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QUALIFIED COMMODIFICATION: THE CREATION OF THE CERTIFIED PROFESSIONAL MIDWIFE[1]

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> commodity 1. Something useful that can be turned to commercial or other advantage. 2. An article of trade or commerce.
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> **—dictionary.com 2005**

This chapter incorporates a rather extreme change in theoretical tone from the preceding chapters, to which I must ask our readers to adjust. I originally wrote it for an anthropological book called *Consuming Motherhood* (Taylor, Wozniak, and Layne, 2004), which utilizes various kinds of theories of commodification and consumption to analyze multiple aspects of motherhood in the contemporary United States, and have adapted it for this book (with permission) because I found that analyzing the creation of the CPM in terms of commodification theory sheds a great deal of light on the richness and complexity of the process

the midwives who created the CPM went through, and on its ultimate results. While homebirth midwives may not immediately appreciate thinking of themselves as commodities, in the introduction to *Consuming Motherhood*, Janelle Taylor writes,

> Scholars of consumption have argued persuasively that we must understand consumption itself as a site of cultural creativity and political agency, and also . . . of subversion and resistance. Consumers are neither passive nor without agency, but rather appropriate mass-produced goods to their own projects and purposes, producing selves and making worlds in the process. (2004:11–12)

These are notions to which I think midwives can easily relate. In fact, contemporary homebirth midwives are engaged in precisely the enterprise Taylor identifies: by appropriating certain aspects of mass production to their own projects and purposes, they are using consumption as a site of subversion and resistance to create new selves and alternative worlds. Starting out at the margins of a consumer society they view with a jaundiced and critical eye, these midwives came to realize over time that their survival as viable practitioners required participation in the technocracy's core processes of commodification and consumption. Their own views of these processes, while initially negative and derogatory, have subsequently expanded to encompass the ambiguity inherent in commodification.

In other words, these midwives came to see that processes of commodification can be not only agents of co-option into standardized mass markets, but also forms of cultural creativity and political agency, and indeed also of subversion and resistance to mass standardization. The selves/identities such midwives make as they commodify in order to occupy a wider terrain in the consumer market, and the alternative realities they explored through the process of commodification as they created the CPM, are the subject of this chapter. I will illustrate their appropriation of the language and strategies of the kinds of consumption and marketing that they themselves originally perceived as negative, in what I identify as a process of *qualified commodification*. Webster's New World Dictionary (2000) gives as the fourth and fifth definitions of the word *qualify*: "to modify, restrict, limit [to qualify one's approval]; to moderate, soften [to qualify a punishment]." Thus, with this term I seek to name the alchemical process through which direct-entry homebirth midwives appropriated the rhetoric and core cultural characteristics of mass forms of commodification in order to

move themselves into the mainstream through creation of the CPM, but modified and moderated those characteristics in an effort to simultaneously remain true to the countercultural ideals and values they have long called their own. Are you with me?

THE MIDWIFERY APPROPRIATION OF COMMODIFICATION STRATEGIES

The intense commodification of reproduction has had some interesting consequences for American midwives, who are managing in some rather creative ways to appropriate it to their own ends. Effectively shut out of birth during the modern industrial era, in the postmodern technocracy American midwives have been fighting their way back (Davis-Floyd, Cosminsky, and Pigg 2001). Their numbers are growing, as is their political and legislative presence in the birth arena. Increasingly unwilling to accept their cultural marginalization, both nurse- and direct-entry midwives are actively starting to think of themselves, and to present themselves to the public, as valuable health-care commodities. Appropriating the notion of women as agentic consumers of maternity care (an image they helped to create), midwives have added themselves to the list of birth care options from which women can now choose. Marketing has become a keystone of their strategies for success in the twenty-first century: in recent years midwives have produced advertisements, brochures, leaflets, videos, and books touting the benefits of midwifery care. They have also become master politicians, successfully selling midwifery to state legislators, nursing and medical societies, and regulatory boards. In some states their search is for greater representation on the boards that govern them and more beneficial rules and regulations; in others, the fight is for so basic a thing as the right to practice legally and to be licensed by the state.

