either lead to a baccalaureate degree or require one for acceptance into the program. After January 1999, all nurse-midwifery programs will have the same requirement. As noted previously, to date there are no pre-baccalaureate DOA-accredited direct-entry programs, although some nurse-midwifery certificate programs are investigating ways to offer the baccalaureate. Should ACNM educators choose to develop a Bachelor's in Midwifery, as has been done in Canada, this degree requirement could quickly become more supportive of many students' search for the most direct route into ACNM-certified midwifery.

At present, the only DOA-accredited direct-entry program currently operating is a two-year program located at the State University of New York (SUNY) Health Science Center on the Brooklyn campus in New York City (colloquially known as SUNY downstate). (Others are under development in Pennsylvania, Texas, and elsewhere). Entry requirements for SUNY downstate include obtaining a baccalaureate in any field if the student doesn't already have one²² and taking courses to satisfy the basic science requirements. Through the establishment, eventually, of many such programs, ACNM direct-entry advocates seek to further the ACNM's stated goal of 10,000 ACC-certified midwives by the year 2001. Within a few years there will likely be distance learning programs like CNEP (a very successful distance learning nurse-midwifery program based at the Frontier Nursing Service in Hyden, Kentucky that allows students to remain in their communities, studying on computer and working with a local CNM preceptor) around the country for direct-entry students, so that they won't have to leave home.

Given that they are going to great lengths to make their version of direct-entry midwifery education more accessible, many ACNM members feel that they have now "opened up" their profession, allowing easy ingress to all those who want to be midwives but don't want to be nurses. Thus some in ACNM feel more than justified in believing that ACNM should be the one and only national midwifery organization. Some of the key players I have interviewed insist that having two national organizations only divides and weakens midwifery, and would like MANA midwives to rally around their new direct-entry standard.

In contrast, many MANA members do not see ACNM's move into direct-entry as an opening up but rather as a closing down, an exclusionary move to redefine direct-entry on ACNM's terms and shut out MANA-style direct-entry midwifery. They insist that having two national professionally-oriented organizations, two certifying bodies (the ACC and NARM) and two accrediting bodies²³ (the DOA and MEAC) strengthens midwifery, keeping important options alive for midwifery education and practice that would vanish if MANA were to disappear. As soon as ACNM's plans for creating the CM became known, those in MANA who equate "direct-entry midwifery" with out-of-hospital training and birth reacted with outrage to what they perceived as incursion into an area they had spent years developing and a co-option of their chosen label (see box 1). They believed that they were doing a very good job of defining "direct-entry midwifery" and of setting national standards for direct-entry education and practice. Anne Frye further explains:

It seemed to us that nurse-midwives with no home birth background teaching direct-entry students would be like direct-entry midwives suddenly deciding to open nurse-midwifery programs within hospitals.²⁴ This would not only be ludicrous, but also a reinvention of the wheel. And the fact that the ACNM thought they could do this without so much as consulting any "real" direct-entry midwives was, in the minds of many MANA members, only proof positive that they did not have any understanding of the uniqueness of direct-entry midwifery as practiced by the members of MANA, NARM, and MEAC. To us it was clear that there are two distinct approaches to midwifery that both have value and which are similar in many ways but certainly not the same—a fact that calls for two different groups to oversee their ongoing development. (Personal communication, 1998)

In Frye's words we can again see the effects of the semantic confusion generated by both organizations' use of the same term (direct-entry) to refer to these two very different models. Frye indicates the desire felt by many MANA members to maintain separation between the realms of nurse-midwifery and direct-entry midwifery, with the ACNM and its affiliates in charge of standard-setting and credentialing for the nurse-midwifery realm, and MANA and its affiliates in charge of standard-setting and credentialing for the direct-entry realm. The conceptual neatness of this distinction was blurred when ACNM established its own "direct-entry" certification process (see endnote 10). Of course, ACNM never intended to create the same kind of direct-entry midwifery practiced by MANA members, but rather, as I noted above, is modeling its direct-entry educational programs on its existing nurse-midwifery programs to produce midwives who, while ideally qualified to practice in a range of settings, are *de facto* primarily qualified to practice in hospitals.

In contrast to the feelings of many of MANA's direct-entry members, others, most especially MANA's CNM members, welcomed ACNM's move into direct-entry education and certification, realizing that to some extent it *does* mean an opening of the College to new ways of thinking about and becoming a midwife. The existence of this entirely new kind of "direct-entry" midwife, the CM, represents fierce determination on the part of many committed CNMs to move their profession into a more autonomous position within the American health care system. The ACNM prime movers who created the CM faced down massive resistance from the nursing-oriented "old guard" members of the ACNM (and, in New York, from the nursing and medical professions) to bring her into existence. (There was tremendous controversy within the ACNM over this issue, as some CNMs believe deeply in the value of nursing training and feel that it would be suicidal for the ACNM to give it up. Indeed, a group of CNMs threatened to secede if the college changed its name to the American College of Midwives.) And they will have to face down opposition from state agencies and legislatures all over the country as they fight to obtain legal status for the CM in all 50 states. It seemed to me as an anthropologist that such an enterprise could be self-defeating in an already marginal group, so I interviewed many of those most involved in creating the CM about their motives for pushing the boundaries of their vulnerable profession (just as I had interviewed many of the prime movers in NARM and MANA about their motives for creating the CPM).

During my interviews with these prime movers within ACNM, their level of commitment to this new kind of midwife became clear. They envisioned her as a way of rapidly expanding their numbers, since she would graduate from one of the numerous new programs educators would eventually design and offer around the country. The existence of this credential would be a way of incorporating PAs into the midwifery fold, and also of incorporating the many foreign-trained midwives living in the U.S. who did not have nursing training. They envisioned that the CM would be an open door to the "lay" midwives who had been vociferously protesting CNM nursing requirements. Or she might simply be someone with a baccalaureate degree who wanted to become a midwife but did not want to become a nurse. She would graduate with the same skills as CNMs, but without having her life derailed by a lengthy passage through nursing training²⁵, much of which is viewed as irrelevant to midwifery. She would be likely to have more independence of thought and spirit than those who had been

socialized into a nursing model²⁶, she would be more likely to work in freestanding birth centers and/or to attend home births,²⁷ and she would be a pioneer who would help to reconstitute midwifery as an autonomous profession and the midwife as a skilled, highly educated primary care professional. Because her existence would help to solidify midwifery as an autonomous profession unattached to nursing, she would help nurse-midwives “get out from under the thumb” of nursing boards, hopefully to be regulated by their own Midwifery Boards in every state.²⁸

ACNM has risked much and will risk more in the future to achieve this transcendent vision of an expanded and more autonomous midwifery profession. Although at this date of writing (May 1998) there are only 7 CMs, all of whom are licensed only in New York, the mere potential that they represent has caused Helen Varney Burst to change the name of her classic textbook from *Varney's Nurse-Midwifery* to *Varney's Midwifery*, and has generated a serious movement within the College to change its name from the American College of Nurse-Midwives to the American College of Midwifery (see endnote 20).

Conflict in New York

New York was the first state to legalize and legitimate the CM. Up until 1992, nurse-midwives in New York practiced under an obscure clause in the Sanitation Code, were granted permits, not licenses, to practice, and had no prescriptive privileges. In the early 1980s a committed group of CNMs began to lobby for a midwifery bill that would establish them as an independent profession regulated by New York's Department of Education, give them real licenses to practice, grant them prescriptive privileges, *and* expand their profession by allowing direct-entry midwives with training deemed equivalent to that of nurses by the state to be licensed as well. It took them ten years of intense effort to get such a bill passed. Had this group of women concentrated only on nurse-midwives, they could have had their bill five years earlier. But they were deeply dedicated to their vision of direct-entry midwifery (that is, to creating a category of practitioners trained in midwifery, not in nursing, who would enter the profession through university-affiliated DOA-accredited direct-entry programs) as a means of expanding and growing and broadening their profession, and so they hung on for an extra five years, fighting not only the New York Medical Association but also the New York Nursing Association for the right to legitimize both their profession and this new kind of direct-entry midwife. They were thrilled when, after a last minute flurry of intense lobbying, they succeeded in pushing their bill through, and in establishing, for the first time in New York history, a state midwifery board through which they could regulate themselves.

This bill, the New York Professional Midwifery Practice Act, which most CNMs lauded as ground-breaking, the wave of the future, turned the practice of unlicensed midwifery from a misdemeanor to a felony and made it impossible for almost all of the practicing direct-entry midwives in New York, all of whom were attending home births, to obtain licensure.²⁹ Seeking inclusion in the law, the Midwives Alliance of New York (MANY) had hired a lobbying firm, established a relationship with a senate sponsor, and organized consumer grassroots lobbying efforts (Sharon Wells, personal communication 1998). Believing that they had succeeded, MANY members mobilized to support the Practice Act. But eleventh-hour changes to the bill left them completely shut out (Wells 1992; personal communication 1998)³⁰, leading to much bitterness and disenchantment in the New York direct-entry midwifery community and, for a time, to the issuing of cease and desist orders to around ten of its members, to the arrest/and or prosecution of three, and to the harassment and investigation of some home birth clients.³¹

Watching ACNM and its affiliates the ACC and the DOA establish a new direct-entry certification, set standards for accrediting direct-entry programs, and grant pre-accreditation to one such program—SUNY downstate in New York City--all using a hospital-based model of midwifery and without consulting any practicing direct-entry midwives, these experienced New York midwives saw themselves and their independent model of direct-entry midwifery ignored and discounted in the ACNM process. They note the emphasis ACNM has placed on making its direct-entry midwifery education exactly equivalent to the training CNMs receive, and are suspicious that in spite of the desire of their creators that CMs be trained in out-of-hospital settings (see endnote 27), the CM will be just another overly medicalized practitioner. From the point of view of the nurse-midwifery educators who designed the new direct-entry program, there was no need to consult any of New York's practicing direct-entry midwives, whom they thought of as “lay,” as they never intended to model the SUNY downstate program on “lay midwifery” practice or education.

