1

ACNM AND MANA: DIVERGENT HISTORIES AND CONVERGENT TRENDS

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The scene is the 1997 MANA conference in Seattle. The conference room is filling up with so many midwives that walls have to be moved to accommodate the crowd. I am on my way to the slide projector and I am so nervous that I drop my tray of slides, then have to work frantically to get them back in order before the

panel—which I am facilitating—is supposed to start. Over the past ten years, I have given hundreds of public lectures and have chaired dozens of conference panels, so why am I trembling? Because this is the most politically charged topic I have ever taken on—a panel designed specifically to address the major issues that place MANA at loggerheads with ACNM.

The current president of ACNM is on this panel, along with the vice president and a past president. Representing MANA are its president, a board member of MANA's sister organization the North American Registry of Midwives (NARM),[1] and a well-known direct-entry midwifery educator. The title of the panel is "ACNM and MANA: A Direct-Entry Dialogue," and the burning question of the day is: What will be the relationship of the two new direct-entry certifications developed by MANA and the ACNM?

NARM began work on national direct-entry certification in the early 1990s and had its process up and running by 1994. A prime motivator for key members of the NARM board had been their belief that ACNM was going to stick to nurse-midwifery and leave direct-entry certification up to MANA and NARM. Thinking they had an open field, NARM board and committee members devoted thousands of volunteer hours to creating a new direct-entry credential, the Certified Professional Midwife (CPM).

But in 1994, after countless hours of deliberation on their own part, the ACNM passed a motion to develop its own direct-entry credential, which was later named the Certified Midwife (CM). From MANA's point of view, this was a massive infringement on the territory it had staked out—direct-entry or non-nurse midwifery. Making matters worse for MANA and NARM, ACNM had sent out a letter to legislators all over the country stating ACNM's support for its own CM credential and casting doubt on the validity of other certifications—an action many in MANA and NARM interpreted as a frontal attack.

Both organizations were facing battles to legalize these new direct-entry certifications in state legislatures across the country. What the 350 MANA midwives packed into the room wanted to know was, were they going to have to fight both the doctors and the ACNM to get their credential legalized, or could their sister midwives in the ACNM be convinced to support both certifications and work collaboratively with them to get both CPMs and CMs legalized and regulated in all 50 states?

So at one point, I asked the ACNM president to clarify whether she might support both certifications. Her response was that she could only stand by ACNM's standards and could not support the standards established by NARM.

Midwife after midwife, some speaking as members of MANA and some as members of ACNM, came to the mikes in dismay to plead for ACNM to take a more supportive position. And then Anessa Maize, the MANA representative from Canada, took the microphone in hand and said, "You know, in Canada, we have resolved these problems and we don't fight with each other like this. We believe we are creating systems that work, that are unifying and not divisive, and we invite you to come and take a look!"

In many areas of cultural life, Americans have prided themselves on establishing models of success that other countries try to emulate. But when the midwives of Canada initiated their worldwide search for the best models of midwifery education, legislation, and practice on which to base their "new midwifery" (Bourgeault, Benoit, and Davis-Floyd 2004), they did not look to the United States because they saw the American situation as something not to emulate but to avoid. Canadian midwives tend to view American midwifery as a fractured profession (Bourgeault and Fynes 1997), noting with dismay that the divisions between nurse- and direct-entry midwives have diverted their energies on multiple occasions into feuding with each other.

Since 1996 these struggles have constituted a focal point of my anthropological research—necessarily so, since my research project (described in the Introduction) has concentrated on the historical emergence at almost the same point in time of the two direct-entry certifications mentioned in the story above. These two new certifications encapsulate one significant agreement between the ACNM and MANA—that nursing should not be a mandatory part of midwifery education—and several significant disagreements over standards of education and practice.

Canadian midwives have both watched and participated as American midwives have tripped over pitfalls that the Canadians later worked hard to avoid. There were several attempts during the first part of the twentieth century, and again in the 1970s, to create American-style nurse-midwifery in Canada (Bourgeault and Fynes 1997:1056–1057), a number of American-trained nurse-midwives have long lived and practiced in Canada, MANA's second conference was held in Toronto (in 1984), and a number of Canadian midwives have been and are still members of MANA. Yet as midwives in Canada have worked to develop their new midwifery over the past two decades, the American story has served not as a model of inspiration, but rather as a *cautionary tale.*

In this chapter I will tell that tale, or at least the parts of it most relevant to our focus in this book on American midwives' efforts to mainstream themselves, in part through the development of direct-entry certification. I will occasionally refer to the Canadian perspective as a useful lens through which to view the American situation. An intracultural, U.S.-oriented telling would recount this story in its own terms, missing the important cross-cultural and transnational perspectives provided by taking an outsider's point of view. And indeed, the U.S. midwifery story has already been thoroughly recounted from an insider's point of view by Judith Rooks in her comprehensive book

Midwifery and Childbirth in America (1997; see also Donnison 1977, Donegan 1978, Leavitt 1986, Litoff 1978, Wertz and Wertz 1977).

In this chapter I seek to complement Rooks's work through an anthropological analysis that focuses directly on the relationships between nurse- and direct-entry midwives, and on points of time in which their interests either converged or diverged. I seek also to lay out the background information essential for understanding the transformations and divisions in contemporary American midwifery that are key to understanding the other chapters in this volume. Because these stem directly from historical developments, a portion of this chapter will recount that history to identify the evolutionary trajectories of nurse- and direct-entry midwifery that made today's clashes all but inevitable. I will identify some historical moments at which things could have unfolded differently, for therein lies the cautionary part of the cautionary tale: not to seize a moment that could lead to unity is, in effect, to accept and perpetuate the disadvantages of division. But that's not how the key players saw it at the time, and that's not how many of them see it even now. Division has its advantages too, and when midwives of good conscience see more to gain from staying separate than from joining together, those who seek to learn from their experience may wish to understand the reasons why.

A BRIEF SOCIAL HISTORY OF AMERICAN MIDWIFERY

The Development of Nurse-Midwifery

Well into the 1900s, in both Canada and the United States, midwives remained, as they always had been, the primary attendants at childbirth. Native American midwives continued to attend women in their tribal groups, as did colonial midwives among the white settlers, Hispanic midwives in their southwestern communities, immigrant midwives accompanying their ethnic groups, and black granny midwives in the American South. Nevertheless, Canada and the United States are the only two Western industrialized nations in which, by mid-century, midwifery was largely eradicated from the health care system. In the United States, three factors were primarily responsible:

Physician resistance. Starting in the early 1900s, physicians determined to take charge of childbirth, along with public health professionals and nurses, waged systematic and virulent propaganda campaigns against the thousands of immigrant midwives practicing in the northeastern cities, as they were seen to be the greatest threat to physician's attempts to take control of birth. These campaigns employed stereotypes of midwives as dirty, illiterate, ignorant, and irresponsible, in

contrast to hospitals and physicians, which were portrayed as clean, educated, and the epitome of responsibility in health care. In *The Medical Delivery Business* (2004:31), Barbara Bridgman Perkins identifies "economic competition, professional and institutional needs to hospitalize birth [these include resident training], gender discrimination [specialization], and fear that midwife inclusion in the medical system would lead to more government regulation" as primary reasons for obstetric and academic rejection of midwifery.

Lack of professional organization by midwives. In Europe, midwifery developed as a profession with formal education and licensure requirements at a very early stage compared to the United States (DeVries et al. 2001). American midwives of the nineteenth and early twentieth centuries did not develop professional organizations to increase their political effectiveness and set standards and educational requirements. Cultural, socioeconomic, and language barrier contributed significantly; even professional immigrant midwives usually served only their own communities and were often not aware of the existence of other midwives serving other communities one neighborhood away. Other impediments to organization included legal and cultural prohibitions against women regarding public speaking, leadership, finances, and so forth, not to mention the non-existence of formal midwifery training programs in the United States, which resulted from all of the above-mentioned factors. So in spite of the high level of training many immigrant midwives obtained in professional European midwifery programs and their extensive experience, it was easy for the medical profession to portray them as untrained and ignorant, and impossible for them to combat these stereotypes in the wider cultural arena.

Cultural influences on women's choices. Fashion and assimilation played key roles here. As many of the ethnic communities within which midwives had flourished assimilated into the larger culture, they adopted its medical practices and values along with everything else. Minority women actively sought access to medical care in hospitals because the state touted it as the best care for their babies—but had also denied it to them for many years based on segregationist health care policies. Once these women finally gained access to hospitals, many began to perceive the use of midwives as "going backwards" (Holmes 1986:287; Brown and Toussaint 1998; Fraser 1998:103). The kind of culture that had supported midwives disappeared, and along with it the midwives (Borst 1988, 1989, 1995; DeVries 1996:179; Fraser 1995). In addition, from the late 1800s on in the United States, it increasingly became the fashion for middle-class women to employ male midwives and later, obstetricians, as the modern and progressive

way to give birth. After all, male-developed technologies were bringing electricity, telephones, railways, cars, airplanes, vacuum cleaners, and a thousand other progressive and modern conveniences. Male, technological attendance at birth seemed part and parcel of this process of modernization—a way up the social ladder of progress (Wilson 1995).

Throughout the 1800s, midwives attended the majority of births in the United States, but by the middle of the 1900s, marginalized and often practicing illegally, they attended only a tiny minority of births.

In reaction to the propaganda campaigns promulgated by obstetricians, public health officials, and some nurses, nurse-midwives (who were the first to create an organized and cohesive professional system of midwifery in the United States) took great care from the very beginning to act, and to portray themselves, as the opposite of the negative Sairy Gamp stereotype created by Charles Dickens of the fat, lower-class, gin-swilling midwife on her way to a birth carrying a bag of dirty instruments (including catheters to perform abortions). Their mechanism for the elevation of midwifery above this damning stereotype was the union of midwifery with public health nursing. This union was initiated in the United States in New York and in Kentucky in 1925 by Mary Breckenridge, who studied both midwifery and nursing and found the British combination of the two to be ideal to meet the needs of the rural Appalachian poor she had dedicated her life to serve. The successful history of the Frontier Nursing Service (FNS) she founded in Hyden, Kentucky, has been recounted in detail elsewhere (Rooks 1997). Here, suffice it to say that the combination of nursing and midwifery Breckenridge imported also seemed ideal for New York City (see chapter 2), where nurse-midwifery gained a toehold through the establishment (with Mary Breckenridge's help) in 1930 of the Lobenstine Clinic, the nation's second nurse-midwifery service, and in 1931 the site of the first American nurse-midwifery educational program, the Lobenstine Midwifery School (Rooks 1997:38). Both were affiliated with the Maternity Center Association (MCA, still extant today), which played a major role in their development, and both sent their midwives to practice in parts of New York City (Harlem, Hell's Kitchen, the Bronx) that had high rates of poverty and high rates of birth, maternal and infant death, and communicable diseases such as tuberculosis. As would be expected, given the ongoing medical campaign against midwives, the Lobenstine services did meet with opposition from physicians, but were able to overcome it because of their judicious combination of midwifery and public health nursing to meet the needs of a population that physicians had left severely underserved.