Within these parameters of the commodification of American midwifery, as we saw in chapter 1, two models and philosophies of midwifery education and practice coexist and sometimes compete for legal status and cultural recognition: the nurse-midwifery and the lay/direct-entry midwifery models. In particular, direct-entry midwives' efforts at professionalization and commodification contrast in fascinating ways with the ongoing value they place on their relationships with their clients and their grassroots social movement fervor. As we have seen, nurse-midwives have worked hard to create a professional image and reputation in keeping with that of other health-care professionals—an image that was seriously threatened by the relatively sudden advent of the lay midwife. In chapter 1, I noted that these new lay

midwives came from a wide diversity of backgrounds; they included hippies, feminists, members of various religious groups, and conservative Midwestern housewives. Yet their most visible public face was countercultural: long hair, long flowy skirts, and Birkenstocks constituted the visual representation they came to conjure up, along with a hippie ethos, a countercultural lifestyle and values, and a laid-back attitude. This public image often had nothing to do with the individual characteristics of particular lay midwives, yet it developed as a stereotype and has tended to remain. This image was a major threat, both stylistically and professionally, to the short-haired, stockinged, and white-jacketed image of mainstream professionalism and competence that nurse-midwives had worked hard to build.

THE POLITICS OF REPRESENTING MIDWIVES

As every anthropologist knows, ethnography is all about representation. As an ethnographer, I first became aware of how concerned direct-entry midwives were becoming with revamping their public image when I began work on a chapter for a book (Davis-Floyd 1998a) being put together by *Midwifery Today* (a magazine and company dedicated to the preservation and promotion of midwifery) called *Paths to Becoming a Midwife: Getting an Education* (Tritten and Southern 1998). For that book, I had been asked to write a comparative description of "the ups and downs of nurse- and direct-entry midwifery" in nine pages or less—a task I should have known would be impossible. Yet I had been conducting fieldwork among nurse- and direct-entry midwives for four years at that point, in an attempt to understand their similarities, differences, and political motivations vis-à-vis each other. I (foolishly) thought that the interviews I had conducted with these midwives, and the dozens of midwifery conferences I had attended, would make it easy to describe them in simple, generalized terms. In the first draft of that chapter, which I wrote in a few days, I noted that direct-entry midwives are more culturally marginalized, work longer hours, and make far less money than nurse-midwives. The direct-entry midwives who saw that first draft reacted with outrage, telling me that I made them sound like "marginalized losers" and the hospital-based nurse-midwives, who make a great deal more money and have more reasonable working hours, like winners. Aware that this *Midwifery Today* book would be read by students trying to make a decision as to whether to become a direct-entry midwife (DEM) or a certified nurse-midwife (CNM), the DEMs wanted me to represent them in the most positive light possible. I asked for suggestions for alternative wording

that would be as true as what I originally had said but that would make them look better; putting our heads together, we came up with the following:

> Direct-entry midwives often work alone or in practices with one or two primary midwives, and are almost always on call. For some, burnout is the result of this constant availability; others find this a viable way of life.... Many direct-entry midwives appreciate the flexibility they enjoy as independent practitioners: should they desire more time off, they can cut down on the number of clients they take on. In areas where interest in homebirth is steady or growing, they can choose to accept more clients until they build their practice to the level they desire. Thus their incomes vary widely: those who attend only a few births a year may make only a few thousand dollars, while some direct-entry midwives make upwards of $60,000 per year. . . .
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> In short, DEMs face the challenges and reap the benefits of being self-employed entrepreneurs. Like some MDs, they run independent practices; their earning ability is not constrained by salaries but rather depends on their level of energy and their ability to attract clients (which itself is constrained by cultural attitudes toward homebirth). In states where they are licensed and regulated, they often serve as the sole proprietors of thriving businesses (at a time when many MDs are being forced to trade in their economically advantageous positions as independent practitioners for the rigid payment schedules of HMOs). Many DEMs make a good living, many do not, but all of them love their work. Most DEMs would not trade the challenges, tribulations, and rewards of their entrepreneurial practices for the constraints of working in a hospital setting. (Davis-Floyd 1998a:75)

Although I had some qualms about being made into an active agent of their marketing strategies, I felt responsible to them to describe them the way they tend to see themselves, so I was happy to find this alternative wording. But the battle was not over; they took me severely to task once again when I tried, in that same article, to describe the damaging stereotypes hospital practitioners tend to create and disseminate about direct-entry midwives. What I said in that first draft was:

> Many medical practitioners, and some nurse-midwives, have serious concerns about the safety of direct-entry practice; they point to the fact that there are some DEMs in practice with truly

> inadequate training. Thus when a DEM makes a mistake, no matter what her individual knowledge and skills, most people in the medical community are only too ready to assume that she is "ignorant" and "incompetent," and go on to assume that incompetence and lack of education characterize all midwives of her ilk.