The fundamental disagreements between these groups in New York have led not only to bitterness and enmity, but also to much loss of livelihood and great reduction in the availability of midwife-attended home birth in New York state, as many DEMs have either stopped practicing or left New York to practice in friendlier climes. (Out of the over 600 CNMs in New York, only a handful attend home births.)

In this type of polarized situation, Midwifery Today often works to play a unifying role, generating dialogue between nurse- and direct-entry midwives at Midwifery Today conferences, and offering opportunities across the country for each group to learn more about the other. For one example, many of the direct-entry and nurse-midwifery students currently enrolled at SUNY downstate attended the Midwifery Today conference in Salem, Massachusetts in March 1998 and seem to be developing a philosophy supportive of both sides of this new direct-entry equation.

Home Birth: Preserving the Full Range of the Spectrum of Care

A prevalent perception among nurse-midwifery educators is that midwifery is midwifery. Said one: "We teach midwifery, not home birth or hospital birth, but midwifery. The setting is irrelevant to how midwifery should be taught." But this perception is contradicted by my interviews with 30 nurse-midwifery students, most of whom had just completed their education. They feel, and I have observed, that the setting of birth has a great deal to do with what they learn and how they practice. Consider this student's description (paraphrased from an interview) of a hospital birth she recently attended:

By the time I got to this woman, her labor was kind of stalled and she was just wild, writhing around, pulling out her IV. I didn't know what to do with her, I simply didn't know what to do. So I called in the OB, who pitted her and got her contractions stabilized, got her under control and her labor back on track. Once she was back on track and pushing, I felt like I could handle the birth.

Q. You say you didn't know what to do with her. What would you have done if you had been at home with no OB to call?

Oh, I would have done everything differently! I would have put my arms around her and asked her what she was feeling. I would have gotten her up, given her something to drink, helped her take a shower or walk around. We would have gotten to the bottom of her emotional issues before we tried anything else.

Q. So it sounds like you did know what to do with her! Why didn't you do that, instead of calling the OB?

Because the circumstances didn't allow it. There was no space for me to connect with her at that level.

This student nurse-midwife (SNM) is reporting on her exposure to the dual models of medicine and midwifery. In this case, as she does, we can attribute her decision to turn over control to a physician and to follow the medical approach to the fact that she is still a student and has not yet matured into a sense of autonomy. Trained and capable of operating in both models, she prefers the midwifery approach as she would be free to apply it at home. But, constrained by her environment, she is practicing (and thus internalizing) the medical way. Calling in the doctor or "pitting" a stalled labor can get her out of a difficult situation once, twice, three times without affecting her too much. But by the time she has taken this approach forty or fifty times, will she even remember that she once knew another way?

A poignant commentary on this SNM's experience is provided by CNM Fran Ventre. She writes: After practicing as a "lay midwife" for several years, I had the same experience in nurse-midwifery school at DC General Hospital as the student quoted above. The difference was a nurturing caring faculty person who, when I was at sea, asked me the same question, "What would you do at a home birth?" After easily rattling off the same things the student said, my teacher replied, "Well, why don't you just do that now?" (Personal communication 1998)

The contrast between Fran's experience and the experience of my student-interviewee provides an excellent example of the individual variations in nurse-midwifery training and thus of the difficulty in trying to explain it in generalized ways. While some programs and some preceptors stress this more holistic approach, in other programs students may find that approach difficult or impossible to apply.

The perceptions of my nurse-midwifery student interviewees of the overall quality of their educational programs were overwhelmingly positive; most gave their program a 7 or an 8 on a 1 to 10 scale. The 2 to 3 points

off were, in almost every case, protests against the lack of opportunity to experience home birth; this lack was one of the two major criticisms that all of these students voiced about their nurse-midwifery training. (The other was a sense of being inadequately prepared to do primary health care.) While ACNM officially sanctions home birth, the reality is that few CNMs attend home births (see endnote 6): most cannot get physician collaboration or insurance for home birth, and few receive adequate training for home birth practice.³² As noted above, nurse-midwifery educators feel that CNM and CM training will be adequate in any setting. But MANA midwives disagree, insisting that hospital-based training makes midwives too afraid of birth and too dependent on technology and support personnel to be qualified for independent home birth practice.

One CNM who agrees with them is Samantha McCormick. Samantha told me that her three years as an obstetrical nurse in a high-risk hospital in New York left her terrified of birth, and that her year in Columbia University's nurse-midwifery program did not 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 at that time was taking 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 way characterized by home birth midwifery for which she had been searching.

Samantha's experience illustrates a very important point: the members of the ACNM and MANA need each other. While CNMs are giving midwifery care to thousands of women in the high-tech world of hospitals, the members of MANA are holding open a spectrum for that care that the ACNM alone cannot preserve. (Fewer than 200 CNMs attend home births—a task that the other 7500 or so members of the college are not undertaking.) Although many ACNM educators would like their students to have the full range of out-of-hospital experience, offering it as part of clinical training is often made impossible by their collaborating physicians, by hospital and insurance policies—the costs of liability coverage would usually be prohibitive—and by the limited number of home births attended by CNMs. Consider the following email request received by Abby Kinne CPM, a direct-entry midwife in Ohio:

Hi Abby! I had a very disappointing meeting with the director of my nurse-midwifery program. After inquiring about spending time with a lay midwife for clinical experience she informed me that the ACNM has policies and guidelines that prohibit me from being involved (participating or observing) with lay midwives while I am a student at a nurse-midwifery program.... I am so frustrated -- how do I provide the option of home birth to my future clients without any experience? She did say that if I could find a CNM that does home birth I could spend time with her -- that would be OK! The only one I know of is in Cincinnati (and I cannot do clinicals there; University of Cincinnati has that site). Do you know of any CNMs around Ohio or out-of-state that do home births??? I REALLY want to get some home birth experience before I graduate!!

As of this writing, her search for an Ohio CNM who does home births has been unsuccessful. In her email message, she added:

Otherwise, I was told that once I am a CNM out practicing on my own, I can do whatever I want, and that I will have to wait until then to get my experience!!!

In response to this latter remark, another midwife wrote back:

This is hardly true. A CNM must be lucky enough to find an OB/GYN (in Ohio anyway) who supports her and her philosophy of care 150% and will be willing to go to bat for her whenever administrators/ bureaucrats begin to question what she is doing; and they WILL question what she is doing unless she practices according to strict standards.

These sorts of exchanges take place on the Internet almost daily. For MANA members, they confirm what they already deeply believe: that their independent, holistic, home-based style of midwifery is unique and special, that it will not be taught in ACNM programs, direct-entry or not, and that it is up to them to preserve what they have to offer, which will be lost if they allow themselves to be subsumed by the ACNM. When I queried direct-entry students about why they chose not to become CNMs, they unanimously responded that they did not want to participate in the medicalization of women and birth, but rather to be agents of their emancipation from that medicalization. When I asked them how they felt about not serving the vast majority of women who give birth in

hospitals, they responded that they believe that each midwife who learns home birth will be a magnet attracting more women away from the hospital, and helping to create home and birth center birth as increasingly viable alternatives. Beyond learning the technicalities of midwifery care, they see their mission as (1) internalizing an attitude of profound respect for the sacredness of birth and women's bodies and fostering this attitude in others; (2) preserving the practice of holistic midwifery, and preserving and furthering its body of knowledge; and (3) preserving and expanding women's options for out-of-hospital birth. They believe passionately in the worth of this mission.

They are confirmed in this belief by the members of the newly birthed Bridge Club. Originally conceived by Fran Ventre (a CNM who is also one of the founding members of MANA), the Bridge Club was spontaneously formed at the 1997 MANA conference in Seattle by a group of CNMs who are also members or supporters of MANA.³³ (Many of them had practiced as lay midwives before they became CNMs.) If ACNM-style midwifery were truly superior in all ways, this Bridge Club might have formed to work within MANA to convince more MANA members of the inadequacy of their training and to encourage them to apply for entry into ACNM-accredited programs. But instead, the members of the Bridge Club are trying to convince the ACNM Board that there is something ineffable and precious about MANA-style midwifery, something that must be preserved and would be lost if all independent midwives decided to become CNMs or CMs, something that is preserved by NARM certification and that ACNM should at best support or at least do nothing to undermine. Many of these women have learned both models with their bodies, hearts, and minds; they seem most qualified to speak to the relative merits of each model. Supporting the CM, they also support the CPM, and advocate for the complementary co-existence of both. With one voice they insist on the value of preserving independent out-of-hospital midwifery and apprenticeship training, as the CPM credential seeks to do.