Thus, at its very beginning, three important elements of nurse-midwifery's evolutionary trajectory were set: First, nurse-midwives (albeit in very small numbers) overcame physicians' stereotypical thinking and got into the system by being educated as nurses and by serving populations (poor, black, inner city or rural) in dire need that physicians were not attending and did not wish to attend. Second, nurse-midwives managed to stay in the system by consistently demonstrating excellent results, right from the start. Mary Breckenridge's development of the Frontier Nursing Service (FNS) and the excellent care its horseback-riding nurse-midwives provided resulted in a dramatic drop in perinatal death rates in rural Leslie County, Kentucky (Rooks 1997:57). At a time when the national average for maternity mortality was 10.4 maternal deaths per 1,000 births, the maternal mortality rate for Lobenstine births was only 0.9 per 1,000, more than ten times lower (Roberts 1995). Excellent outcomes, often better than those demonstrated by physicians, have continued to characterize nurse-midwife-attended births ever since (see Rooks 1997, MacDorman and Singh 1998, Anderson and Murphy 1995, Murphy and Fullerton 1998, Davidson 2002). Third, as with all women's professions that manage to gain a place in a man's world, nurse-midwives benefited from the start from a small number of physicians who worked with them and supported their development. The nurse-midwives of both the FNS and the MCA collaborated with doctors from the beginning; one of Mary Breckenridge's first acts when she started the FNS was to hire a physician to serve as medical director. In both services the nurse-midwives had consultation available from one or more physicians on call twenty-four hours a day (Kitty Ernst, personal communication). Practicing autonomously, these early nurse-midwives and their supporting physicians developed collaborative models of care that still form an ideal for the CNMs of today.

For the next four decades, nurse-midwives opened a small number of other programs and steadily increased their numbers, albeit at a glacial pace. In 1955, the MCA reported that development was very slow, in part because of "connotations of untaught, non-professional midwifery" (Rooks 1997:39), and recommended greater efforts to overcome this stereotype through basing nurse-midwifery education in universities and standardizing educational curricula and admission requirements (Sharp 1983). MCA's recommendations led to the opening in 1956 of a program in maternal and infant health nursing in the graduate department of Yale's School of Nursing, which established a trend toward gearing midwifery education to the graduate level. By 1958 there were six nurse-midwifery programs in the United States; three awarded non-degree certificates and three offered master's degrees

(Roberts 1995). The graduates of these and other programs that formed served the rural and urban poor in the United States or joined missionary organizations and went to work in other countries; some were employed by the public health departments of various states. Many became leaders in public health and other fields, and the few who entered clinical practice were confined to rural areas where there were no doctors, or to urban areas where doctors did not choose to work (Rooks 1997: 40). From 1925 to 1955, those very few nurse-midwives who managed to work in clinical practice attended births in homes and maternity centers; the only hospital in which they could work as midwives was the Frontier Nursing Service's small hospital in Kentucky.

NURSE-MIDWIFERY'S SHIFT TO HOSPITAL-BASED PRACTICE AND THE FOUNDING OF THE ACNM

The FNS nurse-midwives were spread apart in small, isolated rural communities and were constantly available to the families they served. In 1929, sixteen FNS midwives formed an organization, which in 1941 became the American Association of Nurse-Midwives (AANM).[2] The focus of the early FNS nurse-midwives and their MCA colleagues, with whom they worked closely, was not on building nurse-midwifery as a profession, but rather on providing better maternity care for women and babies (Rooks 1997; Kitty Ernst, personal communication).

In 1944, the National Organization for Public Health Nursing (NOPHN) established a section for nurse-midwives; its members kept data on nurse-midwifery practitioners and educational programs and worked to popularize the concept of family-centered maternity care (Rooks 1997:41). The NOPHN dissolved in 1952 during the formation of two much larger nursing organizations: the American Nurses Association (ANA) and the National League for Nursing (NLN). Unable to create a niche for themselves in one of these new nursing organizations, in 1955 nurse-midwives formed the American College of Nurse-Midwifery (ACNM). ACNM's initial goals included developing educational standards and supporting the development of practices and educational programs, sponsoring research, and participating in the International Confederation of Midwives (Sharp 1983; Rooks 1997:42). In other words, with this organization's founding, nurse-midwives began active and sustained efforts to promote the profession of nurse-midwifery, which its members increasingly understood to be essential to eventual success in the larger cause of providing better maternity care to mothers and babies.

By 1955 when the ACNM was founded, the postwar baby boom had resulted in a dramatic increase in the number of U.S. births, overwhelming obstetric residency programs. A few large inner-city hospitals in New York and Baltimore sought relief by bringing nurse-midwives into their obstetric services. With the resultant shift to hospital-based practice, the nature of nurse-midwifery changed significantly over time: much was gained and much was lost. In these inner-city hospitals, nurse-midwives were able to serve far greater numbers of women than they had previously been able to reach, and to attend women with a wide range of complications, thereby expanding their knowledge base and their practice parameters and improving the care provided to poor women (the latter was their primary motivation). The increasing need for their services in hospitals fostered the development of new educational programs and helped to generate more employment opportunities in public charity hospitals, thereby raising their numbers.

These gains came at the price of the autonomy nurse-midwives had formerly enjoyed. In hospitals, nurse-midwives had to submit to some of the subordination that accompanies the nursing role in order to be accepted by doctors, to adapt to a far more interventive model of care, and to accept far greater medical influence over their educational programs and the loss of homebirth experience for their students (Rooks 1997:45). Nevertheless, the reality was that the hospital was where the vast majority of American women were going to give birth. So complete was nurse-midwifery's move into hospital-based practice that in 1973 the ACNM adopted a Statement on Homebirth, which named the hospital as "the preferred site for childbirth because of the distinct advantage to the physical welfare of mother and infant" (ACNM 1973, quoted in Rooks 1997:67).

From its original inception in 1955, the ACNM proved to be a formidable organizational force. ACNM members realized early on that the key to controlling the nature of their profession was to make sure that the ACNM would be the body to both certify nurse-midwives and accredit nurse-midwifery educational programs, so that it could control education and practice standards. By 1963, thirty-eight years after FNS was founded, there were only about forty nurse-midwives actually practicing midwifery in the United States. Most of the five hundred graduates of nurse-midwifery educational programs worked in nursing or public health, or as missionaries abroad (Judith Rooks, personal communication, 1999). Nevertheless, by 1965 ACNM had developed an accreditation process, and by 1970 was administering national certification and accreditation for all nurse-midwifery programs, a move that gave it enormous standard-setting power to define the boundaries

and the nature of its profession.[3] The ACNM further ensured its control over nurse-midwifery education in 1978 by defining the *core competencies* of nurse-midwifery practice—the fundamental knowledge, skills, and behaviors that are the expected outcomes of nurse-midwifery education (ACNM Education Committee 1979).

At the end of the 1970s, after fifty years of hard work on the part of nurse-midwives to achieve cultural acceptance, set standards, and grow their profession, there were nineteen nurse-midwifery educational programs in operation and nurse-midwives were legal and practicing in forty-one states; all together, they attended only slightly more than one percent of American births (Rooks and Fishman 1980). It was in this context of extreme and continuing marginalization, in spite of their careful and rigorous professionalism, that the nurse-midwives of the late 1970s faced the challenge to the model of midwifery they had worked long and hard to create and solidify posed by the lay midwifery renaissance.

LAY AND DIRECT-ENTRY MIDWIFERY

Out of the cultural ferment of the 1960s and 1970s arose the counter-cultural and feminist movements, which became two powerful mainsprings of lay midwifery. A third generative force was women's reactions to the extreme overmedicalization of birth. In the 1950s thousands of women had begun to speak out in letters to magazines like *Redbook* and *Ladies Home Journal* about the horrors of hospital birth in the United States. From the 1930s to the 1970s, scopolamine was heavily employed. A psychedelic amnesiac that was supposed to take away memory, this drug often did not render women unconscious during birth, but rather made them wild. They were strapped down with lamb's wool bands (which did not leave marks on their arms) and often left alone to scream until the baby finally came; many women were subsequently haunted by spotty nightmarish memories. Technological interventions such as forceps and episiotomies became increasingly common as humanistic care for birthing women became increasingly rare.

Some women reacted by trying to change hospital birth. Consumer demand that hospitals change gave a strong boost to nurse-midwifery during the 1970s and 1980s. CNMs were instrumental in achieving the presence of partners, family, and friends in the delivery room, in the development of the labor-delivery-recovery room, in getting rid of restraints on the mother's arms and the sterile sheets that separated the mother from the baby, and in the growth of unmedicated births and of breastfeeding—so much so that hospitals began to market CNM services to attract patients (Deanne Williams, personal

communication, 2005). Other women opted out of the hospital altogether. The choice to opt out was fostered by the countercultural movement, which offered that choice on multiple fronts, yet many women who made that choice were not countercultural at all. The homebirth mother of the late 1960s and 1970s was as likely to be a childbirth educator or a conservative preacher's wife reacting against a negative hospital experience as a feminist seeking self-empowerment through birth or a hippie rejecting the hegemony of the medical establishment. Then, as now, she was likely to be middle class, which meant in part that she was used to exercising her right to choose. Perceiving little room for choice in the standardized hospital births of the time, women across the country began to decide to give birth at home. Usually unable to find licensed practitioners to assist them, they asked their neighbors, their sisters, their friends. In 1970 the proportion of women giving birth in hospitals reached an all-time high of 99.4 percent, but between 1970 and 1977, the percentage of women giving birth at home more than doubled, from 0.6 percent in 1970 to 1.5 percent in 1977 (Institute of Medicine 1982).

Most of the lay midwives who responded to their call were mothers who had given birth themselves; some were childbirth educators, La Leche League leaders, or nurses who wanted to learn about nonmedicalized birth. Some were members of countercultural communes or intentional communities; some were Christians supporting members of Christian communities to give birth with God's help; some were entirely conventional in all other respects. Although a few of the early lay midwives were nurses who chose to opt out of the medical system, most were largely self-taught. They generally arrived at births with few preconceived notions, learning what they came to know from birth itself (see Gaskin 2003 for a fascinating recounting of this educational process as experienced by the midwives of the Farm in Tennessee). Because birth is a fundamentally successful natural process that turns out well the vast majority of the time, their early experiences of birth were mostly positive ones that generated in these incipient midwives a sense of trust in birth and belief in women's ability to give birth. Their positive experiences of birth were facilitated by the fact that they were attending a primarily middle-class population of women who enjoyed good nutrition and good health.

Understandably, lay midwives' grassroots emergence on the cultural scene horrified many of the nurse-midwives who had worked so hard to set educational standards and gain professional status. Here was the very stereotype they had tried so hard to overcome rearing its head again, this time activated by laywomen, most of whom, unlike those

earlier generations of immigrant midwives, had no formal midwifery training. Occasional reports of the death of a mother or baby at home (despite the fact that babies also died in the hospital) fostered public perceptions that *all* such practitioners were practicing improperly, and nurse-midwives across the county began to take pains to distinguish themselves in the public eye from the lay midwives—an endeavor that usually proved fruitless because the American public did not then, and does not now, have a good understanding of who midwives are or what they do.

While nurse-midwives were concerned by what they perceived to be the lay midwives' lack of training, many were also in awe and sometimes jealous of the untrammeled beauty, naturalness, and woman-centeredness of the homebirths that lay midwives were attending (Rooks 1997:287). Here was midwifery in its pure, nonmedicalized form—women being with women as they gave birth. Photos and videos of radiant women pushing their babies out in the nurturing environment of their own homes, surrounded by family and friends, reminded nurse-midwives of what had been lost with their move into the hospital, and pointed up just how intensely medicalized hospital birth had become. The contrast made some nurse-midwives begin to question whether they were really offering midwifery care, and stimulated a debate over "who is a real midwife?" (Burst 1990).