Immediately I received irate phone calls from a midwife and a midwifery advocate, both of whom asked me "how dare I call direct-entry midwives 'ignorant' and 'incompetent'?" Of course I had not done so—I had simply tried to describe the stereotypes other people held. Painful and irrational as this accusation was, it pointed out to me the extreme level of concern today's DEMs bring to public representations of their image. Fighting generations of such stereotypes applied to them by the medical profession, today's professionalizing homebirth midwives react strongly to any such negative associations. They and their clients sometimes suffer in extreme ways from the effects of such stereotypes, as the home-to-hospital transport stories recounted in chapter 10 describe in detail. The negative reactions midwives encounter when they transport a client to the hospital (not to mention those they also encounter in state legislatures) vivify the problematic nature of the interface between midwives and medical practitioners and the consequent deep need midwives feel for cultural legitimacy. It is one thing to proudly hold a countercultural space in which women can make alternative choices, and another to watch your clients suffer the effects of the negative stereotyping of midwives. Thus, although many direct-entry midwives remain countercultural to the core, they are keenly aware of the need to make themselves more viable in the technocracy, not only to keep themselves out of jail, but also to protect their clients from being medically mistreated because they chose a homebirth midwife. One obvious route to cultural viability would have been nurse-midwifery, but that would have meant losing the kind of independent midwifery they had worked so hard to create. How could they sell themselves without selling themselves out?

QUALIFIED COMMODIFICATION: MAINSTREAMING MIDWIVES

> A Certified Professional Midwife (CPM) is a knowledgeable, skilled, and professional independent midwifery practitioner who has met the standards for certification set by the North American Registry of Midwives (NARM) and is qualified to provide the Midwifery Model of Care. The CPM is the

only international credential that requires knowledge about and experience in out-of-hospital settings.

—NARM, *How to Become a Certified Professional Midwife*

For the first three decades of their existence, several factors handicapped direct-entry midwives in their efforts to gain a toehold in the technocracy. These included: (1) some degree of public awareness of their lack of credentials and their illegal status in various states; (2) the vast variances in their educational processes, which range from pure apprenticeship to private three-year schools; (3) the negative publicity generated around occasional bad outcomes at homebirths, some of which were attended by insufficiently trained practitioners (a publicity rarely applied to negative hospital outcomes); (4) the negative stereotyping of midwives in general as less competent than physicians. As I described in chapter 1, they created a national organization, MANA, in 1982 and developed national practice standards and identified core competencies during the 1980s. But full voting membership in MANA was open to anyone who called herself a midwife, and there was no obligation to abide by the standards that MANA had set. Increasingly aware that only a standardized national certification process could convince the public, including politicians, legislators, and the courts that they were safe and savvy practitioners, compensate for the variations in their educational processes, help them avoid arrest and legal persecution, and minimize the possibility of inadequately trained midwives out there doing births, the members of MANA were at the same time concerned that any kind of nationally standardized certification would compromise their ability to meet women's unique needs and requirements in out-of-hospital settings.

No one was more aware of this danger than the members of the organization created by MANA to develop an exam and later a full-fledged certification process—the North American Registry of Midwives (NARM). Desiring to design a psychometrically valid testing and certification process in line with the standards set by the National Organization of Certifying Agencies (NOCA), NARM board members also, and just as ardently, desired not to co-opt themselves and their sisters or compromise their practices in the process. Since 1994, in my dual roles as ethnographer and member of the NARM Board, I have watched them struggle with the tensions generated by the often conflicting pulls to (1) enhance their public image to better market themselves to the public through creating a rigorous certification process; (2) preserve their ability to practice according to their own individual values and beliefs and those of their clients, which they believe constitutes the

essence of out-of-hospital midwifery; and (3) establish certification requirements that work with the logistical realities of their day-to-day practices, educational processes, and the legislation in various states.