Didactic and Experiential Learning: New Combinations in Midwifery Training

What is so important about apprenticeship, you may ask? To understand that, it is important to understand the difference between *experiential* and *didactic* learning. Didactic instruction is linear, logical, sequential, and often abstract, involving graphs, charts, diagrams, and rote memorization. Experiential learning is learning with the whole being, not just with the mind.³⁴ This is the oldest and most effective method of human learning. It is how children learn to function in their cultures—they simply participate, absorbing the rhythms, patterns, conceptual categories, and techniques of daily life, along with their underlying system of values and beliefs. Whereas it is obvious when didactic training is taking place—someone is clearly being taught by someone else, or is studying alone--experiential learning is often invisible: you can't see it happening so you don't know it's there.

Apprenticeship in traditional societies takes place through just this sort of experiential, whole-being learning (Jordan 1993; Singleton 1989). For example, the master potter might say to the apprentice, "bring me a lump of clay." The apprentice complies, and is told the clay is too hard. S/he tries again, and is told it is too soft. Getting it right the third time, the apprentice has just learned the right texture of clay for this type of pot at this moment in its making, but all the master potter has done is to save herself a trip! When Western anthropologists and filmmakers have tried to film apprenticeship training and record how it takes place, they have often found themselves stymied. Applying didactic models, they look for physical and especially verbal interactions between apprentice and teacher, waiting for the teacher to "teach." But such moments of didactic instruction are relatively rare in traditional apprenticeships--most learning takes place as the apprentice simply participates in the task at hand, absorbing through doing (Coy 1989, Lave and Wenger 1991). Thus how or what the apprentice learns is often not visible to the didactically-trained eye, nor easily put into logically-sequenced words.

An example of the difference between didactic and experiential training in midwifery is provided by Charis Smith, a student nurse-midwife enrolled in a distance learning CNM program who is simultaneously apprenticing with a pair of direct-entry midwives in her community. (I have used a pseudonym instead of her real name because, like the Ohio SNM, she was explicitly forbidden by the head of her program to work with "lay" midwives.) Thus Charis is experiencing the difference between didactic and experiential styles of education first-hand. She comments,

I had been reading for school about fetal positioning and where what parts should be and how to feel them and types of pelvises. I thought that having that information stored in my head would help my hands figure out what they were doing. The next morning I went to [my direct-entry mentors'] clinic to do prenatal exams. They told me to put my

hands on the mother's tummy and assess the baby's position. I was trying to think my way through feeling the baby. I felt totally lost. [The midwife] told me to erase everything from my head. To get rid of any ideas that I might have about where the baby should be and close my eyes and feel the baby through my fingers and hands. Let the baby tell me where she is. The same idea with fetal heart tones. She told me not to think about what they should be while I am listening with the fetoscope. Rather, close my eyes and feel the beat in my ears and in my body. At first all I was hearing were the trucks going by in the street below, Mom's belly gurgling, and the kids playing on the floor next to me. As I shut that off and tried to feel what was coming through, the babe's heartbeat jumped right out at me, clear as can be. And like feeling the baby, I could feel the presence of this child right through my ears and into my being.

In all types of contemporary midwifery training in the U.S., both experiential and didactic learning are brought into play. Linear didactic instruction, for example, is often creatively combined with non-linear methods such as the case study approach, which combines experiential learning with synthesis of new information and critical thinking and analysis. While didactic teaching is most strongly emphasized in university-based nurse-midwifery programs, it also plays an important role in private midwifery schools and even, nowadays, in apprenticeship (see below). Experiential learning is most strongly emphasized in apprenticeship, but it also constitutes a major part of nurse-midwifery training, under a different name and in a different form—preceptorship.

The number of preceptors involved in the education of a given SNM (student nurse-midwife) can vary widely. Many SNMs work with more than one preceptor, which some nurse-midwifery educators see as an advantage. Others work closely with only one preceptor and gain very little experience with other practice styles. Nurse-midwifery educators generally value one-on-one learning, but feel that it must take place within the structured didactic framework of a formal, university-affiliated program. Aspects of such programs that they consider to be important include specific criteria for entrance into the program, structured learning objectives that work to ensure that every student masters the necessary body of knowledge, formalized didactic instruction, clinical experience with more than one clinical instructor, and involvement of several faculty members in judgment about the student's ability to provide safe, effective beginning level midwifery care, which the director of the program must attest to in order for the graduate to be eligible for the ACC exam (Judith Rooks, personal communication), as the ACC does not test skills (Peter Johnson, personal communication 1998). Most ACNM accredited programs are based on a modular format that places responsibility for learning in the hands of the student (Johnson and Fullerton 1998). The use of modules is predicated on the concept of adult learning, which takes an individualized approach to mastery of the needed knowledge or information (Lisa Kane Low, personal communication 1998).

The small but growing number of private direct-entry midwifery schools around the country essentially include all of these above components as well; like nurse-midwifery programs, they combine didactic with experiential training, often in a modular format. MEAC-accredited schools and programs have specific entrance criteria, incorporate learning objectives and formal instruction, and offer varied clinical experiences; their faculty members regularly evaluate student competency. Here we can see the transformations in midwifery being wrought in the 1990s: the differing approaches of nurse-midwives and direct-entry midwives to midwifery education these days form not a dichotomy but a seamless continuum. One end of this continuum is defined by formal university programs; the other by pure apprenticeship and self-study. The middle range moves from at-distance university-affiliated programs (like CNEP and SUNY Stonybrook) to college-based direct-entry programs (like the program at Miami-Dade Community College in Florida) to private midwifery schools with entrance requirements, faculty, and formal curricula (like Seattle Midwifery School, the Florida School of Traditional Midwifery, the Utah School of Midwifery, and Birthingway Midwifery School in Oregon). (See my overview of types of midwifery training, this volume.)

And these days, even apprenticeship training is moving toward that middle range. In many cities, senior midwives take turns teaching weekly classes for all of their apprentices, adding the didactic element to traditional apprenticeship. The Utah School of Midwifery and the Midwifery Institute of California have both developed distance-learning/apprenticeship programs in modules that can be adapted for use by mentors and apprentices anywhere in the country. The modular form ensures that learning objectives can be formally set, and that what the apprentice learns can be tracked and evaluated, so these two have become the first apprenticeship programs to receive MEAC accreditation.³⁵ And increasingly, midwives serving as mentors are using the NARM Test Specifications in the *Candidate Information Bulletin* as a guideline for the apprenticeship training process, in order to ensure that their apprentices will be fully prepared to achieve CPM certification. NARM certification also requires that there be more than one midwife who evaluates the abilities of the student: all CPM candidates must

pass not only a written examination but a hands-on skills exam administered by an experienced midwife trained to serve as a NARM Qualified Evaluator.

Given the increasing convergence of didactic and experiential models in direct-entry midwifery training, it is important to ask why MANA, NARM, and MEAC have gone to such lengths to preserve stand-alone apprenticeship as a valid route. My observation is that they honor it for the connective and embodied experiential learning it provides, but most especially for the deep trust in women and in birth that it builds. The apprenticeship training that produces many of today's direct-entry midwives takes many creative and original forms, but fundamentally involves attending births with one or more practicing midwives, assisting them in myriad ways, observing the way they interact with and care for pregnant, laboring, and postpartal women, watching and helping them deal with emergencies, and talking endlessly with them about every detail of their care. During countless hours jointly spent in prenatal exams, home labors and births, postpartum visits, the routine maintenance of equipment and office space, and the mundane necessities of running a business, doing everything together from cervical checks to cooking, labor support to laundry, pelvic exams to paying bills, the mentor and apprentice develop a connective and intimate relationship that facilitates rapid and integrated learning within a context of trust in one's teacher and one's self.

Birth is a fundamentally successful natural process that turns out well with very little intervention most of the time; thus, apprentice-trained midwives are mostly exposed to women working hard and successfully giving birth. Although they have opportunities to experience pathology and emergency management over the course of their apprenticeship training, these incidences form the periodic punctuation, not the defining ethos, of their clinical experience. Thus apprentice-trained midwives generally develop a strong faith not only in themselves, but also in the inherent trustworthiness of the birth process and in women's ability to give birth. They can and very often do include as part of their training a stint in a high-volume program either overseas or in the U.S. (such as the MEAC-accredited program offered at Maternidad La Luz in El Paso), where they will encounter many complications, but this exposure takes place against an already-established background of trust in the power of women and in the normal process of birth.

The relationships between student nurse-midwives and their preceptor(s), while often rich, rewarding, and mutually supportive, seldom take on the particular depth and intensity of the apprentice-mentor relationship, which some nurse-midwifery educators criticize as too all-encompassing. Another difference is that SNMs' exposure to complications in childbirth can vary widely. Some who train in settings where patients with complications are quickly transferred out may graduate without ever having seen shoulder dystocia, a postpartum hemorrhage, or true fetal distress. Others who train in high-volume, high-risk settings may be exposed in rapid succession to multiple complications. Many CNM educators make concerted efforts to minimize exposure to pathology until later in student training, but in some settings that can be difficult to achieve. (Many CNM educational programs offer clinical experience in the care of indigent women, who have a higher incidence of complications.) In addition, as we have seen, the standard of care in the hospital environment in which SNMs receive most of their clinical experience is based on a medicalized, technological approach to birth which itself often creates pathology--too much monitoring leads to too many Cesarean sections, too much haste leads to too many episiotomies, etc. Tension prevails, rather than trust. Thus the hospital norm is to intervene to prevent possible complications, rather than to wait patiently for the natural process of birth to unfold.