The homebirth midwives were prolific and productive and quickly began to carve out a cultural space far greater than their small numbers would seem to warrant, in part because their generally countercultural philosophy was shocking, newsworthy, and ultimately critically important to the American cultural scene. The United States owes much of the expansion of its cultural range during the 1990s to the then-radical countercultural movement of the 1960s and 1970s, including the continued existence of homebirth.

Unlike nurse-midwifery, which arose from conscious efforts to develop a profession, lay midwifery was a grassroots movement. Throughout the 1970s, enclaves of lay midwives emerged all over the country, in Santa Cruz, California; in El Paso, Texas; in Boston; on the Farm in Summertown, Tennessee; at the Fremont Women's Clinic in Seattle, Washington; and in many other places. At first unknown to each other, through word of mouth, articles in newspapers and magazines, and eventually the publication of a number of books, they learned of each other's existence and realized they were part of a national movement. Raven Lang's *The Birth Book* came out in 1972 and started the cultural discussion of homebirth. Ina May Gaskin's *Spiritual Midwifery*, first published in 1975, became so popular that the printing presses on the

Farm (an intentional countercultural community that she and her husband Stephen helped found) were kept rolling twenty-four hours a day for four months straight to meet the national and global demand. In El Paso in 1977, Shari Daniels, who had started one of the first private midwifery schools, organized the first national gathering of lay midwives, called the First International Conference of Practicing Midwives. In Oregon, Arizona, California, and elsewhere, these new lay midwives began to get together and form statewide associations; meeting in groups at birth conferences, they began to generate a nationwide social movement.

Some of these early lay midwifery pioneers knew about nurse-midwives and consciously chose to avoid that route because they wanted to practice nonmedical midwifery outside of the hospital. Others practiced for years without even knowing that nurse-midwives existed. At the end of the 1970s, when nurse-midwives were attending around one percent of American births, lay midwives were also attending around one percent of American births. Both groups were very small in numbers, and in spite of nurse-midwifery's fifty-five-year history, both groups were about as culturally unknown and marginal as any group of health care practitioners can be.

Faced with a similar situation, in the early 1980s Canadian lay and nurse-midwives decided to join forces and establish common cause. The difference was that in Canada, neither group was legal and regulated: lay midwives practiced without regulation attending births at home; in hospitals nurse-midwives could only work as nurses (Bourgeault and Fynes 1997). So neither group had anything to lose from an alliance and much to gain, whereas the members of ACNM had already spent fifty years building a legal and regulated profession with a solid organizational base and long-established standards of education and practice in which they deeply believed. Thus many members of ACNM experienced the lay midwifery renaissance as a "gut-level threat" to all that they held dear.

THE FOUNDING OF MANA AND ITS WORK DURING THE 1980s

In 1981, Sister Angela Murdaugh, the incoming president of ACNM, sat in an ACNM Open Forum meeting taking notes on a yellow pad. The topic on the floor was "lay midwifery." At the end of the heated discussion, during which some nurse-midwives expressed a desire to obliterate lay midwives and others took a more moderate stance, the overall message that Sister Angela (a woman of encompassing goodwill) wrote down was that the membership of the ACNM wanted to be "in

dialogue with lay midwives." In response to that message, she invited a few well-known lay midwives, and some nurse-midwives who had started out as lay midwives, to meet 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. Some of them welcomed her suggestion while others were resistant, interpreting organization and standard setting as potential "sellouts to the patriarchy." Nevertheless, it was during that initial meeting called by Sister Angela that the idea leading to the creation of MANA was born. For her trouble, Sister Angela later took a great deal of criticism from various ACNM members, primarily those who identified nursing as the only viable route to professional midwifery. Some thought that she should not have given this kind of impetus to lay midwifery, while others insisted that instead of encouraging lay midwives to form their own organization, she should have urged them to obtain nurse-midwifery education and join ACNM.

Retrospectively, it is clear that decisions made by the ACNM in 1981 and 1982 were crucial to the events that later unfolded. For a brief moment in time, nurse-midwives very likely could have precluded the formation of MANA by opening the ACNM to non-nurse midwifery—a move they did make thirteen years later in 1994. We can imagine that had the leaders of the ACNM chosen to sit down with the lay midwives who came to that 1982 conference and ask them how ACNM might change to accommodate their values and needs, American midwifery today might be one unified profession, as Canadian midwifery has chosen to be. ACNM had already retracted its earlier position on homebirth, coming out in 1980 with a statement endorsing nurse-midwifery practice in all settings (hospital, freestanding birth centers, and homes) (Rooks 1997:182). A bachelor's degree was not a requirement at the time—many nurse-midwives graduated from certificate programs, so that would not have been an issue as it is today. Most of the midwives I interviewed who were practicing as lay midwives during this time have assured me that MANA quite likely would never have been formed if in 1981 ACNM had dropped the nursing requirement and addressed some of the lay midwives' philosophical concerns. Indeed, at that time there were some ACNM members who would have been happy to do so. In Ontario, by 1984 nurse- and direct-entry midwives were able to agree on goals and standards and to achieve unity (Bourgeault, Benoit, and Davis-Floyd 2004). But in the United States, that is not how history unfolded. The consensus among my ACNM interviewees is that ACNM would have been split in two by any such decision. Its current president, Katherine Camacho Carr, asks, "Did we

want revolution or evolution? We chose evolution" (personal communication 2005).

So instead, during the 1982 ACNM convention in Lexington, Kentucky, a group of like-minded lay and nurse-midwives gathered in a hotel room to charter an organization that would give them and their "sisters" a sense of group identity and common cause. Some of them expected this to be an American organization; initial names they played around with included the "American Midwives Association" (AMA(!)) and the "National American Midwives Association" (NAMA—a bit too chant-like). The American midwives present at that meeting were keenly aware of the transnational nature of the grassroots movement they represented, and wanted to include the midwives they thought of as "their sisters" in Canada and Mexico, so the Midwives' Alliance of North America (MANA) was born. (This name was originally suggested by Fran Ventre, a former lay midwife who had become a CNM, and whose practice and ideology have ever since bridged the gap between the two. For more detail, see Schlinger 1992:14–27.)

Given the lack of consensus about change on ACNM's part, most of the midwives who created MANA could see no advantage to becoming nurse-midwives and joining ACNM because they believed that nursing training should not be a requirement for midwifery. In fact, they saw it as fundamentally detrimental to midwifery to require that midwives become nurses first, because they deeply believed in the value of a non-medicalized approach to birth. Past MANA vice president Anne Frye explains:

> As 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. (Personal communication 1998)

Throughout the 1980s, the women who started out in the late 1960s and early 1970s as lay midwives educated themselves, attended births, trained apprentices, and further developed a unique body of knowledge about out-of-hospital birth, eventually codifying it in books and articles (for examples, see Bruner et al. 1998; Frye 1996, 2005; Davis 1997, 2004; Gaskin 1990, 2003). They joined together to create core

competencies and standards for practice, to lobby for workable legislation, and to create educational programs and state certification processes. In the mid-1980s they created an International Section of MANA consisting of midwives licensed in their states, which, despite ACNM's opposition, qualified for membership in the International Confederation of Midwives (which accepts as members only national groups whose members are government-recognized). They thrived in spite of the ill wishes and often-active persecution of the medical establishment and developed a powerful Statement of Values and Ethics that fully encapsulates the principle elements of their shared beliefs about birth.[4] As all this was being accomplished, MANA members, like the members of ACNM, gained a vested interest in preserving what they had worked so hard to create.

Over time, MANA became the spearhead of a movement powerful beyond its small numbers because of public support from the dedicated and numerous members of the alternative childbirth movement. In this effort, MANA has been continuously bolstered by support from many nurse-midwives: nurse-midwives participated in MANA's inception in that hotel room in Lexington, one-third of MANA's membership has always consisted of CNMs, and a number of CNMs have for many years trained direct-entry apprentices and taught in direct-entry programs and schools. Approximately 300 of ACNM's members belong to MANA, and a significant number of nurse-midwives were direct-entry midwives before they became CNMs; many of them retain an orientation to independent, out-of-hospital midwifery. The divisions between these organizations exist in spite of, and not because of, their multiple interlinkages and the extremely cooperative relationships of their members at the grassroots community level in some regions (Davis-Floyd 1998a).

The possible development of national certification was a subject for discussion at the annual MANA conventions as early as 1985. At the time, many MANA members were highly suspicious of such a potentially exclusionary move. From the start MANA defined itself as an inclusive organization, one that exists, ideally and ultimately, to represent all midwives. Unlike ACNM, which admits to voting into membership only midwives certified by the ACC (see note 1) and students enrolled in ACNM (DOA)-accredited programs, MANA then and now allows anyone who calls herself a midwife to become a voting member. Its inclusivity means that MANA cannot qualify as a professional organization in the usual sense; although its members developed core competencies, unlike ACNM, MANA could not enforce them as educational requirements. Nor could MANA ensure consistency or set national standards

for the many mentors training apprentices or for the educational programs its members developed, which tended to vary widely in scope and quality. So although some state midwifery organizations did develop rigorous credentialing programs, MANA members entered the 1990s wide open to the accusation, often leveled at them by physicians and nurse-midwives, that they had no national mechanism for protecting the public: in most states anyone could "hang out a shingle and call herself a midwife," regardless of her background or training. Compounding the problem, the lack of such a mechanism was hindering midwives' fights for legalization in many states.

THE CARNEGIE MEETINGS OF THE INTERORGANIZATIONAL WORK GROUP

During this time of flux in MANA's development, the Carnegie Foundation for the Advancement of Teaching sponsored a series of meetings between representatives from the ACNM and MANA; the meetings led to the creation of an Interorganizational Work Group (IWG) charged with trying to unify midwifery and thus to jumpstart its growth. During these meetings (1989 through 1994), the MANA and ACNM representatives compared their core competencies and deemed them to be equivalent. This equivalence resulted in part from deliberate efforts on the part of MANA members during the 1980s to model their core competencies on those of ACNM, in hopes of facilitating an eventual convergence. But by this time, the philosophical divides between the two organizations were too deep. MANA had worked for a decade to develop and to appreciate the value of its body of knowledge about out-of-hospital birth, and one of its prime purposes had become the preservation and perpetuation of that body of knowledge in unadulterated form. And MANA members had plenty of time to crystallize their awareness of the value of apprenticeship training and the critical role it plays in the preservation of homebirth midwifery knowledge.