Karl Marx asserted that commodification is a transformative process, but he viewed it in negative terms. Since then, anthropological theories about commodification have come to encompass its many variables and its often-creative qualities (Hebbdige 1979, McRobbie 1988). MANA midwives not familiar with such writings maintain deep suspicions about commodification and tend to see it in more culturally negative terms. Their view of commodification resonates more with those of social scientists like Adorno and Horkheimer (1999), Bourdieu (1984), Baudrillard (1988), and others. In what follows I will utilize a list of the characteristics I have noted that midwives seem to associate with commodities and commodification, combining those characteristics with some thoughts of my own.

For wide success, a commodity must, among other things, be:

1. produced in a standardized way.
2. subject to mechanisms of quality control.
3. quantifiable, measurable, and legally accessible.
4. purchasable and user-friendly.
5. able to tap or to create a market niche and to be marketed successfully through advertisements or other means to reach that market niche.
6. designed and redesigned in ways responsive to consumer desires and cultural trends.
7. have a brand name that gives it a unique identity (the most successful commodities, from Coca-Cola to the iMac, have a brand name that maintains consumer demand for that particular product, even in the face of clones and competitors).
8. reflect market conditions and fluctuations (inevitably, commodities are embedded in the local/global political economy—their price, availability, and symbolic worth reflect market fluctuations, competitive pressures, government priorities, political realities and tensions, and *glocal* [local and global] cultural biases and beliefs).

Most of the above characteristics of commodification are antithetical to the ethos and the values that characterized lay midwives in the early days of their development (Reid 1989, DeVries 1996). They started out in resistance to the standardization of hospital birth, experienced a non-quantifiable spiritual calling to midwifery, often attended women who could not pay, and would not have dreamed of marketing

themselves too visibly, as they were illegal or alegal in most states.[2] But in the early 1980s they gained legalization and licensure in Washington state, Florida, New Mexico, Arizona, and Texas, created their national association (MANA) in 1982, started to formalize and codify their knowledge base in books, articles, and formal vocational curricula, and by the mid-1980s began to exhibit many of the characteristics of incipient professionalization, including developing various state certifications. By the early 1990s many of them were moving into full-scale participation in the technocracy.

From their beginnings as a grassroots social movement, they had created a unique style of midwifery that they wanted to preserve, so their challenge in the 1990s became how to professionalize and commodify themselves without losing the essence of who they are and what, uniquely, they have to contribute. In the rest of this chapter, I will utilize the above list of characteristics to shed light on their commodifying strategies and to analyze their degree of success in achieving their primary goal: preserving the autonomous, woman-centered, and holistic style of midwifery they had created by making it viable in the technocracy, primarily through the development of CPM certification.

CHARACTERISTICS OF COMMODIFICATION AND HOW CPMS FIT

Standardized Production

> The Certified Professional Midwife (CPM) has been educated through a variety of routes, including programs accredited by the Midwifery Education Accreditation Council (MEAC), the American College of Nurse-Midwives Division of Accreditation (ACNM-DOA), apprenticeship education, and self-study.
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> —NARM, *How to Become a Certified Professional Midwife*

As this quotation indicates, direct-entry midwifery education takes many forms and shapes; it cannot be considered standardized. Rather, DEM training ranges along a spectrum, from the most hands-on and the least didactic (self-study and apprenticeship) at one end, to highly didactic formal programs at the other. This lack of standardization has been the source of many of its public relations problems. For many years, ACNM's rigorous educational standards (see chapter 1) contrasted sharply with the lack of such standards for DEMs. Some DEMs responded to this situation by creating rigorous licensure processes in a few states, and/or by opening formal vocational programs, usually of three years' duration. Within these formal programs, students are evaluated according to

standards set by the faculty of each program. By the mid-1990s, these programs themselves could apply for evaluation by the Midwifery Education and Accreditation Council (MEAC). In an effort to maintain clarity and consistency for midwifery students, MEAC kept its educational requirements in line with those established by NARM; often, details were worked out jointly by both groups.