CNMs are educated to deal with a wide variety of "normal variations" in childbirth, and in certain settings must deal with many complications themselves. But, as we have seen, the majority of CNMs work in large hospitals where help is generally readily available should an emergency arise that is outside of their competence or comfort level. At home, if a complication arises, the mother must either be transported to the hospital or the midwife and her partner must handle the problem on site. If the complication develops when birth is imminent or so rapidly that transport is out of the question, home birth midwives must have the skills to deal with it themselves. Thus they tend to develop an independence of thought, a strong self-reliance, a sense of trust in birth, and a self-confidence in the face of crisis that nurse-midwives trained only in hospitals may lack.³⁶ The most common criticism leveled at nurse-midwifery training by the direct-entry midwives I have interviewed is that it produces midwives who are afraid of birth. Knowing that fear itself can generate birth complications, these direct-entry midwives fiercely defend apprenticeship, which they honor for its production of midwives who truly trust birth and the women who give birth—

--to which many CNMs would respond that lack of formalized training will not bring recognition in the technocracy, and will result in the narrow scope of practice and cultural marginalization Joyce Roberts described above.

Again the waters are muddy here: this is true in many places, but not all—in California, for example, full scope well-woman care is in the new direct-entry licensure law as a valid part of direct-entry practice, all of the 100 or so California licensed midwives, including those who were apprenticeship trained, passed a rigorous challenge examination based on the Seattle Midwifery School's formal educational program, and a few licensed midwives in California and Florida who are apprenticeship-trained and practice primarily at home now have hospital privileges as well. This California situation, though a bare beginning, indicates some of the long-term possibilities for increasing convergence between these two midwifery systems.

My Dream

I see in this present dispute over the proper nature of direct-entry midwifery two completely different worldviews that stem from disparate histories, disparate values, disparate perceptions of the nature of midwifery and the meaning of midwifery care—in short, disparate midwifery cultures. It seems almost impossible for these two cultural systems to agree (a situation that is particularly hard on those who are members of both). Everything the ACNM does makes perfect sense if one accepts the belief and value system of the ACNM. Everything MANA does makes perfect sense if one accepts MANA's belief and value system. These belief systems are not just intellectually understood but are felt, lived, experienced, expressed in myriad aspects of life, from the kinds of clothes midwives wear to the kinds of conventions they put on.

MANA has long been an irritating thorn in the ACNM's side. Faced with bigger issues, from recalcitrant physicians to managed care, since MANA's inception many ACNM members have wished it would just go away. Indeed, by her own report Sister Angela was almost subjected to impeachment proceedings for having called the initial meeting. Sixteen years later, although MANA's supporters within ACNM have grown in number, some CNMs are still wishing MANA would disappear. At the very least, many of those in the ACNM wish that all non-ACNM midwives would just accept ACNM as the one and only standard-setting organization for midwifery, and study for ACC certification. As noted above, these CNMs strongly believe that it harms midwifery to have two major national organizations, and that it would help midwifery to speak with one unified voice—i.e., theirs.

In the fall of 1997, I facilitated a panel at the MANA conference in Seattle entitled “ACNM and MANA: A Direct-Entry Dialogue.” In the most dramatic moment of that panel, I asked ACNM President Joyce Roberts if she could support CPMs and CMs to be legal and licensed side by side in all 50 states. I was grateful that she courageously and honestly answered with a straightforward “No,” as it helped to clarify to the MANA midwives that President Roberts' intention, and that of many in power in the ACNM, is to advance their direct-entry certification and to establish the ACNM as the only recognized standard-setting midwifery organization. (This was hard for some MANA midwives, whose own philosophy is so much more inclusive, to believe.) It is important to understand that President Roberts and many of her colleagues *quite sincerely* believe that would be the best for midwifery; they honestly see their standard as superior. Everything in their training and experience (not to mention the values of the wider culture) tells them that university degrees and university education produce midwives who will be both more qualified and more empowered to function effectively in the technocracy and to make needed changes in the health care system.³⁷ Of course, the members of MANA and its affiliates believe equally deeply in the superiority of their CPM certification as the standard for out-of-hospital birth, in the value of diversity in educational routes and practice styles, and in the importance of holding open more options for out-of-hospital birth.

Thus it seems clear that for the present, MANA and its affiliates may have to fight not only against the medical profession but also against some state ACNM chapters to establish MEAC accreditation and NARM certification as legitimate in a given state.³⁸ This is a tragic situation, a major waste of energy that could be much better spent, and I hope it will not last for very long. It is a point of extreme sorrow to me that many midwives in MANA, NARM, and MEAC feel that in some states they are engaged in a war in which the ACNM is on the wrong side. We must remember that MANA is not threatening the survival of the ACNM, so there is no need to defend the ACNM from being subsumed by MANA, whereas MANA midwives fear that as the ACNM works to legalize the CM in all 50 states, the members involved in this legislative effort will be branding the CPM as an inferior

credential and, openly or subtly, will encourage state legislators to make the CM the *only* legal and licensed direct-entry credential.

As I discussed with members of MANA and NARM the possibilities for peaceful co-existence of the two credentials (their desired goal), I have been told various times, with deep feeling, “This is not a tea party, it is a war. We are in a war for our survival.” These MANA midwives have realized that they cannot defend all of direct-entry midwifery in state legislatures; they can only defend their CPM credential. Thus they are increasingly coming to interpret their survival as independent practitioners, and the survival of their out-of-hospital Midwifery Model of Care, as dependent on the legitimation of that credential. Although some prominent members of ACNM have stressed to me that they are not fighting MANA, that is not the experience of MANA members who watch other CNMs subtly or overtly denigrate the CPM in state legislatures and elsewhere, insisting that ACNM should be the only organization to “set the standard” for direct-entry midwifery.

I prefer to dream a different dream. In my dream, all parties choose to reject the kind of rigid and hierarchical thinking that assumes that there can be only one standard, so that if there are two, that has to mean that one is better and the other is worse. There is more than one good way to do something good! A number of states have already been successfully modeling a dual system of midwifery for more than ten years, including Oregon, Washington, New Mexico, Arizona, and Texas. As an anthropologist I say, for the immediate future let there be two kinds of certified direct-entry midwives: two educational standards, two national certifications, two certifying bodies, two accrediting bodies (see endnote 22). Let us not make the mistake of believing that the existence of one weakens the other and is bad for midwifery, but rather let us understand that each strengthens the other. The existence of ACC-certified (CNMs and CMs) midwives opens the technomedical realm of the hospital to midwifery care where it is most urgently needed. And the existence of the strong independent midwifery movement that MANA represents lengthens the spectrum of midwifery care, keeping a wide range of out-of-hospital options open for midwifery practice that would shrink considerably if the field should narrow down to CNMs and CMs. (Again, only about 200 CNMs attend home births; most of them are members of MANA and draw much of their inspiration and support from that wellspring.)

The fact that MANA midwives are working hard to preserve apprenticeship, to develop innovative new educational models, and to codify and strengthen their holistic, out-of-hospital midwifery model of care means that all that is precious about who they are and how they practice will grow as a strong and viable part of American midwifery. These models and these midwives will be available now and in the future as a resource that any CNM will be able to tap should she wish to learn how to attend home births, or simply to strengthen her sense of independence and self-confidence.³⁹ Like the thousands of women in hospitals who will benefit from the care offered by CNMs and CMs, thousands of mothers who want out of hospital birth will benefit from CPM care. As their value becomes recognized, CPMs will eventually be able to obtain licensure and regulation in every state, as well as insurance reimbursement. Clearly, today’s MANA midwives strongly desire to move beyond marginalization—the theme of the 1998 MANA conference in Traverse City, Michigan will be “Midwifery in the Mainstream.” They aren’t there yet, but through development of their own direct-entry certification and accreditation processes have taken several major steps in that direction. With a little luck, I envision that 5 or 10 years from now CPMs will be recognized and respected practitioners, legal and licensed in all 50 states, whose specialty is out-of-hospital birth, most especially home birth. The prospective CPM statistical data collection project that is currently being worked out will be successfully completed; these data will demonstrate the safety and efficacy of CPM practice, and effectively refute the stereotypes of ignorance and incompetence that home birth midwives have long suffered under.⁴⁰

Meanwhile, in my dream CNMs and CMs will continue to increase their numbers and their presence at in-hospital, birth center, and home births. As envisioned by many of the prime movers in the creation of the CM, the new CMs will indeed be more independent-minded. Never having been through nursing training, they will not internalize a sense of structural subordination to physicians, and thus will help to recreate ACNM-style midwifery as an increasingly autonomous profession. They will expand the scope and scale of midwifery practice. Their independence of thought will attract many CMs to out-of-hospital birth; many of them will work in birth centers and attend home births, often working in tandem with CPMs. It will be in the trust and intimacy of these individual relationships between direct-entry midwives that the two opposed meanings of the term “direct-entry” will finally converge.