The early, largely self-taught lay midwives soon began to train others in the time-tested system of apprenticeship. Extensive interviews with MANA midwives have led me to understand the importance they continue to attribute to apprenticeship. From their perspective, apprenticeship is more effective in fostering trust in the natural process of birth and in women's ability to give birth than any other educational system. Following a practicing midwife from home to home, the apprentice experiences women in the fullness of their individuality, rather than in the altered and often subjugated identities forced on women in hospitals. The apprentice smells, touches, sees, hears, and

engages in birth at its most powerful and elemental, and for the most part witnesses woman after woman successfully giving birth with little or no technological intervention. She experiences the natural rhythms of birth, resonating with their ebbs and flows, and learns to avoid judgments about labor progress based on time charts, machines, and institutional routines. In such a context, her intuitive skills are honed. Reliance on intuition and trust in women's innate ability to give birth facilitate homebirth midwives' special ability to "normalize uniqueness" (Davis-Floyd and Davis 1997)—to make decisions based not on standardized measures but on what works for an individual woman at a given time and place. In short, everything important about the homebirth midwifery approach is most thoroughly and effectively transmitted through the intensely personal and committed relationship of mentor and apprentice. Thus apprenticeship remains far too important to MANA's essence and philosophy for its members to be willing to give it up as an educational pathway. The preservation of the choice to become a midwife through apprenticeship is as important to most MANA members as the choice to give birth at home, and so the MANA members of the IWG declared that it was impossible for them to compromise on this educational issue.

Given their long history of valuing university education, it was equally impossible for the ACNM members of the Carnegie group to accept pure apprenticeship. Leveling accusations of fostering illiteracy and ignorance among midwives at the MANA representatives, they decided that reaching effective agreements with them was also impossible. From the ACNM's point of view, it was disempowering to women to offer them a professional career that included study worthy of a university degree that did not result in that degree. Their focus was, as it had always been, a pragmatic one (see chapter 2): university degrees are what work in the wider society. From their perspective, apprenticeship, for all its sentimental value, implied the lack of a culturally valued education, as did the vocational schools that some MANA members had established. (For a comparison of apprenticeship, vocational, and university-based methods of educating midwives, see Davis-Floyd 1998b; Benoit et al. 2001.) Whereas the MANA midwives saw these private vocational programs as places where their brand of midwifery could be fully preserved, unadulterated by the hegemonic influences of university education, to the ACNM representatives, they were no more than "trade schools," an educational model they saw as hopelessly out of date. Ultimately the ACNM and MANA representatives to the Carnegie IWG settled on agreeing not to agree. They passed a statement acknowledging that there are different types of American midwives with overlapping

scopes of practice, and ended the Carnegie dialogues in 1995. And so another chance for unity in American midwifery was lost.

APPRENTICESHIP IN CANADA AND THE UNITED STATES

A bit of transnational comparison is in order here. Preserving apprenticeship was also a heartfelt desire of many of Ontario's lay midwives as they began to work for legalization in the early 1980s; they understood its value, as it was the manner in which most of them had been trained. In the end they adopted a pragmatic approach. They realized that neither the nurse-midwives, with whom they were in dialogue about alliance, nor the Ontario government, would accept anything less than university education as a bottom-line prerequisite for midwifery licensure. So they compromised, accepting university education but insisting that it be at the baccalaureate and not the postgraduate level, and that the community apprenticeship model form a major component of the baccalaureate program.[5] Today's Canadian midwifery students begin clinical training under a modified apprenticeship model from day one of their university education, following individual women through complete courses of care (see Kaufman and Soderstrom 2004; Bourgeault, Benoit, and Davis-Floyd 2004).

American nurse-midwives also value apprenticeship and have sought to incorporate it into their university programs in the form of clinical preceptorship. But unlike the Canadian model, university-based student nurse-midwives in the United States generally find their training split among the pre-, intra-, and postpartum periods, during which they often work in different sites under different preceptors. In contrast, this sort of split tends not to characterize the clinical training of American nurse-midwives enrolled in distance learning programs, which are university affiliated but allow students to remain at home studying didactics on computer, then spending a year in a preceptorship with a nurse-midwife who practices in the student's community.[6] This training is community based, allowing students to remain at home instead of having to leave their families to study in a university setting. It splits didactic and experiential learning, not only in place but also in time—students spend one year studying didactically at home before they enter their clinical preceptorship. Their clinical experience is gained almost entirely on an in-hospital basis, just as the training of direct-entry midwives (except CMs) takes place almost entirely out-of-hospital. In contrast, all Canadian midwives trained since passage of the new legislation in various provinces attend births in all settings

throughout their training, and are then able, qualified, and supported by law and insurance to attend births in any setting. This is clearly a superior model for birthing women, as it allows them a full spectrum of choice and continuity of care along that spectrum, and for midwives, who are not limited by site of birth as they are in the United States. The practicality and success of this model is one of the reasons for the present rapid growth of midwifery in Canada (Bourgeault, Benoit, and Davis-Floyd 2004).

THE LATE 1990s: CONVERGENT TRENDS

The Carnegie IWG meetings, intended to generate dialogue and ideally to foster unity between MANA and the ACNM, ultimately deepened their divisions. I can imagine a different outcome only if these Carnegie meetings had taken place at a different time. Within a few years of their ending, certain unstoppable trends somewhat lessened the distance between lay and nurse-midwifery. These trends were visible at the time of the IWG meetings, but much less so than they were a few years later. In hindsight, one can see that a better understanding of these trends and their implications might have softened the Carnegie dialogues and opened up wider possibilities for collaboration. These convergent trends, which intensified throughout the 1990s and early 2000s, include:

1. A trend among MANA members toward the growth and improvement of formal direct-entry educational schools and programs. There were only a handful of such schools during the 1980s; today there are approximately twenty. These formal vocational schools combine a strong apprenticeship/preceptorship component with didactic classes, and are increasingly popular with a younger generation of direct-entry midwifery students most comfortable with formalized curricula, as long as what is taught is the out-of-hospital, holistic midwifery they seek. This trend was clearly visible during the Carnegie meetings, as by 1991, MANA educators had created the Midwifery Education and Accreditation Council (MEAC) (see note 1) to evaluate and accredit direct-entry educational programs. MEAC's stated mission was and is to improve the quality of direct-entry midwifery education, as well as to support innovative and diverse midwifery education programs, including apprenticeship. But at the time of the meetings, MEAC's work had barely begun. By 1999, MEAC had accredited ten of twenty existing programs, close to the number ACNM had accredited by the late 1960s (Davis-Floyd 1998b; Tritten and

Southern 1998, 2003; www.meacschools.org). In 2000, MEAC received federal government recognition as an accrediting agency for direct-entry midwifery schools from the U.S. Department of Education (DOE). ACNM's DOA had received DOE recognition as an accrediting agency for nurse-midwifery programs in 1982, and in 2001, the DOA was also recognized by the U.S. DOE as an accrediting agency for direct-entry (CM) programs. In other words, the United States government recognizes both MEAC and the DOA as being qualified to accredit direct-entry programs. This recognition entitles MEAC- and DOA-accredited programs to participate in the Title IV government funding program for student education, and ensures that graduates of such programs meet the international definition of a midwife, which requires graduation from a government-approved program. DOE recognition of both MEAC and the DOA has proved a powerful equalizer of the value and legitimacy of the education of both the CPM and the CM. In addition, as of January 2005, five of the twelve MEAC-accredited programs are degree-granting, further blurring the formerly distinct separation between ACNM's emphasis on university programs and MANA's lack of concern with them.[7]

2. A trend among MANA members toward the formalization of apprenticeship and its expansion as a learning system. In many cities, senior midwives take turns teaching weekly classes for all of their apprentices, adding a didactic element as part of the traditionally experiential apprenticeship. In addition, the Midwives College of Utah, the National Midwifery Institute, and the National College of Midwifery have developed 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; these became the first apprenticeship programs to receive MEAC accreditation. A charge often leveled against apprenticeship training is that it produces midwives who have very little experience with complications. This is less and less true: today most apprentice-trained midwives spend some months in a high-volume program where they can learn how to deal with multiple complications. Most apprentices study with at least two mentors, have completed relevant college-level courses, and participate in numerous continuing education programs given by nationally recognized experts (Jo Anne Myers-Ciecko, personal communication, 2005).

These two trends on the MANA side (the growth of formal direct-entry programs and the formalization of apprenticeship) are paralleled on the ACNM side by two equally significant developments:

1. ACNM's embrace in 1994 of the notion that one does not have to be a nurse before becoming a midwife, encapsulated in their creation of the CM (see chapter 2)—an idea that the lay midwives of the early 1980s tried to convey to nurse-midwives without success.
2. The massive expansion of ACNM's distance learning programs, which today graduate the majority of new nurse-midwives and are thus largely responsible for the rapid growth in the numbers of CNMs (see note 6). These programs are affiliated with a university and require a bachelor's degree for entry, but they do not require a move to a university campus. They allow the student to remain at home, studying didactic components on computer and in books, and learning clinical skills through one-on-one preceptorship with a practicing midwife in her community. Thus they foster a community-based approach to midwifery that has long been a MANA priority, and the educators who develop their curricula are freer than they might be on campus (where they are likely to be located inside of nursing or medical departments) to do so under a holistic, woman-centered midwifery philosophy. In addition to the benefit of being able to work with their preceptors in their geographical communities, students also report benefiting from the sense of community established through the periodic get-togethers of students and staff, and regular online communication. Nurse-midwives' development of these distance learning programs, which now graduate more students annually than resident university-based programs do, thus represents a trend toward convergence with more MANA-like educational philosophies and styles.

I will address further convergent trends, but let me mention one that is stylistic and very evident to the anthropological eye. The first MANA conferences I attended, beginning in 1991, were, in a word, flowing: time and schedules seemed not of the essence, sessions tended to be informal, openings and closings involved rituals, candles, poetry, and dance, many stories about beautiful births were told, and continuing education unit (CEU) forms were not much of an issue. In contrast, the first ACNM conferences I attended were far more formal, contained many more sessions about medicalized aspects of birth and women's health care, confined dancing to the Wednesday night party, and included rigorous requirements for the submission of CEUs. Since

then, while MANA conferences continue to constitute "a dip in the holistic spring," many sessions are highly professional, schedules are more closely kept, and requirements for sessions have been standardized because licensed and certified homebirth midwives now also have ongoing CEU requirements to meet. ACNM conferences, while still very formal, now include storytelling sessions, sometimes dance and poetry at opening sessions, and more attention to the spiritual and intuitive aspects of birth. From what I can tell, these stylistic shifts within each organization stem, to some extent, from the influence of each on the other.

During the 1990s and early 2000s, MANA became a bit more like the ACNM, and the ACNM became a bit more like MANA. These convergent trends have not resulted in unification, as they did in Canada, because the ideological divisions between the groups over education are still deep, and in recent years have expanded to include differences in scope of practice. (The core competencies of both groups were declared equivalent during the Carnegie meetings, but subsequently, based on task analysis of what CNMs were actually doing, ACNM revised its core competencies to encompass gynecological practice and primary health care for women. MANA's core competencies remain focused on the childbearing year.) Nevertheless, these convergent trends represent increased possibilities for mutual respect, communication, and understanding across the ideological divides.

A fourth potential force for convergence has been a distinct trend among MANA members toward the professionalization of lay midwifery, including setting standards for the accreditation of educational programs and the professional certification of direct-entry midwives. During the Carnegie meetings, the dialogue was between one group of midwives who embraced professionalism in all its exclusivity and equated it with university training, and another group whose members were deeply ambivalent about calling themselves professionals and vehemently disagreed that to be a professional, one had to have a university degree. Some aspects of that situation have shifted, as the following section describes.