But how do you evaluate in a publicly convincing way the knowledge, skills, and experience obtained through self-study or apprenticeship with a practicing midwife? How do you standardize the unstandardizable learning process called apprenticeship? How, in other words, do you commodify an anti-commodity? This was one of the most daunting challenges of developing NARM certification. Midwifery apprenticeship is a thoroughly individualized process whose shape and nature depends on the personalities and abilities of the apprentice and the mentor(s), and most especially on the relationship that develops between them. When it is successful, the apprentice/mentor relationship provides a supportive and nurturing educational context within which the apprentice can learn about pregnancy and birth through the immediacy of touch and experience, and can supplement that embodied knowledge with reading and long discussion with her mentor and others. Apprentices accompany their mentors to homebirths, witnessing woman after woman give birth successfully on her own, and developing comprehension of the normal birth process. Where hospital training tends to focus on pathology and generate a fear-based approach to birth, homebirth apprentice training generates trust. Midwives who fundamentally trust birth are more likely to be able to create an atmosphere within which women can find their own power and trust themselves to give birth. Thus, preserving apprenticeship has been and remains essential to the ethos and ethics of MANA members' philosophy and practice (Davis-Floyd 1998a, 1998b; Benoit et al. 2001).

NARM's response to the challenge apprenticeship presented was to standardize its educational *requirements* without trying to standardize direct-entry educational *processes*. NARM certification is open to midwives educated through all possible routes, including apprenticeship, self-study, formal vocational programs, university training, and all combinations thereof. NARM certification is competency based: where or how you gained your knowledge, skills, and experience is not the issue; that you have them is what counts. In other words, it is what you know and can do that matters, not how you learned it or what degrees you obtained.

Thus the decisions the members of the NARM board had to make as they developed CPM certification came to center around the issue of

what criteria to use for standardizing their educational requirements. The discussion quickly crystallized around three ingredients—knowledge, skills, and experience. What knowledge base did an entry-level applicant have to master; what skills did she have to learn; how much experience was enough? In establishing answers to these questions, the eight members of the NARM board[3] faced the difficult task of balancing the competent and professional public image they desired for the new CPM against the pragmatic realities of her training and practice. Urged by the MANA membership not to undertake this task alone, the NARM board held five Certification Task Force (CTF) meetings around the country to seek input from the American midwifery community. Any midwife of any kind was welcome to participate in these meetings, as were consumers and advocates; approximately 150 did so, including some CNM members of MANA (Alice Sammon, personal communication, 2003). All NARM and CTF decisions were consensus-based, meaning that everyone present had to agree to every major decision. Strict adherence to the consensus process carried its own set of challenges, but ultimately ensured that the outcome of the process was supported by all of its creators, as it continues to be.

One of the early issues the members of the NARM board and the CTF faced was the number of births to require that CPM candidates must have attended. They knew it would "look better" to the outside world if CPM candidates had to attend more births as primary caregivers than the twenty births required of student nurse-midwives, but resisted that temptation because requiring more births would, among other reasons, make achieving certification too difficult for midwives practicing in rural areas where the births can be few and far between. Likewise, they knew it would look better, more "midwifery-like," to require that CPM candidates give large numbers of courses of continuity of care to their clients (caring for the same woman throughout the childbearing cycle), but resisted that temptation because some of the most important midwifery training centers, such as Maternidad La Luz in El Paso, primarily serve poor Hispanic women from northern Mexico, many of whom do not show up for any kind of prenatal care nor return for postpartum visits, making continuity of care extremely difficult for many students to achieve. (Wanting to require ten or more courses of continuity of care, they ultimately settled on three.)

They also knew it would "look better" to require the ability to insert IVs as an entry-level skill required of all CPM candidates—in the extensive discussion of this issue during a CTF meeting, one of the arguments repeatedly used in favor of requiring this skill was that homebirth midwives "look really good" to hospital personnel when

they transport a woman who is hemorrhaging with the IV already in place. Another was that this skill is essential to safe homebirth practice. It was here, in this heated debate over whether or not to require IV insertion as an entry-level skill, that the depth of their commitment to preserving midwifery (as it is understood and practiced by homebirth midwives) through this new certification was put to its greatest test.

It was January of 1995. The members of the CTF, including myself,[4] were in a hotel on Captiva Island in Florida. These members of MANA knew that this was about creating the future of their brand of midwifery, so a full forty of them showed up at their own expense. The sun was shining and the beach was calling on that warm and breezy day. Nevertheless, we sat in a meeting while everyone in turn spoke their mind on the important issue of which skills should be required for entry-level practice. Written on the board were IV insertion, catheter insertion, and pitocin administration for hemorrhage as the skills in immediate question. Many participants saw these as high-tech and highly medical skills, yet, as I listened with astonishment, midwife after midwife spoke in favor of requiring all of these skills for entry-level midwives.