Under siege from the advancing army of holistic practitioners and from the unified legislative front the midwives will present, MDs will lose legislative clout as their petty “because I said so” tactics to maintain their hegemony in each state are exposed, and midwives will increasingly be able to control their own destinies. Since a strong desire of many nurse-midwives at present is to get out from under regulation by nursing boards (see endnote 28), we can predict the emergence of midwifery boards in some, if not all, states. By the time this starts to happen, in my vision nurse-midwives will have gotten over their doubts about the NARM process and will understand the benefits that can accrue to each group from working together and presenting a united legislative front. Perhaps one obstetrician, one pediatrician, and one consumer will sit on these boards in advisory capacities, but they will mostly consist of midwives: one CNM, one CM, and two CPMs, so that balance between ACNM’s and MANA’s philosophies and styles will be created and maintained.

Rather than opposing the legalization and regulation of CPMs, in my vision ACNM will support them in every state, working to educate legislators about the importance of providing trained professionals for the women who choose home birth, affirming the value of the NARM process, and demonstrating the benefits that accrue to mothers and babies when (1) CNMs and CMs collaborate with CPMs, receiving their clients at the hospital door and assuring continuity of care by welcoming the CPM to continue to serve her client in the hospital as caregiver or doula; and (2) CPMs train interested CMs and CNMs in out-of-hospital birth. Physicians will be able to observe for themselves the benefits to mothers when midwives work together in such mutually supportive ways.

During my three years of research into the development of direct-entry midwifery in the U.S., I have found in interviews that MDs’ perceptions of direct-entry midwives are greatly influenced by what the CNMs they work with tell them. When the CNMs speak favorably of the home birth midwives, the doctors tend to welcome their transports and treat both the midwives and the home birth mothers with more respect. CNMs who denigrate the direct-entry midwives in their communities may well be harming mothers who will need their care. I have also found that the CNMs who have little or no exposure to independent direct-entry midwives are the ones most likely to perceive them as uneducated and unsafe. In contrast, CNMs who have worked or interacted socially with DEMs tend to have great respect for their knowledge, training, and practice styles. The more regular the interaction, the better they tend to understand each other and get along. So in my dream, monthly potluck dinners, joint regional conferences, Internet chat groups, and mutual friendships will keep communication lines open between nurse- and direct-entry midwives (see endnote 10), even when they don’t practice together. But increasingly, they will establish joint practices owned by the midwives themselves (sometimes even hiring physicians, as Elizabeth Gillmore CPM has done in Taos, New Mexico), and make common cause.⁴¹

Unity in Diversity

At the individual level, there are countless interlinkages between these two national organizations which seem on the surface of things to be so diametrically opposed. Consider the following:

- Most CNMs and DEMs share basic values and beliefs about the normalcy of birth and the importance of woman-centered, non-interventive care for facilitating women’s ability to give birth.
- The midwives of MANA and of the ACNM are vulnerable and culturally marginal groups jointly attending only a small fraction of American births. Because most of them try to offer connective, nurturant care that honors the normalcy of women’s individual rhythms, they—nurse- and direct-entry midwives alike—are subject to harassment and persecution for failing to adhere to conventional medical norms.
- From the 1970s on, CNMs have played an important role in the development of direct-entry midwifery; some CNMs have trained direct-entry apprentices and taught in direct-entry programs and schools.
- Likewise, DEMs have introduced some nurse-midwives to the magic of home birth, and the holistic philosophy and writings of DEMs like Ina May Gaskin, Elizabeth Davis, Jan Tritten, and many others have inspired countless students to enter midwifery, including many SNMs.
- MANA was created at an ACNM convention, and one-third of MANA’s members are and have always been CNMs.

- Approximately one-fifteenth of ACNM's members belong to MANA, and a significant number of nurse-midwives were direct-entry midwives before they became CNMs.
- Some CNMs always attend MANA conferences for a “dip in the holistic spring,” as several of them have expressed it, and MANA always has a presence at ACNM conventions, in the interests of exchanging information, working together, and improving relationships between the two groups.
- The Presidents of MANA and the ACNM make a point of attending each other's annual convention; indeed, for several years in the recent past the President of MANA was also a CNM.
- In part, CPM certification was created in response to criticism from ACNM regarding the lack of standards for direct-entry midwifery education. In part, CM certification was created in response to direct-entry midwives' criticism of the CNM educational nursing requirement (Scoggin 1996:41).
- Across the country, there are hundreds of occurrences of interdependence between CNMs and DEMs. For example, I have heard numerous stories of hospitals that suddenly become willing to hire CNMs after direct-entry midwives open a birthing center nearby. Sometimes, direct-entry midwives and nurse-midwives work together in private practices; often, they create informal collaborative arrangements that benefit them both.

My point about the intense interlinkages between MANA and the ACNM on the individual level is reinforced by the fact that the first person in the world to receive CM certification was already a CPM. Her name is Linda Schutt--she was trained in England and practiced midwifery both in Africa and in New York, illegally, as an independent homebirth midwife for years before she challenged the new CM process under the new New York law. Linda has been a member of MANA since 1983 and of ACNM since 1995. Julia Lange Kessler provides another example of these interlinkages: as a CPM in the second CM class at SUNY downstate, she sees herself, not as exclusively aligned with one camp or the other, but as a bridge builder between them. So do many of the former direct-entry midwives who became CNMs, retaining their independent midwifery knowledge and spirit and their memberships in MANA. They include the 112 members of ACNM's new Bridge Club, which is urging the ACNM to rethink both its attitudes and its policies toward the CPM, and to find the path toward peaceful and mutually supportive co-existence—a petition I am happy to support.

I personally would like to see much more of this sort of bridge building. I would like some CPMs to go on for ACC certification when it can serve their needs, and I would like some CNMs and CMs to go on for NARM certification when it can serve them and their clients. It benefits both midwifery and women for midwives from both groups to expand their scopes of practice and knowledge bases. I want CM programs accredited by the ACNM to also seek MEAC accreditation, and look forward to the day when the ACNM will recognize the excellence of MEAC-accredited programs and offer them ACNM accreditation as well. In this way, and over time, these divergent educational models can find increasing convergence and common ground.

Picking Your Path:

Some Advice from an Anthropological Activist Who Supports All Sides of This Midwifery Story

If you, my reader, would like to become a midwife and are confused, as you well may be, about what path to take, I advise you to research all available options and pick the one that will best set you up to be the kind of midwife you most want to be, serving the clientele that you most want to serve (see “Types of Midwifery Training,” this volume). I also advise you to remember that the choice does not have to be an exclusive one. Many students, as I noted above, are creatively combining didactic training with apprenticeship; a few are even enrolled in distance nurse-midwifery programs and are at the same time participating in apprenticeships with home birth direct-entry midwives. Such enterprises are risky; not only can they result in expulsion from the nurse-midwifery program, but also, getting training simultaneously from opposite ends of the spectrum can be intellectually disjunctive and emotionally trying. Those who do attempt this mixture, like Charis Smith, are aware of the dangers but seem to find it a valuable combination that gives them the best of both worlds (see endnote 26.)

Whichever path(s) you pick, I ask you most earnestly to honor all paths to midwifery education and practice. Don't pick one and then tout it as the best or the only acceptable route. I would be so happy never again to hear direct-entry midwives criticize nurse-midwives as “medwives” and “physician extenders,” or nurse-

midwives to level charges of incompetence or ignorance at direct-entry midwives who choose not to walk through ACNM's "open door." *It is damaging to midwifery for some midwives to destructively criticize other midwives and their training.*

Once in practice, if you find yourself interacting, perhaps working, with a midwife whose training and orientation are different from yours (e.g., you are a DEM and she is a CNM, or vice-versa) and seem to you to be problematic (I have heard that story from *both* sides), I ask you not to badmouth her but if at all possible to work with her and the other midwifery colleagues in your community through peer review to understand where she is coming from and to either expand her skills or your understanding, as appropriate. Sometimes (not always) what at first glance appears to be bad practice may, in fact, reflect a totally different way of doing things that you have not been exposed to before. It may only seem "wrong" because you are unfamiliar with it. Therefore, beware of rumor and gossip about how another midwife practices. If you have questions about a midwife's practice, **try to address your questions directly to her and encourage others to do the same.** Offer her your own expertise and be open to what she has to teach you. Help her or let her help you connect with others who may be able to act as teachers. **Unless the peer review consensus is that she truly presents a danger to her clients, don't turn her in or lobby for legislation that works against her; you may find out one day that what she knows is lifesaving to one of your own clients** (see endnote 13). In the words of a song I often hear midwives sing:

*Humble yourself in the sight of your sister
You need to bow down low and
Humble yourself in the sight of your sister
You need to know what she knows and
We shall lift each other up, higher and higher
We shall lift each other up!*

As we debate the relative merits of the various models of direct-entry education and practice, let us keep our eyes on the prize, which is not a better future for midwifery but rather better health care for mothers and babies. While I understand that many in ACNM believe that this better care can only be offered by midwives trained in DOA-accredited programs, I don't agree that this kind of limitation is best. Midwives are the only caregivers who can keep open the full spectrum of choice for birthing women in hospitals, in freestanding birth centers, and at home. Midwives must go where the mothers are, and that includes the mothers who give birth in hospitals where most CPMs cannot go, as well as the mothers who choose home birth whom most CNMs cannot serve. Let us honor all kinds of mothers, and create midwives who can offer them all kinds of choices.