FROM LAY TO DIRECT-ENTRY: THE DEVELOPMENT OF THE CERTIFIED PROFESSIONAL MIDWIFE

By the early 1990s the word *professional* was a subject of much discussion in MANA, and the lack of consensus among MANA members on the appropriateness of its use was yet another source of tension in the Carnegie/IWG meetings. The nurse-midwives thought professionalism

to be integral to the nature of midwifery, while the MANA midwives worried that calling themselves professionals would be too exclusive and hierarchical. But in spite of these doubts and the reluctance of the MANA IWG members to embrace the word, MANA midwives were increasingly feeling the need for a mechanism to prove the professional competency they had been developing. These midwives, whom the ACNM still characterized as *lay*, were feeling, acting, and running businesses like professionals. Their desire to rid themselves of the connotations of ignorance and lack of training encompassed by the word *lay* led them, during the early 1990s, to initiate efforts to drop that label in favor of the more professional term *direct-entry*. In Europe, this term had long been used to describe formal, government-recognized midwifery education that did not require nursing training as a prerequisite; MANA midwives, apparently beginning with MANA members in New York state (see chapter 2), adopted and transformed the term to mean simply that one enters any kind of midwifery education directly, without passing through nursing first.

During the Carnegie IWG meetings, the nurse-midwife participants repeatedly hammered on MANA's lack of educational requirements and general inability (beyond licensure in certain states) to evaluate the competence of its members. Their criticism came at a time when this call was being more loudly heard from MANA members themselves. Their transformation during the 1990s from lay to direct-entry midwives was paralleled by their increasing desire for a professional credential that would validate their knowledge of midwifery and help them interface with the medical system. (Those who had been the victims of medical persecution report being "forced" to this conclusion.) Problems generated by a few midwives who did practice without essential skills clarified the need for a common and established base of knowledge and skills, and for clear mechanisms for peer review and professional discipline (Pam Weaver, NARM board member, personal communication 1998).

The strong desire for such a credential on the part of many MANA members was paralleled by great concern that the uniqueness of the form of direct-entry midwifery they had been developing would become co-opted in the process of professionalization, which involved certain kinds of standardization. Concern about co-option led to the gradual step-by-step development of certification, as consensus had to be reached at each step.[8] After initial development of an examination and a national registry of those who had passed it, by 1994 MANA's daughter organization NARM had expanded into a full-fledged testing and certifying agency, designing, developing, and implementing the

Certified Professional Midwife (CPM) credential. (For more detail about this process, see chapter 3, this volume; see also Houghton and Windom 1996a, b; Rooks 1997: 248–252; and Davis-Floyd 1998a.)

CPM certification is competency based; *where* a midwife gains her knowledge, skills, and experience is not the issue—the fact that *she has 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. Thus the major criticism that ACNM educators level at NARM certification is that it does not require completion of a formal educational program. The NARM process has been streamlined for graduates from MEAC-accredited programs and from programs accredited by the ACNM's Division of Accreditation (DOA) (see note 1), but it is and will remain open to anyone trained by any method who can demonstrate that they meet NARM's entry-level requirements.

Here we find the crux of the philosophical differences involving educational issues that divide these two organizations. Although CPM certification can be obtained through formal educational programs, NARM board members do not accept the argument that formal, standardized education is essential for creating safe and competent practitioners. Citing recent trends in adult education in other fields, they stand behind competency-based education, and have designed a certification that can accommodate both midwives who graduate from formal programs and those who trained as apprentices. For the latter, CPM certification includes what is known in adult education as a *portfolio evaluation process* (nicknamed PEP). 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 seventy-five prenatal exams, attendance at twenty births as an active participant and twenty more as primary caregiver (a minimum of ten of these births must be on an out-of-hospital basis), and so forth, as listed in the NARM publication *How to Become a CPM* (available at www.narm.org). Knowledge is tested through the NARM written exam. The skills of apprentice-trained midwives are verified in two ways: the candidate's educational supervisor(s) or mentor(s) must attest that she has achieved proficiency in 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.

In contrast, to be eligible for certification by the ACNM Certification Council (ACC), a student must graduate from a DOA-accredited educational program and pass the national ACC exam, which tests knowledge but not skills; these are attested to by the student's educational preceptors. While there is increasing variety among DOA-accredited programs, which now range from university- to community-based, all of them stress a system of knowledge based on in-hospital practice. Fewer than two percent of ACNM's members attend homebirths; most CNMs are prevented from doing so by state laws requiring physician supervision and/or the refusal of insurance companies to provide coverage for homebirth. Thus it is not surprising that MANA members feel so strongly that the preservation of the homebirth option is almost entirely up to them. They see their knowledge base as overlapping with that of the CNMs, but as fundamentally different, and they have designed their certification to preserve that knowledge base and their midwifery model of care[9]—a holistic approach to childbirth practiced by the first generation of midwives who founded MANA in 1982; in the same year, this midwifery model of care was, for the first time, fully described in writing by sociologist Barbara Katz Rothman in *In Labor: Women and Power in the Birthplace* (1982).

ACNM, THE DEVELOPMENT OF THE CERTIFIED MIDWIFE (CM), AND MANA'S RESPONSE

Of course, MANA midwives are not alone in laying claim to the midwifery model of care, as nurse-midwives also use this term to describe the woman-centered alternatives they offer in the hospital (Paine, Dower, and O'Neil 1999; Rooks 1999). And, as we noted above, MANA midwives are not alone in thinking that linking nursing with midwifery may at this point be causing more problems than it solves. Some influential members of the ACNM have been calling for its expansion into direct-entry education since the 1970s, believing that midwifery should be a unique, autonomous, and independent profession separate from nursing.

By the time of the Carnegie IWG meetings in the early 1990s, the dialogue within ACNM about the need for a direct-entry certification and new direct-entry educational programs was intensifying. The issue was brought to a head by events in New York state, where nurse-midwives in 1992 had achieved passage of the New York Midwifery Practice Act (see chapter 2). One of the conditions they had worked hardest to obtain was state acceptance of a new direct-entry certification. Now such a certification had to be developed, a void that ACNM could rush

to fill or that could be left to New York state to develop on its own. Perceiving their window of opportunity, the proponents of direct-entry certification within the ACNM moved quickly to educate their membership about the reasoning behind a move into direct-entry certification.

Precedents for minimizing the role of nursing education in nurse-midwifery programs had been established in the 1970s with the development of a three-year masters' level program at Yale University (whose driver and visionary was Helen Varney Burst) that allowed a fast track through one year of nursing into two years of midwifery education. During the 1980s, several other such programs were developed. These programs stood in contrast to what had been the standard route: two to four years of nursing education, followed by several years of clinical practice as a labor and delivery nurse prior to applying to a nurse-midwifery education program. It was common in nursing programs to hear criticisms of midwifery students who did not practice labor and delivery nursing "long enough," as there still exists a belief among nurses that it takes years of practice to make one "a real nurse," and that extensive obstetrical nursing experience is a necessary precursor to midwifery training. Many within ACNM highly value their identity as both nurses and midwives and were vehemently opposed to creating a direct-entry route. Colloquially known as the "old guard" by direct-entry proponents, these nursing-oriented midwives resisted the development of the CM. But nurse-midwifery educators seeking more rapid growth for their profession realized that many students who wanted to become midwives did not want their lives "derailed" by a lengthy passage through nursing.

Other factors that influenced ACNM's move into direct-entry education and certification included the following: (1) the increasingly strong role identification felt by many CNMs with midwifery and not with nursing ("I am not a nurse, I am a midwife!" is a statement I have heard countless times during my interviews with CNMs; see also Scoggin 1996); (2) a desire for more autonomy coupled with resentment over regulation by state nursing boards, whose interests and priorities sometimes conflict with those of nurse-midwives; (3) the fact that physician assistants[10] with little obstetrical training had begun to attend births in some states (Burst 1995); these PAs needed to be able to obtain midwifery training but had already received all the basics of nursing training, which they should not be required to repeat; and (4) the realization that only specific aspects of nursing knowledge are relevant to providing quality midwifery care, and that this knowledge can be obtained outside of nursing education (Rooks 1998). In addition, although NARM was already in the process of creating a national

direct-entry credential, many CNMs did not believe that NARM would set standards they could support. 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, the year that NARM certified its first group of CPMs, ACNM members voted overwhelmingly for the ACC to create a direct-entry certification process and for the ACNM DOA to develop a process for accrediting direct-entry educational programs. In 1995 they chose Certified Midwife (CM) as the name of this new type of practitioner. In 1996, the first educational program leading to the CM (at State University of New York/Brooklyn in New York City) was preaccredited by the DOA; and in May 1997, when the first graduates of this program were anticipated to emerge, ACNM passed a resolution making this new CM a full-fledged voting member of the college. Only DOA-accredited university-based programs and university-affiliated distance learning programs lead to the CM credential.[11] 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).

Eleven years after the 1994 ACNM vote to create the CM, SUNY Brooklyn (colloquially known as SUNY Downstate) is still the only DOA-accredited direct-entry program currently operating. It graduates approximately five students per year (approximately thirty-five students to date). (Other programs are under discussion, but lack of appropriate licensure and hospital privileges in all other states discourages their development).[12] CMs can presently be licensed as equivalent to CNMs in New York and New Jersey (except that in New Jersey they do not have prescriptive privileges as they do in New York). (To summarize the regulatory and practice variations in each of the states, the ACNM publishes *Direct Entry Midwifery: A Summary of State Laws and Regulations*, which is updated annually.) Nationally speaking, ACNM leaders and educators have not yet thrown their legislative support to this new CM certification, which has spoken strongly to issues in New York but has not seemed all that relevant to CNMs' concerns in other states (see chapter 2).

Many ACNM members felt that in accepting the CM, they were "opening up" their profession, generating the potential for easier ingress to all those who want to be midwives but don't want to be nurses. Thus some in ACNM felt more than justified in believing that ACNM should be the one and only national midwifery organization.

Insisting that having two national organizations only divides and weakens midwifery, they believed it would be best for midwifery if MANA members would rally around ACNM's new direct-entry standard.

In contrast, MANA members at the time did 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 (homebirth) direct-entry midwifery. As soon as ACNM's plans for creating the CM became known, those in MANA who equated 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 the meaning of *direct-entry*, their chosen label. 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 homebirth background teaching direct-entry students would be like direct-entry midwives suddenly deciding to open nurse-midwifery programs within hospitals. 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 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. Of course, ACNM never intended to create the same kind of direct-entry midwifery practiced by

MANA members, but rather is modeling its direct-entry educational programs on its existing nurse-midwifery programs.

In this chapter I have recounted several historical moments that could have led to increased unity in American midwifery but instead resulted in increased division. Another such pivotal moment occurred in Seattle in 1995. The Director of ACNM's Division of Accreditation (DOA) was paying a courtesy visit to the Seattle Midwifery School (SMS) shortly before the DOA was to meet to develop criteria for accrediting direct-entry programs. SMS was one of the first (vocational) direct-entry midwifery programs to be created in the United States, in 1978. The quality of its faculty and curriculum had earned it the respect of ACNM leaders, and much discussion had ensued around the possibility that the DOA would set accreditation criteria that SMS could meet. Then, the expectation went, SMS could arrange the requisite affiliation with a university and apply to the DOA for accreditation. DOA accreditation for SMS would mean that its graduates would be eligible to sit for the ACC exam and become certified as CMs. This development would have made SMS a major point of convergence between ACNM and MANA, would have increased student enrollment at SMS because education there would lead to either the CPM or the CM credential, and would have enabled SMS to establish relationships with hospitals and to offer hospital-based clinical training to its students along with their traditional out-of-hospital training. DOA accreditation for SMS would mean that direct-entry students with baccalaureate degrees could receive a holistic and feminist-oriented midwifery education, with out-of-hospital experience, in a private school with a strongly holistic midwifery model orientation.