Halfway into the process I raised my hand and asked for a quick sense of the room—how many of the midwives present favored requiring all these skills? When thirty-six out of the forty sets of hands went up, I was amazed to realize that I was bearing direct witness to the professionalization of lay midwifery. Even Ina May Gaskin, an irrepressible and eternal hippie and internationally known point person for "spiritual midwifery," argued for the IV requirement. She noted that after many years of holistic midwifery practice, she realized she had been relying on EMT technicians on the Farm to insert IVs in those rare cases of severe postpartum hemorrhage, and had finally taken responsibility for learning the skill herself. She felt that it was now an invaluable part of her midwifery repertoire, and she stressed not only its lifesaving potential, but also its positive value in terms of the public image of midwives, saying, "When we have a hemorrhage and we transport the woman with an IV already in place, we really look good to the hospital personnel who receive our clients. It helps them to trust us as practitioners."

Only four of the midwives there were in active opposition. Their primary spokesperson was Sandra MorningStar, a midwife from Missouri who had been sent to the meeting with a mandate from her state midwifery association not to allow IVs to be required as an entry-level skill for CPM certification. (In the consensus process used by members of MANA, one person can block a proposal even if everyone else supports it.) As midwife after midwife tried to get her to change her mind, Sandi

held fast, insisting that requiring IV insertion sent the wrong message to student midwives. She said that IV insertion was "an advanced, not an entry-level skill," because the proper first courses of action in case of a hemorrhage were, in this order: (1) to speak to the mother, commanding her to stop bleeding (an intervention that midwife/anthropologist Janelli Miller calls "magical speech"), (2) to administer the herb shepherd's purse, (3) to utilize bimanual compression of the uterus, (4) to give a pitocin injection, and only after all that had been tried, (5) to insert an IV and transport. Sandi herself had learned IV skills a decade before, but she didn't want student midwives thinking that they should jump straight to the IV without learning all the other techniques that homebirth midwives had "rediscovered" for dealing with hemorrhage, because usually those less interventionist techniques were all that is needed. The midwives in her state, who were practicing illegally, did not want to be required to carry IV equipment, as this would open them to the serious charge of practicing medicine without a license. So steadfast was Sandi in her insistence on blocking the IV requirement that, after four hours of trying to get her to change her mind, the others gave up, put the matter in the hands of the steering committee, of which Sandi was a member, and took a break before dinner.

At dinner I was curious to see how Sandi would be treated by those who had opposed her so vehemently only an hour before. (She had been in tears at one point, openly questioning whether she should even become a CPM.) Ina May got to the dining room first, rushed over to Sandi, gave her a big hug, and thanked her for "speaking her truth" and "holding her space." Ina May said that when one midwife holds her space, it always works out better for everyone than if she had given in against her will and compromised her principles. And so the dinner went, with everyone hugging Sandi and expressing their appreciation. They still disagreed with her, but their trust in the consensus process was deep—experience had taught them that somehow it would work out.

By the time the steering committee met, everyone on it was exhausted. We sprawled around the room and tentatively started the discussion. Sandi still wouldn't budge until someone said, "Well, Sandi, if you knew that most of the midwives in the United States wanted IVs to be required, would you still hold this position?" Sandi answered, "Of course not! I'm not here to tell the majority of midwives what they *should* do! It's just that I don't think the forty women at this meeting [all of whom were midwifery leaders or directors of private midwifery schools] really represent the majority of practicing midwives—I'm trying to speak out for the ones who are not here, who don't think as you do." At that point, with dawning amazement, the group began to

realize that they had just been handed a golden key. It occurred to all of us simultaneously that none of us could really say *what* the majority of practicing midwives thought about which skills should be required for entry-level practice, and it wasn't long before the steering committee was actively and excitedly planning what later turned out to be the largest survey of practicing midwives ever conducted in the United States, the *NARM 1995 Job Analysis.*

Some months later, after hundreds of volunteer hours of work, 3,000 surveys were mailed, and although they were so detailed they took over twelve hours to fill out, 800 of them were returned in usable form (Houghton and Windom 1996 a, 1996b).[5] As a result, the NARM process is based on midwifery as actually practiced by these 800 out-of-hospital midwives, not just by the forty who had been present on Captiva Island that day. These grassroots midwives themselves set the standards by which they were to be judged, and thereby avoided two of what they saw as the primary potential downsides of commodification—the many being co-opted by the rule-making few, and quality and individualized design and service giving way to mass standardization. They ultimately did standardize the production of CPMs, but the criteria they used were not arbitrarily established by an elite governing group, but rather were consensually chosen by a majority of practicing DEMs. In other words, they qualified (modified, moderated) the ways in which they commodified according to the internal standards of the larger, and still countercultural, group.