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Notes

1. As of this date of writing (June 1998), there are presently 7717 members of the ACNM. MANA has 1400 active members, so the total membership for both groups is 9117. But one-third of MANA members are CNMs, and most of them are also members of the ACNM. (About one-fifteenth of ACNM's members belong to MANA.) So it is very difficult to tell how many active members of each group there are without counting some of them twice. This figure of 8700 is my best guess! Also, it is important to remember that there are many practicing home birth midwives who are not members of MANA. We do not have exact figures on these midwives, many of whom are members of religious groups, but there are probably at least as many of them as there are members of MANA, and possibly as many as 4000 or more.

2. Nurses usually classify nurse-midwifery as an advanced form of nursing, but many nurse-midwives do not consider it to be so. Rather they say that they are cross-trained in two professions, nursing and midwifery--a

subtle but important difference (Judith Rooks, personal communication). Furthermore, the ACNM official definition of a nurse-midwife is someone who is “educated in the two disciplines of nursing and midwifery”—wording that provides firmer grounds for ACNM to distance itself from nursing than coding nurse-midwifery as advanced nursing (Lisa Kane Low, personal communication 1998).

3. A technocracy is a society organized around an ideology of technological progress. The general evolutionary thrust in a technocracy is upward, toward ever less dependence on nature and ever “higher” levels of educational and technological development.

4. This decision was controversial and was opposed by a number of prominent members of the ACNM (Lichtman 1996; Rooks and Carr 1995) who believed that requiring degrees would limit the accessibility of midwifery education. These researchers pointed out that there was no evidence that CNMs with degrees were safer or more effective midwives than those prepared through certificate programs. In a 1995 study that compared performance on the national certification examination for nurse-midwives, Fullerton and Severino were unable to demonstrate any practically significant difference between candidates on the basis of highest educational degree obtained. An earlier study showed that certificate students spent more time in clinical practicums and course work directly related to midwifery practice than did Master’s candidates (Sulz et al. 1983).

5. Requiring the baccalaureate could restrict the number of nurses eligible to become CNMs; 65% of nurses do not have a baccalaureate degree (Roberts 1995:152; Bureau of Health Professions, Division of Nursing, 1997). Thus it may be important for nurse-midwifery programs to assist their potential applicants to obtain the Bachelor’s degree. Currently a Bachelor’s in Midwifery does not exist in the U.S., but I believe that it should, as should the Master’s and the Ph.D. The success in Ontario of the new baccalaureate programs in midwifery (see Bourgeault, Benoit, and Davis-Floyd, n.d.) may offer possibilities that some U.S. programs might wish to explore.

6. ACNM conducted a membership survey in 1994 which showed that 137 out of 2789 respondents attended home birth, or 4.9%. This is not a definitive figure, of course, but exact numbers are not available. According to Alice Bailes, Chair of the Home Birth Section of the ACNM, at present fewer than 200 CNMs attend home births. Out of the current total membership of 7717, that is less than 3%. Primary factors keeping nurse-midwives away from home birth include the unavailability of both malpractice insurance and physician collaboration for home birth.

7. State regulations defining the nature of this collaboration vary widely. In some states, such as New York, CNMs must have written practice agreements signed by a specific physician; in other states, such as New Mexico, they are not tied to any individual MD. For more information, see Rooks 1997: 205-210.

8. In *From Doctor to Healer: The Transformative Journey* (1998), Robbie Davis-Floyd and Gloria St. John delineate the three major paradigms that define the contemporary medical spectrum in the U.S.: the technocratic, humanistic, and holistic models of medicine. The technocratic model defines the body as a machine, stresses mind-body and patient-practitioner separation, and insists on a short-term aggressive, interventive approach. The humanistic model softens these hard edges, stressing the connection of mind and body, a mutually considerate and respectful partnership between patient and practitioner, the importance of individualized, compassionate care, and prevention of illness instead of aggressive intervention for a short-term cure. The humanistic model can be applied in an intensely technomedical context; care can be humanistic at the same time as it is technological. The more radical holistic paradigm defines the body as an energy field, stressing the oneness of the body, mind, and spirit and of client and practitioner, and suggesting an all-encompassing long-term approach to healing that involves self-responsibility and consideration of the emotional and spiritual aspects of illness as well as their physiological dimensions. (For more information, see Davis-Floyd and St. John 1998.)

9. MANA midwives believe that a “narrow domain” would be created should training options be limited to university-affiliated programs. Current MANA President Ina May Gaskin notes that

university-affiliated programs are not considered essential in most European countries. To make them so ignores the possibility that if the ACNM stood in solidarity with MANA on this issue, we might really open a door wide enough to rapidly and significantly increase the number of working midwives in this country. ACNM often points to how many new CNMs there are, but they often neglect to note how many CNMs are not actually practicing as midwives.

An ACNM membership survey in 1994 revealed that out of the 4399 respondents, 71.3% were in active clinical practice.

10. Common usage in midwifery parlance has for some years now contrasted “nurse-midwives” with “direct-entry” midwives when the topic is the difference between ACC-certified midwives and others. I follow this usage here. But this distinction between nurse- and direct-entry midwives will not hold for long. Right now there are only 7 ACC-certified direct-entry midwives (CMs). But as their numbers increase, the term “direct-entry” will come to apply to both ACNM-certified and non-ACNM-certified midwives, and will cease to be useful as a means of distinguishing between the two groups. At that point, will “direct-entry” come to include only non-nurse midwives with a professional credential (CM, CPM, LM)? Or will it also continue to apply to non-nurse, non-licensed, non-certified midwives?

11. Here is the complete breakdown, as of June 1998:

Regulated states: AK, AR, AZ, CA, CO, FL, LA, MT, NH, NM, OR, SC, TX, WA. (14 states)

Unregulated but practice legally (by judicial interpretation or statutory inference, or simply not prohibited): 19 states: CT, ID, IL (though current legal cases may change IL to illegal), KS, MA, ME, MI, MS, NE, NV, ND, OK, SD, TN, UT, VT, WI, WV, WY. (PA used to be on this list but a recent legal opinion discovered a change in the medical law several years ago definitively makes DEMs illegal in PA.)

License required but unavailable: 8 states: AL, *DE, GA, HI, MN, NJ, *NY, *RI.

**Note:* In DE and RI a single midwife in each state has been “grandmothered” in, but no new DEMs will be licensed according to the law. In New York, as in Washington state, licensure is available only to direct-entry midwives who can demonstrate that their education meets the education requirements of the law. But in New York, these requirements are too stringent for most practicing direct-entry midwives to meet. Ironically, in Washington state, requirements for direct-entry licensure would be too stringent for the New York CMs to meet--they include three years of midwifery education and attendance as primary midwife under supervision (see note 12) at 50 births. The SUNY-downstate direct-entry program is only two years long, and requires attendance as primary at only 20 births. (Its students are expected to practice with supervision for a period of time after certification, whereas Seattle Midwifery School’s students are expected to be fully qualified to practice on their own upon graduation.)

Prohibited by statute or judicial interpretation, 10 states (including DC): DC, IN, IA, KY, MD, MO, NC, OH, PA, VA

It is interesting to note the geographic distribution -- ALL illegal states and states where a license is required but unavailable are in the Eastern half of the country (except for HI). Also, DEMs practice legally in many more states than they are illegal -- 33 legal states vs. 18 “illegal” (51 because Washington DC has been included as an “illegal” “state”).

(My thanks to Susan Hodges, President of Citizens for Midwifery (CfM) for most of the above information.)

12. According to the NARM publication *How To Become a CPM* (1998:4), “The primary midwife has full responsibility for provision of all aspects of midwifery care (prenatal, intrapartal, and postpartal) without the need for supervisory personnel. “

13. Most midwives I have interviewed, CNMs and DEMs alike, insist that unless a midwife has attended home births, she cannot understand the vast qualitative difference between births at home, where the woman’s own rhythms hold sway, and birth in the hospital, where institutional rhythms are constantly superimposed. It is impossible to understand the ebbs and flows of normal birth in hospitals where labor is highly regimented and regulated. For example, in the hospital, “normal” labors are supposed to take less than 24 hours. If labor does not steadily progress within the allotted time period, pitocin is administered and ultimately a Cesarean may be performed. Home birth experience expands a midwife’s understanding of what “normal” means. At home, where personal, not institutional, rhythms prevail, “normal” labors may stop and start, and can take one hour or three days. Mothers will eat and drink as much as they like to keep up their strength; in the hospital, these options are usually denied.

14. In states where they have licensure, some DEMs do apply for hospital privileges, of which a very few have been granted. (I personally know of one in Louisiana, two in Florida, and two in California.) Certainly most DEMs would like to be able to accompany their clients into the hospital should they require transport, and to continue to serve them there. Were hospital privileges more readily available to licensed midwives, as they are in Canada, no one really knows what percentage of DEMs would choose to practice in hospitals.

15. While this statement is true, any attention given to the mistakes made by some DEMs must be counterbalanced by the acknowledgment that hospital practitioners also often make mistakes, and “botched hospital births” are an all too common occurrence. It is also important to note that CNMs and even MDs who attend home births are often subjected to the same stereotyping process when they transport their clients to the hospital.