Thus there was a great deal of excitement at SMS around the DOA director's visit. Things seemed to go pleasantly during her tour of the school, after which a small group settled down for tea. During that conversation, according to my interviews, the DOA director made a comment about MANA's choice (in October 1994) of the title Certified Professional Midwife—this was the name some had long thought would be used for ACNM's new direct-entry midwife, but by pure happenstance, MANA's Certification Task Force meeting to choose the name had occurred a few months before ACNM's meeting. The DOA director's comment was something to the effect that she wondered if this had been a challenge? The atmosphere was light, and SMS's director of education (jokingly, in her mind) responded, "Well I guess so!" A strong misunderstanding ensued, which seems to have affected the DOA's decisions to set standards for the accreditation of direct-entry programs that SMS could not meet. (These standards included the

requirement that full-time faculty in such programs had to be either CNMs or CMs—something SMS could not achieve without changing its staff.) Feeling "betrayed" and "bitterly disappointed" by this DOA decision, the SMS staff turned the energies they would have devoted into convergence with ACNM toward MANA, NARM, the promotion of the CPM, and the development of MEAC. (Two SMS staff members became long-time members of MEAC's board and were instrumental in MEAC's achievement of DOE recognition.) And so, apparently because of a miscommunication resulting in ill feelings, another opportunity for increased midwifery unity was lost. Some ACNM leaders who had been hoping to choose CPM as the name of their new direct-entry credential felt that this choice by MANA was "a slap in the face" (it was not, as we shall clearly see in chapter 3). This example is but one of various miscommunications I could describe between ACNM and MANA members that illustrate how easily misunderstandings can result when ideological differences make every communication fraught.

In contrast to the feelings of many of MANA's direct-entry members, others, 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 the certification into existence. And they will have to face down opposition from state agencies, legislatures, and nursing and medical associations all over the country if they fight to obtain legal status for the CM in all fifty states.

ACNM has risked much and may risk more in the future to achieve its vision of an expanded and more autonomous midwifery profession. The mere existence of the CM has already had a profound conceptual effect. As soon as the CM was accepted as a full voting member of the college, Helen Varney Burst changed the name of her leading midwifery textbook from *Varney's Nurse-Midwifery* to *Varney's Midwifery;* the name of the ACNM journal was changed from the *Journal of Nurse-Midwifery* to the *Journal of Midwifery and Women's Health.* In addition, those most in support of letting go of the name *nurse-midwife* generated a serious movement within the college to change its name from the American College of Nurse-Midwives to the American College of

Midwifery. The proposal was put to a mail ballot in 1998. The fact that it did not pass seemed to indicate that the majority of the membership was not willing to let go of their identities as both nurses and midwives.

THE CONTEMPORARY STATUS QUO

Since the mid-1980s, nurse-midwives have been legal, licensed, regulated, and able to obtain insurance coverage from private companies and Medicaid in all fifty states and the District of Columbia. In February 2005 the total membership of the ACNM was around 7,000 and the voting membership was 5,411. Forty DOA-accredited nurse-midwifery (and one direct-entry) educational programs are currently in operation, graduating approximately 300 students each year (see www.acnm.org for the latest information). There are approximately 6,000 CNMs (about 25 percent of CNMs do not belong to the ACNM) and fifty CMs in active practice; exact figures are not available. Most CNMs stay in practice for an average of five years, earning salaries that average $65,000 per year. Most work in group practices that enable them to keep a reasonable work schedule and take time off for their families.

No one knows exactly how many non-ACNM direct-entry midwives are in practice across the United States; because many of them do not belong to MANA, they are difficult to count. My best estimate (based on informal surveys I have conducted) is that the number of state-licensed or nationally certified DEMs in the United States is around 2,000, while there are approximately 1,500 "plain" midwives who have neither state licensure nor national certification. MANA's total membership in February 2005 was 882 and its voting membership was approximately 750; 145 (around one-fifth) of these were CNMs and 287 were CPMs (most CPMs and many state-licensed midwives belong to their state organizations rather than MANA) (Nina McIndoe, MANA membership chair, personal communication 2005). Independent direct-entry midwives are legal, regulated, and licensed, registered, or certified in twenty-one states (over 700 DEMs practice in these states) and have varying status in the others (see www.narm.org for the latest information). Their services are covered by private insurance companies in most states where they are licensed, and by Medicaid (and sometimes managed care) in eight states. (In many other states licensed midwives are fighting for Medicaid and managed care coverage with varied results. In most states, homebirth attended by direct-entry midwives is still an out-of-pocket expense.) Most direct-entry midwives practice solo or in partnership with one other midwife; they are often constantly on call. Their annual incomes vary widely,

according to the number of births they attend. Many make under $20,000 per year; a few make over $100,000.

In January of 1995, there were twenty-five CPMs. By June of 1998 there were approximately 400 CPMs; as of December 2005, there were 1,095—an average growth of 100 per year. (Today, one out of seven practicing midwives is a CPM.) All twenty-one states where direct-entry midwifery is "legal" use some or all of the CPM process as a requirement for licensure (www.narm.org). The CPM was conceived and created as an international certification. At present, there are forty-five CPMs in practice in Canada, four in Mexico, and one each in France, Ireland, South Africa, and Hungary. The CPM application process has been streamlined for United Kingdom midwives and may eventually become an option for midwives in the European Union who wish to practice in the United States or elsewhere, and who can document attendance at the requisite number of out-of-hospital births.

In the United States for the past two decades, ninety-nine percent of births have taken place in hospitals, with planned homebirths accounting for less than one percent of all births. Data from 2000 distributed by the National Center for Health Statistics show out-of-hospital births holding at .9 percent. That percentage is higher in Oregon (around six percent) and may rise in Florida, Washington, New Mexico, and other states where midwifery is legal and well integrated into the system, but on a national level it is still minuscule. While many decry this low figure, Ina May Gaskin, past president of MANA, points out that this low percentage of homebirths:

> 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 homebirth 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 homebirths will rise, not fall, during the years to come. We see the sixfold increase in homebirths 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)

In fact, most of American midwifery is still a "best-kept secret." The medical monopoly in the United States remains firmly in control of birth: physicians attend around ninety percent 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 8,000 or so practicing midwives, who cumulatively attend a mere nine percent of American births, [13] are still profoundly marginal in relation to the 35,000 or so obstetricians (and other doctors) who attend the rest. In this context, it might make sense for MANA and the ACNM to face the future battles they must fight for their continued existence by presenting a more unified front. After all, in various Canadian provinces nurse- and direct-entry midwives have come to agreement and unity by focusing on their shared values on woman-centered care and practice in all sites, a value that MANA and ACNM members also share.

In contrast to the Canadian situation, the divisions American midwives continue to face in part are created and defined by the philosophical divide between home- and hospital-based attendance at births. Although nurse-midwifery educators do make concerted efforts to stress the importance of minimizing interventions, hospital practice has had its effect: birth certificate data from 1997 showed that nurse-midwives use of technological interventions was rising at the same rates as obstetricians (Curtin 1999). This rise does not mean that nurse-midwifery care is not woman-centered: many American women expect and request interventions such as electronic monitoring and epidurals (Davis-Floyd 2004), and many nurse-midwives arrive at the realization that "woman-centered care" can mean meeting such requests.

Obviously, homebirth midwives are buffered from the medicalizing influences of such demands. Canadian midwives, who formerly practiced only at home, are finding themselves under increasing pressure to medicalize as they move more and more into hospital practice, serving a clientele that is less and less ideologically aligned with the spirit of the homebirth movement (Daviss 2001, Sharpe 2004). Ideally, Canadian midwives' continued presence at homebirths will effectively counteract the medicalizing pressures of hospital practice. Unfortunately, the mitigating influence of homebirth is not available to most American nurse-midwives, who are prevented from attending homebirths by various factors, including (1) their own lack of experience in (and sometimes fear of) homebirth; and (2) the conditions of their licensure in most states, which require them to have both insurance coverage and physician backup for homebirth, both of which are very difficult to obtain.

Largely confined to attending births in hospitals, like physicians many CNMs do become accustomed to routinely employing unnecessary interventions. In such cases, consumers point to the overmedicalization of CNM practice and training. On that 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 overmedicalized. 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 World Health Organization [WHO] definition says midwives practice in. One has to weigh the risks of protecting themselves from overmedicalization and the realities of our health care system today, or take the consequences of limiting your practice to a very narrow domain.

Such limitation has indeed been the choice of many MANA midwives. They consider the degree of marginalization that results from out-of-hospital practice to be a worthy price to pay for maintaining autonomy, avoiding overmedicalization, and holding open a wide spectrum of care that the ACNM alone cannot preserve.

They are supported in this belief by the members of the Bridge Club, which was spontaneously formed at the 1997 MANA conference in Seattle the day after the Direct-Entry Dialogue panel (described at the beginning of this chapter) by a group of CNMs who are also members or supporters of MANA. Bridge Club members, who can belong to either or both organizations, now number over 100 and are trying to convince the ACNM Board to be more supportive of NARM certification, or at least to do nothing to undermine it. Supporting the CM, they also support the CPM, and advocate for the complementary coexistence of both. One result of their efforts was the establishment in 1999 of a liaison group consisting of three representatives each from ACNM and MANA, which at the very least constitutes a formal mechanism for dialogue between the two organizations.[14]

A very recent development is the creation by some members of MANA of the National Association of Certified Professional Midwives (NACPM). Its birth was sparked by events in Massachusetts: legislators there insisted that they could not accept the CPM unless it was backed by a professional organization that requires CPM certification for membership (which MANA does not) and sets national standards specifically for CPMs. The board members of NACPM, with the help of an advisory committee and with input from NARM, completed these

standards in October 2004 (see chapter 3 for more detail, and www.nacpm.net).

NACPM's creation generated controversy within MANA, in part because some MANA members would have preferred such an organization be a section of MANA, and in part because of a fear that if all or most CPMs join NACPM (the professional organization) and leave MANA (the social movement organization), MANA's existence might be threatened in what could become a case of "matricide"—the daughter organization killing the mother organization. NACPM founders are making every effort to avoid such an event—the NACPM has no plans to hold its own national conferences, but rather will incorporate its meetings into MANA's annual conferences, and NACPM mailings have encouraged midwives to join both organizations. For the foreseeable future, it appears that MANA, to which hundreds of DEMs hold a 20-year allegiance, will continue to serve as the umbrella organization and the ideological catalyst that holds NARM, MEAC, the consumer organization Citizens for Midwifery, and the new NACPM in close alliance and cooperation.[15]

CONCLUSION: A CONVERGENT NETWORK OF OPTIONS FOR AMERICAN WOMEN

Thus ends my initial summary of the American midwifery story; far more detail is provided in the remainder of this volume. Two groups of midwives have so much in common that one came into existence at a conference held by the other, and some members of each belong to both. Yet they remain divided over seemingly irreconcilable differences in values and philosophy, most especially regarding educational routes (MANA values all routes, ACNM requires university degrees) and certification processes (MANA believes in the validity of CPM certification, which ACNM does not fully support). In the recent past, the members of these organizations have battled each other in state legislatures over whose direct-entry certification should prevail—a painful circumstance that often hinders the legislative efforts of both groups. The continued existence of these divisions means that every potential midwifery student, and many of the mothers seeking midwifery care, must examine these differences, consider their implications, and choose. A woman cannot at this point make a simple choice to use a midwife; rather, she must also choose which type, which educational philosophy, which knowledge system, which standards, and which site of care. Certainly, the existence of both ACNM and MANA in the United States creates a broader spectrum of choice for women than

would exist if either organization and its members were to vanish, and the diversity these organizations represent gives women multiple options. But viewed in the Canadian context, where all midwives can practice at home or in hospital and can offer the full range from low- to high-tech birth, the home/hospital split that characterizes American midwifery can be seen to limit, not expand, women's spectrum of choice. And of course, it is these limitations which for Canadians, who have concentrated on unifying their profession, encompassing multiple knowledge bases, and developing systems that allow midwives to practice autonomously in all sites of care, have constituted the most cautionary part of this cautionary tale.