16. Midwifery works best when midwives act as team players. A few midwives who work outside of the peer review consensus in their communities do sometimes present real problems for midwifery in that community and real dangers to parents. In such cases, when peer review is not effective, action is generally taken by the state. The dangers presented by such practitioners, who are sometimes referred to as “renegade midwives,” constitute one of the major reasons why many MANA members have come to believe in the importance of some degree of standardization of education to meet established criteria for professional certification.

17. The ACC is relatively new; all CNMs certified before 1992 were certified by the ACNM. The ACC was created as a separate organization in order to comply with antitrust laws that require separation between a professional organization and its certification process (Lisa Kane Low, personal communication).

18. Technically speaking, you do not have to be a member of the ACNM to take the ACNM examination and be certified by the ACC as a CNM; but this is rare. Over 90% of CNMs belong to the ACNM.

19. Until recently, CNMs who wished to obtain NARM certification did not need to take the NARM written or skills exam, but, in addition to meeting other criteria, did have to document attendance as primary caregiver at 10 out-of-hospital births, and 3 courses of continuity of care (which means they have to be the primary midwife for at least 3 women whom they follow throughout pregnancy, birth, and the post-partum period). Continuity of care is sometimes difficult to achieve during nurse-midwifery training, and sometimes even during direct-entry training in high-volume clinics like the ones in El Paso, where women often appear in labor with no prior prenatal visits. Nevertheless, documenting continuity of care with at least three clients is a NARM requirement because members of MANA, NARM, and MEAC consider it to be an essential ingredient of out-of-hospital midwifery practice. (There is a qualitative difference in the relationship a midwife has with a client whom she sees all the way through the childbearing experience.)

DOA-accredited programs must demonstrate that they encompass the ACNM Core Competencies (see the Appendix to this volume), which require that CNMs and CMs provide care “on a continuous and comprehensive basis”; no specific numbers are required.

The CPM credential, which qualifies midwives to attend out-of-hospital birth, reflects a different body of knowledge than the knowledge CNMs and CMs attain. Recently, the NARM board decided to add the CM to their application form as a route of entry, but to require from this point on that all CMs and CNMs applying for NARM certification take the NARM written exam, in addition to attending 10 out-of-hospital births and documenting the care of 3 women throughout their pregnancies (continuity of care), to ensure that all CPMs will share a common body of knowledge and expertise in the MANA Midwifery Model of Care (see box 4).

20. A major issue that accompanied the acceptance of the CM as a voting member of the college was the issue of a possible name change, from the American College of Nurse-Midwives to (1) the American College of Nurse-Midwives and Midwives (ACNM) or (2) the American College of Midwives (ACM). Very few people liked option 1, as it is so unwieldy; a majority of the membership voted in a survey that they prefer option 2. The motion for a name change was defeated by a narrow margin at the 1997 Boston convention, and subsequent motions asked for alternative name options and for the implications of a name change to be considered and explained at the 1998 convention in San Francisco. During the San Francisco convention, yet another option was added: the American College of Midwifery. This is the preferred option of the ACNM board, because it would name the profession, not the practitioner, and thus would easily encompass both nurse- and direct-entry midwives without invalidating or giving primacy to either one. (Additionally, it has a historical precedent: in 1968, the American Association of Nurse-Midwives (formed in Kentucky in 1929) merged with the American College of Nurse-

Midwifery (which had been formed in 1955) to become the American College of Nurse-Midwives (Roberts 1995:145)). A motion to put the name-change issue to a mail vote by the fall of 1998 passed by a large majority.

21. The ACC exam is based on Task Analyses, the latest two of which were carried out in 1985 and 1993-1994. This latest Task Analysis is based on multiple sources, examples of which include “state statutes and regulations which define the practice of nurse-midwifery and midwifery in those jurisdictions, the ACNM Core Competencies, the MANA Task List, and relevant contemporary literature describing nurse-midwifery and midwifery practice” (Judith Fullerton, personal communication, 1998). These task analyses are revised every 5 to 7 years; a new Task Analysis Research Project is currently underway.

22. In New York, ACNM members have worked to make the baccalaureate requirement as easy as possible to meet: Empire State College will give a great deal of credit to individual students for life experience, which helps to minimize the number of courses that need to be taken for the baccalaureate degree. 22 hours of credit are currently available at Empire State College for having a CPM (Julia Lange Kessler, personal communication).

23. Some professions, including medicine, have two national accrediting bodies. The following examples are taken from *Nationally Recognized Accrediting Agencies and Associations*, published by the U.S. Department of Education, 1996. Two agencies accredit Allied Health Programs: the Accrediting Bureau of Health Education Schools, and the Commission on Accreditation of Allied Health Education Programs. Emergency Medical Services are accredited by the Joint Review Committee on Education Programs for the EMT-Paramedic, and the Commission on Accreditation of Allied Health Education Programs. Occupational education has the Accrediting Commission of Career Schools and Colleges of Technology and the Council on Occupational Education, as well as the American Occupational Therapy Association. Christian colleges are accredited by the Accrediting Association of Bible Colleges, the Transnational Association of Christian Colleges and Schools, the Association for Clinical Pastoral Education, Inc., and the Association of Theological Schools in the United States and Canada. Medical Laboratory Technician Education is accredited by the Accrediting Bureau of Health Education Schools and the National Accrediting Agency for Clinical Laboratory Sciences. Programs leading to the M.D. degree are accredited by the Liaison Committee on Medical Education of the Council on Medical Education of the (1) American Medical Association and (2) Association of American Medical Colleges. (Mary Ann Baul, personal communication, 1998)

24. This generalization has important exceptions. Some nurse-midwives have long been involved in direct-entry education. For example, Katherine Camacho Carr CNM taught the first class at Seattle Midwifery School and has kept on teaching there for years. She says, “We are all midwives and must teach each other!” (personal communication 1998).

25. The length of the passage through nursing varies considerably, depending on the kind of nursing training undertaken and the requirements of the program. Students I have interviewed who entered nursing training specifically to become midwives usually spend about a year and a half learning to be nurses. Those who enter Master’s level nursing programs can take much longer. Many pre-midwifery nursing students are repeatedly told by nurses that one should not become a midwife without several years of practice as a labor and delivery nurse. (A strong characteristic of the culture of nursing is to regard those who have practiced for less than two years as not having really practiced at all.) Those who take this advice seriously can find themselves “stuck” in a nursing job for years before they can get back on the midwifery track. The fastest passage through nursing is found in three-year post-baccalaureate nurse-midwifery programs such as the one created by Helen Varney Burst at Yale: only one year is spent in nursing training.

26. I do not mean to denigrate nurses here. Many nurses show great independence of thought, develop innovative programs and styles of care, and treat patients holistically. But all of the midwifery students I have interviewed noted a strong difference between their socialization as nurses and their socialization as midwives. They report that as nurses they were expected to defer to doctors, to mute their opinions or express them subtly, and to know and keep to their place in the medical hierarchy. As nurse-midwives they find themselves above nurses in the hospital hierarchy and are encouraged by their educators to develop more autonomous, collaborative, non-subordinate relationships with physicians. (Nursing students are often taught the same thing, but physicians are not--they continue to be taught to treat nurses as subordinate, which makes it difficult for nurses to establish themselves as collaborative equals.)

27. ACNM/DOA standards for the accreditation of direct-entry midwifery education programs say that the program must have "a patient population large and diverse enough in both in-hospital and out-of-hospital settings that students can acquire the elements contained within the 'Skills, Knowledge, Competencies, and Health Sciences Prerequisite to Midwifery Practice' document." "Out-of-hospital" could be technically interpreted to mean, for example, Planned Parenthood clinics where prenatal and well-woman care is provided, but the intent of most of my CNM interviewees is that the CM will have the skills and experience to attend out-of-hospital birth. Apparently, the intent of the DOA requirements is somewhat different. DOA head Helen Varney Burst (1995:291-292) stressed that ACNM was not creating certification for MANA-style direct-entry midwives, but rather for "health care professionals," and that hospital experience would be a requirement for ACNM's new CMs. According to Laura Slattery at ACNM headquarters (personal communication), DOA-accredited direct-entry programs do not have to require out-of-hospital experience. The issue as Slattery explained it was that because nurse-midwifery programs require a credential, the RN, it was assumed that applicants already had experience in hospital birth because of their familiarity with the hospital. But it could not be assumed that CM applicants had ever worked in a hospital, so the exposure to hospital birth during their training, which they must have, may be the only exposure they get. (The criteria for nurse- and direct-entry programs are presently under evaluation and are being merged, so that as of July 1998 there will be only one set of criteria for both.)

28. Most nurse-midwives are regulated by state boards of nursing, yet surveys conducted in 1991 and 1995 showed that in only 8 states did CNMs have designated places on those boards (DeClerq et al. 1998). New York and Utah were the only states in which CNMs constituted a majority of the board members; in most states there was not even a formal route for them to provide input. Interviews in both surveys suggested conflicts between the content of CNM education and certification and the nursing boards' definitions of CNM scope of practice. "This lack of control of their own regulatory boards is in sharp contrast to the traditional physician dominance on the boards that regulate medical practice " (DeClerq et al. 1998:193).

29. The law states that to be eligible for licensure, direct-entry midwives must have an education "equivalent to that of nursing" and must pass through a state-accredited midwifery program or demonstrate an equivalent education, and must pass the state licensing exam (which through special contractual agreement with the ACC is exactly the same exam as that given to CNMs (Judith Fullerton, personal communication, 1998)). Those who pass the exam are awarded the CM along with their New York midwifery license. Many of the practicing DEMs in New York were eager to take the exam, but were not eligible do so because they could not meet the education requirements.

30. New York CNMs insist that the Professional Midwifery Practice Act would never have passed had the DEMs been included. But the DEMs vehemently disagree, insisting that they had legislative backing for a version of the bill in the NY Senate that did everything that both the DEMs and the CNMs wanted. When it was about to be brought before the House, under circumstances too complex to go into here, the bill was suddenly and drastically changed. The direct-entry midwives who had invested 5 years lobbying for the Professional Midwifery Practice Act felt betrayed by the CNMs. The CNMs in turn insist that the changes were necessary compromises to get the bill past the opposition posed by the nursing and medical associations. More detailed discussion of this difficult and painful chapter in midwifery history is beyond the scope of this chapter. I will soon begin work on a lengthy article on this subject, entitled "Birth of a Dream, Death of a Dream: The Development of Direct-Entry Midwifery in New York."

31. Pat Burkhardt, CNM, a member of the New York Midwifery Board, notes that:

We nurse-midwives in New York state who were working desperately to obtain passage of the bill were focused on fighting off the state medical and nursing societies and did not stop to consider the ultimate consequences of legalizing ACNM-certified direct-entry midwives. Once the law passed and was being implemented, most of us were shocked to realize that the practice of unlicensed midwifery had been transformed into a felony. When the members of the new Board of Midwifery became aware that the state attorney's office had begun prosecuting unlicensed midwives, we were appalled and we did not understand why they were doing so. We were told that complaints from consumers were what led to the prosecutions, but our further investigations did not completely verify that statement. We talked with the state attorney's office, asking them to back off and insisting that unless there was clear indication of a need to investigate a particular midwife, there was no reason to enforce a law just to enforce a law. The situation has calmed down considerably since then, but those were very trying times. (Personal communication, 1998)

32. It is important to note that home birth experience is available to nurse-midwifery students, albeit on a very limited basis. Alice Bailes, Chair of the ACNM Home Birth Section, notes that the ten students in Georgetown University's midwifery program have the opportunity to experience out-of-hospital birth at four birthing centers and in one CNM-run home birth practice in the Washington metropolitan area. Students in the University of Pennsylvania's midwifery program have an opportunity to do their integration in CNM Rondi Anderson's home birth practice among the Amish. Most of the 180 or so CNMs who attend home birth try to offer clinical opportunities for students whenever possible. Students who want home birth experience would do well to explore these options before picking their training program. Bailes is presently engaged in compiling a database of available opportunities for SNMs and SMs to gain clinical experience in home birth, which she plans to make available by spring 1999. For more information, contact Alice Bailes at Birth Care and Women's Health (703-549-5070) or at home (703-243-0189). (Alice Bailes, personal communication, 1998).

33. Earlier meetings of the Bridge Club had taken place, but had not led to any type of ongoing organization or plan of action.

34. In Chapter 7 of *Birth in Four Cultures* (1993), Brigitte Jordan provides an outstanding and useful discussion of the differences between experiential and didactic learning.

35. To date, MEAC has given full accreditation to Seattle Midwifery School, the Utah School of Midwifery, and Maternidad La Luz in El Paso, Texas, and pre-accreditation to the Midwifery Institute of California, the Oregon School of Midwifery, Birthingway Midwifery School in Oregon, and the Sage Femme Midwifery School in Oregon and California. Pre-accredited programs have met all standards and requirements for full accreditation but have not yet graduated enough students to demonstrate success consistent with their missions.

The members of MEAC, all of whom are deeply involved in direct-entry midwifery education, have designed their evaluation process in full accordance with the specifications of the U.S. Department of Education (US DOE) (which recognizes both categories of accreditation and pre-accreditation), and they plan to apply for DOE recognition for MEAC in the latter part of 1998. (The ACNM's DOA, which has had DOE recognition for nurse-midwifery programs since 1982 (Roberts 1991), has already applied once for US DOE recognition to accredit direct-entry programs; their application was refused on the basis that they have no experience with direct-entry programs. After they graduate the necessary number of students, they will apply again, and are on track for receiving DOE recognition.) Much is riding on the success of MEAC's application: if they succeed, all MEAC-accredited programs will be qualified to apply for approval to give out government-funded grants and loans to students. This will help to increase accessibility to midwifery education and to further MEAC's goal, which is to improve the quality of that education while preserving its diversity. US DOE recognition will also put MEAC on the same level as the DOA in the eyes of federal state agencies. The US DOE officially welcomes the existence of dual routes to accreditation within a given profession as long as all criteria and standards are met. (Mary Ann Baul, personal communication).

An additional benefit of MEAC's gaining US DOE recognition may be that all graduates of MEAC-accredited programs, including apprenticeship programs, will meet the international definition of a midwife (see above), whether or not they are recognized in the states in which they are located. At present, all direct-entry midwives currently licensed by their jurisdictions who graduated from educational programs recognized by that jurisdiction are understood to meet the international definition and are thereby qualified to hold membership in the International Confederation of Midwives, which many of them do. The narrow interpretation of the international definition published by the WHO in *Care in Normal birth* reads as follows: ". . . the international definition of a midwife, according to WHO, ICM and FIGO (the International Federation of Obstetricians and Gynaecologists) is quite simple: if the education programme is recognized by the government that licenses the midwife to practice, that person is a midwife." But the exact wording of the definition is less specific: "A midwife is a person who, having been regularly admitted to a midwifery educational program duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery." This definition does not specify that the midwife is licensed, only that she has graduated from a program "duly recognized in the country where it is located." Thus, a case could clearly be made that if MEAC gains US DOE recognition (which would mean that MEAC-accredited programs will be "duly recognized in the country in which [they] are located"), graduates of MEAC-accredited programs will conform to the international definition, even if they practice in states in which they are illegal. This would add additional strength to the refutation of the claim that only ACNM-certified midwives meet that definition, and would work to legitimize the apprenticeship route to midwifery (for those apprenticeship

programs that achieve MEAC accreditation) and to preserve the diversity of private midwifery education programs.

36. Most direct-entry midwives I have interviewed seem to understand the fine line between confidence and over-confidence, between self-reliance and knowing your limitations, between trusting birth while remaining aware of its risks. Most complications occur to low risk women, because most women are low risk. Good training and a good balance between trust in women and birth, and level-headed, informed awareness are essential components of any brand of midwifery. (In addition, it is important to note that CNMs trained to work in homes, birth centers, Level I community hospitals, or high-risk tertiary care hospitals where they practice with a great deal of autonomy tend to develop the same skills and sense of self-reliance as independent home birth midwives.)

37. Everything, that is, except their own data. In *Midwifery and Childbirth in America*, Judith Rooks also points out that:

there is no evidence that nurse-midwives with masters' degrees provide safer, more effective or more satisfying care to women. Nor are CNMs with master's degrees more likely than certificate program graduates to do well on the national factors nurse-midwifery certification examination...(Fullerton and Severino 1995). In addition, a 1985 study of affecting the level of success experienced by individual CNMs found no association between type of nurse-midwifery education and the level of professional success. (Haas and Rooks 1997:172)

38. Their fight will be an inclusive one—plans are underway for including the CM as yet another route to NARM certification (see note 13). In other words, in states where the CM has no legality but the CPM does, a CM could become a CPM and be licensed as such.

39. It is important to remember that most of the 200 or so CNMs who attend home birth are MANA members. These home birth CNMs, who constitute less than 3% of their national organization, draw inspiration, support, courage, and companionship from MANA; they find that their independent and holistic model of birth is given louder voice and more definitive shape in MANA than in ACNM.

40. The MANA database being compiled by a Canadian epidemiologist already has data on 10,000 births turned in by MANA midwives on the extremely detailed MANA data form. These data, which are as yet unpublished, show excellent outcomes, but because they are voluntary, they are not as statistically valid as would be a prospective study of every outcome of every birth attended by a CPM in a given year. Plans are underway to carry out such a study in the year 2000.

41. Late-breaking news: The common cause I envision may come soon. At work on the final draft of this chapter, I have just received word that during the Board meeting held in May 1998, the ACNM Board of Directors, following a convention vote by ACNM members, voted to establish another joint ACNM-MANA work group, to be composed of 4 representatives from each organization. The purpose of this group as the ACNM BOD conceives it will be three-fold: (1) to create appropriate language for a model state practice act that would encompass both new direct-entry certifications; (2) to explore the possible mutual articulation of ACNM and MANA-style models of education (in other words, how could the gaps between these models be bridged without a student having to repeat large portions of her education? E.g., if you are a CPM, what might be a streamlined way to become a CNM or a CM? and vice-versa. If you are a graduate of a MEAC-accredited program, how might a DOA-accredited program give you credit for that, and vice-versa?); and (3) to develop new and better ways for ACNM and MANA to communicate and continue to work together. This ACNM initiative is the result of a motion put on the convention floor by the members of the new Bridge Club, which passed by a large majority. It reflects the good will many ACNM members feel toward MANA, and now awaits MANA's response.

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