Happily, the American midwifery story does not end here. The most recent events in the evolution of MANA and the ACNM predict that a more positive, mutually accommodative part of the story will unfold. MANA members have largely accepted the existence of the CM and have come to see it as the step forward for midwifery that ACNM intended it to be. After initial rejection and scorn, increasing numbers of CNMs have gained respect for the CPM credential and the midwives who obtain it, especially because recent statistics on the outcomes of the births they attend have demonstrated the value and competence of their care.[16] Across the country there are hundreds of occurrences of interdependence between CNMs and DEMs. Sometimes, direct-entry midwives and nurse-midwives work together in private practices; often they create informal collaborative arrangements that benefit them both. CNMs sometimes mentor direct-entry apprentices and teach in direct-entry programs and schools.

Improved communication between ACNM and MANA members involved in national administration and in state legislation efforts has prevented a number of political battles that otherwise would have occurred. In some places the legislative efforts of nurse-midwives to expand their scope of practice, add prescriptive privileges, and so forth have benefited from long-established relationships between legislators and direct-entry midwifery state organizations, and the loyal support and social activism of homebirth midwifery clients often spills over to CNMs fired by hospitals or persecuted by physicians. Leaders of both national organizations have come to know and respect each other.[17] The two current presidents of ACNM and MANA, Kathy Camacho Carr and Diane Holzer, collaborate in many ways. They and other midwifery leaders participate mutually in national projects like the Safe Motherhood and the CIMS Mother-Friendly Initiative.[18] They meet at the conferences of MANA, the ACNM, Midwifery Today, and the International Confederation of Midwives (in which both organizations

participate). As a result of careful epidemiological review of new data on CPM-attended homebirths (Johnson and Daviss 2005), ACNM leaders worked together with MANA leaders on a resolution passed by the American Public Health Association to increase access to out-of-hospital birth attended by direct-entry midwives (APHA 2002:453–455). The relationships they develop with each other in such arenas often lead to further dialogue and understanding. All these factors, combined with all midwives' intense devotion to women, babies, and their care will, over time, enhance the trends toward convergence I described above. While this convergence may take decades, or may never result in organizational unification, it is my hope that over time, the viable structures that members of both organizations are creating will form an increasingly strong network of options for American women and the ways they give birth.

TIMELINE OF EVENTS IN THE COMPARATIVE HISTORY OF ACNM AND MANA

This timeline is not a comprehensive history. It is based on the dates used in this chapter and provided to help the reader clarify the sequence of events discussed herein.

1925 Mary Breckenridge founds the Frontier Nursing Service in Hyden, Kentucky.
1929 Formation by FNS nurse-midwives of the American Association of Nurse-Midwives.
1930 Founding in New York of the Lobenstine Clinic.
1931 Founding of the Lobenstine Midwifery School.
1944 National Organization for Public Health Nursing establishes a section for nurse-midwives.
1955 Founding of the ACNM.
1956 Opening of Yale nurse-midwifery program.
1958 Six nurse-midwifery (NM) educational programs are operating in the United States.
1963 There are 500 graduates of these programs; only forty actually work as NMs in the United States.
1965 ACNM develops an educational accreditation process.
1970 ACNM begins administering national certification and accreditation for all NM programs.
1970 Hospital birth reaches an all-time high of 99.4 percent; homebirth at 0.6 percent.
1972 Publication of Raven Lang's *The Birth Book.*

1973 ACNM adopts a Statement on Homebirth naming the hospital as the "preferred site."

1975 Publication of Ina May Gaskin's *Spiritual Midwifery* and of Suzanne Arms's *Immaculate Deception.*

1976 Midwife Shari Daniels opens the Maternity Center, the first midwife-owned for-profit freestanding birth center, which she ran for ten years.

1977 Homebirth doubles to 1.5 percent as the grassroots lay midwifery movement grows.

1977 Shari Daniels opens the first professional direct-entry midwifery school, in El Paso, Texas.

1977 Shari Daniels organizes the First International Conference of Practicing Midwives, in El Paso, Texas.

1977 CNMs receive licensure in Massachusetts, one of the last states to grant it.

1979 Nine NM educational programs in operation.

1979 NMs attend one percent of births. Lay midwives also attend one percent of births.

1980 ACNM retracts its earlier position on homebirth, producing a statement endorsing NM practice in all settings (hospital, birth centers, homes).

1981 Sister Angela Murdaugh, president of ACNM, invites lay midwifery leaders to meet at ACNM headquarters in Washington, D.C.

1982 The midwifery model of care is fully described in writing by sociologist Barbara Katz Rothman in *In Labor: Woman and Power in the Birth Place.*

1982 ACNM's Division of Accreditation receives federal DOE recognition as an accrediting agency for nurse-midwifery programs.

1982 Founding of MANA.

1984 At the second MANA convention, held in Toronto, Ontario, Canadian nurse- and direct-entry midwives achieve organizational unity, creating the Ontario Association of Midwives (OAM).

1989 MANA establishes the Interim Registry Board to explore a national registry exam; the IRB later evolves into NARM.

1989–1995 Carnegie Inteorganizational Work Group (IWG).

1991 Creation of the Midwifery Education and Accreditation Council (MEAC).

1992 Passage of the New York Midwifery Practice Act legalizes the ACNM's new non-nurse-midwife.

1994 ACNM votes for the ACC to create a certification process and title for the new direct-entry midwife.

1994 NARM and the CTF choose Certified Professional Midwife as the name of the credential they are developing.

1994 Abby Kinne is the first to receive CPM certification, in October.

1995 ACC/ACNM choose Certified Midwife (CM) as the title for the new ACC-certified direct-entry midwife.

1995 NARM conducts a survey returned by 800 practicing midwives to determine entry-level requirements for the CPM, called the *1995 NARM Job Analysis.*

1995 ACNM/DOA sets criteria for the accreditation of direct-entry programs leading to the CM.

1996 The first educational program leading to the CM (at SUNY/Brooklyn in New York City) is preaccredited by the DOA.

1996 Linda Schutt CPM becomes the first CM in the United States.

1997 ACNM grants full voting membership to CMs.

1997 ACNM sends letter to state legislatures advocating recognition of only the CM. The Bridge Club forms.

1997 Helen Varney Burst changes the name of her leading midwifery textbook from *Varney's Nurse Midwifery* to *Varney's Midwifery.*

1997 The name of the ACNM journal is changed from the *Journal of Nurse-Midwifery* to the *Journal of Midwifery and Women's Health.*

1998 ACNM revises its core competencies to include lifetime gynecological, reproductive, and well-woman primary care, thus greatly enlarging its scope of practice. MANA's core competencies remain focused on the childbearing year, as mandated by NARM's Job Analysis (1995).

I998 A movement to change the name of the ACNM from the American College of Nurse-Midwives to the American College of Midwifery is put to a mail ballot but does not pass.

1999 MEAC has accredited ten of twenty existing direct-entry educational programs, close to the number of nurse-midwifery programs ACNM had accredited by the late 1960s.

2000 MEAC receives DOE recognition as a federally recognized accrediting body for direct-entry midwifery programs.

2001 The DOA receives DOE recognition as a federally recognized accrediting body for direct-entry midwifery programs.

2001 Formation of the NACPM at a MANA conference, and of a CPM section of MANA.

2005 Five of the twelve MEAC-accredited schools are degree-granting institutions.

2005 The total membership of the ACNM is around 7,000 and the voting membership is 5,411. There are forty-three ACNM/DOA-accredited programs.

2005 In January, NARM certifies its 1,000th CPM.

2005 Direct-entry midwifery legislation passes in Virginia and Utah, bringing the number of states in which non-ACC-certified DEMs are legal, regulated, and licensed, registered, or certified to 21.

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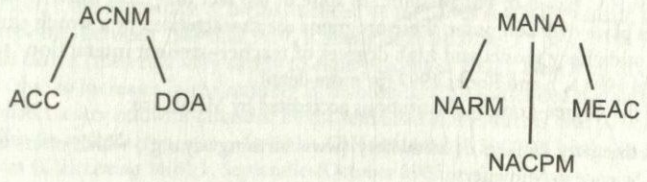
ENDNOTES

1. The figure below shows the structural relationships between the organizations related to ACNM and MANA. In the United States, national legislation requires that certification and accreditation be carried out by separate bodies. The ACNM is a professional organization that requires certification as a certified nurse-midwife (CNM) or certified midwife (CM) by its affiliate, the ACNM Certification Council (ACC), for membership. All nurse-midwifery educational programs must be accredited by ACNM's Division of Accreditation (DOA). The DOA can accredit both intra-institutional programs and freestanding degree-granting institutions (Carrington and Dickerson 2004).

   MANA is not a professional organization in that it does not require certification for membership, but the North American Registry of Midwives (NARM) has created an optional certification, the Certified Professional Midwife (CPM), and a new professional organization, the National Association of Certified Professional Midwives, created in 2001, requires this certification for membership. MANA does not require program accreditation, but there is an accrediting body, the Midwifery Education Accreditation Council (MEAC), which has set rigorous standards and has accredited twelve direct-entry programs to date (www.meacschools.org). MEAC accredits both intra-institutional programs and freestanding degree-granting institutions.



These structural similarities mask important differences. The ACC and the DOA are true affiliates of ACNM, in the sense that they grew out of the ACNM and are fully philosophically and politically aligned with it. Likewise, NARM and MEAC grew out of MANA and share a strong ideological commitment to the midwifery movement and out-of-hospital birth. But MANA is inclusive and represents the midwifery movement. NARM's certification, while it has been made as accessible as possible is, by definition, exclusive. Thus NARM represents the professionalizing enterprise within direct-entry midwifery, as do MEAC and the new NACPM (National Association of Certified Professional Midwives, described more fully later in this chapter). So NARM, MEAC, and the NACPM are, strictly speaking, not affiliates of MANA, but rather sister or partner organizations with agendas that are related but distinct.

2. The American Association of Nurse-Midwives continued to exist until 1969; it consisted mostly of CNMs who had worked or did work at the Frontier Nursing Service. As roads were paved and the isolation of the FNS nurse-midwives decreased, there was no longer a need for the functions it had provided (Kitty Ernst, personal communication). And so in 1969 it merged with the ACNM, which at that point changed its name from the American College of Nurse-Midwifery to the American College of Nurse-Midwives, keeping the acronym (ACNM) the same.
3. In many other countries, the government sets midwifery educational standards, not the midwives themselves. This is common: governments of countries with national health services set the standards for medicine and nursing as well as for midwifery (Judith Rooks, personal communication). ACNM is one of the few national professional midwifery organizations in the world able to set standards for its own profession.
4. At the same time, factions of lay midwives around the country chose not to participate in any professionalizing efforts and to remain entirely outside the system. As I have done no research on these midwives, they are not considered in this chapter (but see chapter 5 by Mary Lay, and chapter 11 on "renegade" midwives). My estimate is that they number around 1,500.
5. In 1984, lay and nurse-midwives in Ontario merged into one organization, the Association of Ontario Midwives, which represented a union of the Ontario Nurse-Midwives Association and the Ontario Association of Midwives (see Bourgeault, Benoit, and Davis-Floyd 2004). Further illustrating the strong connections between midwives in Canada and the United States, this merger was accomplished at the 1984 MANA conference in Toronto, which carried the theme of "creating unity." The merger was fostered by (1) the congruence between the philosophies of both organizations, which focused on woman-centered care; and (2) a desire on the part of both to pursue integration into the public health care system (Bourgeault and Fynes 1997).
6. Distance learning is an important innovation in both nurse- and direct-entry midwifery. The program that graduates the largest number of nurse-midwifery students annually (approximately ninety-five) is a distance-learning program called the Community-based Nurse-midwifery Educational Program (CNEP)—an outgrowth of the Frontier Nursing Service, which is based in Hyden, Kentucky, at the original site of the FNS (www.midwives.org). Other major distance learning CNM programs include SUNY-Stonybrook in New York and the Institute of Midwifery and Women's Health (IMWHA) based in Philadelphia. In spite of the fact that most didactic instruction takes place over computer, these programs are characterized by a strong emphasis on the midwifery model and high degrees of teacher–student interaction (see Davis-Floyd 1998 a, b and Rooks 1997 for more detail.)
7. The five degree-granting institutions accredited by MEAC are:

   • Birthingway College of Midwifery (www.birthingway.org), which offers a Bachelor of Science in Midwifery;

- Midwives College of Utah (www.midwifery.edu), which offers Associate of Science in Midwifery, Bachelor of Science in Midwifery, and Master of Science in Midwifery degrees;
- National College of Midwifery (www.midwiferycollege.org), which offers the same three degrees plus a Doctorate of Science in Midwifery (Ph.D.);
- the Midwifery Program at Miami Dade Community College (www.mdc.edu/medical/Nursing/Programs/Midwifery_Prog/main.htm), which results in an Associate in Science Degree in Midwifery;
- the Midwifery Program at Bastyr University (www.bastyr.edu/academic/naturopath/midwifery/), which results in a Certificate of Naturopathic Midwifery in addition to the Naturopathic Doctor (N.D.) degree.

8. The ACNM makes major decisions by democratic vote of the membership; in contrast, MANA makes decisions based on consensus, which means that everyone has to agree. In both organizations, most decisions are made at the board level. The MANA board operates by consensus; in most cases, the ACNM board does as well.
9. Representatives of MANA, NARM, MEAC, and CfM developed the following definition of the Midwifery Model of Care, which was copyrighted in 1996 by the Midwifery Task Force (an already existing but inactive 501(c)3), which later also took on the task of maintaining the trademark registration of the logo developed to accompany the definition:

   > 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; 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. (www.narm.org)

   In 2002, the name of this model as delineated above was changed to the Midwives Model of Care primarily because of the difficulty legislators and others have in pronouncing the word *midwifery.*
10. A physician's assistant (PA) receives extensive training in primary health care and is qualified in all fifty states for autonomous clinical practice.
11. Several direct-entry midwives who did not graduate from DOA-accredited programs have successfully challenged the licensure process in New York State and have been allowed to take the ACC exam; upon passing it, they qualified as CMs. (See chapter 2, note 10 for more detail.) As of 1999, like nurse-midwifery programs, all DOA-accredited direct-entry programs must either lead to a baccalaureate degree or require one for acceptance into the program. As noted previously, to date there are no pre-baccalaureate DOA-accredited direct-entry programs.
12. The nurse-midwifery program at Baystate Medical Center in Springfield, Massachusetts, developed a DOA-accredited direct-entry track for a particular student who had practiced as a lay midwife and is also a PA. She is now a CM and remains the only direct-entry graduate of this program, although other PAs could apply.
13. Although the percentage of births attended by midwives is still very small, it is steadily increasing. Between 1989 and 1997, it nearly doubled from 3.7 percent to 7 percent of total births (then rose very slowly to eight percent in 2002). Nearly all of this growth was due to increases in the number of in-hospital CNM-attended births; the percent of direct-entry midwife-attended births remained stable during that period, but may suffer from underreporting. In 2001, CNMs attended 305,606 births in the United States (*Quickening* 34(6):1, September/October 2003).

The U.S. Standard Certificate of Live Birth—source of data on the numbers and percentages of births attended by midwives—did not distinguish between any kinds of midwives until the 1989 revision, which distinguishes between CNMs and Other Midwives. The revisions made in 2003 distinguish between midwives certified by the ACNM or ACC—CNMs and CMs—and all other kinds of midwives.

Out-of-hospital births have accounted for less than one percent of all births in this country each year since 1989. CNMs attended fewer than 10,000 out-of-hospital births in 2002, of which the majority took place in freestanding birth centers (Martin et al., 2003). In 2002 the National Center for Health Statistics reported 5,689 births attended by CNMs in birth centers, and 2,726 births attended in birth centers by "other midwives" (Martin et al. 2003).

"Other midwives" attended almost 13,000 out-of-hospital births in 2002, the majority of which were homebirths. (Physicians attended almost 4,000 out-of-hospital births, including almost 2,000 in homes.) Someone other than a midwife or a physician signed the birth certificates of almost 9,000 babies born in out-of-hospital settings, including 7,500 that occurred in homes. Some of these were precipitous births with the baby caught by whomever was there. Some were planned homebirths with a family or church member attending, or midwife-attended homebirths in which the father signed the birth certificate. The latter is common in states where direct-entry midwifery is unregulated or illegal. Thus some of those births should also be attributed to "other midwives," raising the total of births attended by midwives who are not CNMs to somewhere between 13,000 and 20,000 per year. According to national vital statistics data from Centers for Disease Control (CDC), one out of twenty midwife-attended births is attended by midwives who are not CNMs (Martin et al. 2003, available at www.cdc.gov/nchs/data/nvsr/nvsr52/nvsr52_10.pdf).

14. The personal goals of members of this ACNM-MANA Liaison Group have at various times included developing appropriate language for a model state practice act that would encompass both new direct-entry certifications, and examining possibilities for making it easier for midwives credentialed by one organization to become certified by the other; these have not been realized. The group did develop a statement that endorsed all three national midwifery certifications (the CNM, CM, and CPM). This statement was accepted by the MANA Board but rejected by the ACNM Board of Directors. According to Rooks (2006): "The ACNM's budget was tight, and since the product of the group's work was inconsistent with ACNM positions, the ACNM ended its participation in the group in October 2001. In response to an outcry against this action by members attending the 2002 ACNM Convention, the ACNM [Board] reinstituted participation in the Liaison Group with guidelines regarding topics to be addressed by the group and the understanding that ACNM representatives would be self-funded. The group meets at both the MANA and ACNM annual meetings, although more of its members are usually present at the ACNM annual meeting." The ACNM Board of Directors and the MANA Board of Directors have agreed to three purposes for this group. They are: (1) to identify common areas of concern and mutual interest that may lead to joint ACNM/MANA initiatives; (2) to keep each organization informed on any state legislation that might impact the practice of the CPM and/or CNM/CM; and (3) to share with one another information related to the education and practice of CNMs, CMs, and CPMs.
15. Citizens for Midwifery is an independent consumer organization started by mothers who were interested in promoting and preserving the option of midwife-attended homebirth; thus its interests have always been in alignment with some of MANA's. President Susan Hodges (personal communication 2005) noted: "As CfM developed, the organization realized that our focus needed to be broader—that women really don't care what initials their midwife has or doesn't have after her name, they care

about the kind of care they get. Our mission/vision evolved and became: that the Midwives Model of Care should be the standard for maternity care and available to all women in all settings (regardless of provider)." CfM is also attempting to work with ACNM.

16. While nurse-midwives have a long-proven record of safety in attending both in- and out-of-hospital births (MacDorman and Singh 1998; Rooks 1997; 1999; Rooks et al. 1989), a constant criticism leveled at direct-entry homebirth midwives has been that they have no definitive statistics about the outcomes of their births. To combat this criticism, in the year 2000, all direct-entry midwives certified as CPMs were required to submit prospective data on all their clients, resulting in data on 7,000 courses of care (Johnson and Daviss 2005). I present the results of this study in chapter 3.
17. Examples of the increasing respect CNMs hold for CPMs include a 2000 article in *the Journal of Midwifery and Women's Health* in which Alyson Reed and Joyce Roberts suggested to CMs who need to find employment outside of the three states in which they are licensed that they obtain their CPM and practice out-of-hospital birth, and an initiative proposed by then-President of ACNM, Mary Ann Shah (2003), includes "explor[ing] ways of fast-tracking qualified CPMs . . . through ACNM-accredited education programs. Additionally, many of my more recent CNM interviewees express their appreciation for the CPM and the quality of practice for which it stands.
18. The Coalition for Improving Maternity Services (CIMS) was created through an alliance between various individuals and twenty-seven alternative birth organizations, including Lamaze International, ICEA, ACNM, MANA, AWHONN, DONA, La Leche League, and others. These groups realized that they had similar goals but were each working to achieve them on their own, and that they might have greater impact if they joined together. The common purpose all agreed on was the creation of a document called the Mother-Friendly Childbirth Initiative (MFCI) outlining "Ten Steps to Mother-Friendly Hospitals, Birth Centers, and Homebirth Services" and of a process of evaluation to achieve CIMS designation as "Mother-Friendly." The members of CIMS understand that many American women have little or no interest in natural childbirth; they are also keenly aware of the vast overuse of obstetrical interventions and the unnecessary damage to mothers and babies caused by this overuse. Their intention therefore is to work toward the goal that one day there will be a mother-friendly hospital in every community, so that women have access to all kinds of care, including care that is based on a natural childbirth/midwifery philosophy (see www.motherfriendly.org).

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Fig. 1.1 Joint MANA/NARM/MEAC/NACPM Boards, October 2004. Photographer: Robbie Davis-Floyd

Fig. 1.2 "Floor Discussion at the 2005 ACNM convention in Washington, D.C. on June 13 about conducting a survey of the membership regarding their opinions about changing the name of the American College of Nurse-Midwives to the American College of Midwives. The resulting survey showed no clear majority opinion, so the name has not been changed."

Fig. 1.3 Katherine Camacho Carr, ACNM President, and Diane Holzer, MANA President, at the triennial conference of the International Confederation of Midwives, Brisbane, Australia, 2005. Photographer: Robbie Davis-Floyd.

2

IDEALISM AND PRAGMATISM IN THE CREATION OF THE CERTIFIED MIDWIFE: THE DEVELOPMENT OF MIDWIFERY IN NEW YORK AND THE NEW YORK MIDWIFERY PRACTICE ACT OF 1992

Maureen May and Robbie Davis-Floyd