Quality Control

> The education, skills, and experience necessary for entry into the profession of direct-entry midwifery were mandated by the Midwives' Alliance of North America (MANA) Core Competencies and the Certification Task Force; were authenticated by NARM's current Job Analysis; and are outlined in NARM's *Candidate Information Bulletin* and the *How to Become a Certified Professional Midwife (CPM)* booklet.
>
> ***—How to Become a Certified Professional Midwife***

As these midwives perceived it, a commodity must be subject to mechanisms of quality control. Part of the professionalizing enterprise is the inclusion of those who meet established criteria for education and practice—in other words, for quality—and the exclusion of those who do not. This simple fact was the subject of intense debate among MANA midwives during the 1980s and early 1990s. At that time, the social movement was (and remains) MANA's dominant ethos, and inclusiveness its dominant ethic. MANA's nonprofessional inclusiveness was in deliberate and direct contrast to the ACNM's professional exclusiveness.

Voting membership in ACNM entailed ACC (ACNM Certification Council) certification as a CNM (or later, as a CM) (see chapters 1 and 2). Membership in MANA entailed the simple statement that one was a midwife. At the first MANA conference I attended in El Paso in 1991, some MANA midwives were refusing even to utter the word "professional" because of its exclusionary connotations. Nevertheless, it was clear that they were evolving into professional midwives with a codified and cohesive body of knowledge and skills. Their creation of NARM certification was a strong expression of this evolving sense of professionalism.

Their motivations for seeking a more secure cultural status included not only their desire to protect mothers and babies from the mistreatment that results from medical stereotyping of midwives, but also to protect them from mistreatment by midwives who are insufficiently educated. Although DEMs do not like to talk about it, it is a fact that in the early days of lay midwifery, when everyone was on a learning curve, occasional bad outcomes in out-of-hospital births resulted from a midwife's lack of knowledge or skill. Today, DEMs have a named category for the *renegade midwife* (see chapter 11) who practices outside the protocols and parameters of her peers in her local midwifery community. Thus, a means of testing midwives to ensure that they have the necessary knowledge, skills, and experience became increasingly desirable to DEMs themselves, and NARM certification became the mechanism of quality control they chose.

It is a given that any certification process will include those who meet all requirements and exclude those who do not. This process of exclusion starts with requirements for candidacy. The DEMs' desire to minimize the exclusiveness of their certifying process led NARM board members, in consensus with the Certification Task Force, to establish four educational categories through which student midwives can apply for NARM certification as a CPM. Applicants in all four categories must meet NARM's General Education Requirements, which include attendance at forty births, twenty as primary attendant under supervision; three courses of continuity of care; seventy-five prenatal exams; twenty newborn exams; forty postpartum exams; CPR (adult and neonatal) certification; and other criteria (see www.narm.org for more details), but how an applicant must demonstrate that these requirements have been met varies by the educational category through which she applies.

The first category listed in *NARM's How to Become a CPM* booklet is graduation from a formal program accredited by the Midwifery Education and Accreditation Council (MEAC). Because the education of

these students has already been evaluated by the faculty of the school, in general, upon completion of their program, they have only to pass the NARM written exam.

The second category is "certification by the ACNM Certification Council (ACC)." Inclusion of this category was not without effort. As we saw in chapter 2, Sharon Wells and Alice Sammon had been prime movers in the DEMs' effort to be included in the CNM bill. Defeated in New York, they had turned their prodigious energies to the national level, and had become two of the most influential and visionary members of the NARM board, along with Carol Nelson, who had also practiced midwifery in New York. Thus, and understandably, the initial debate among the members of the NARM board over whether or not to allow ACNM-certified midwives (CNMs and CMs) to apply for CPM certification was tinged with intense bitterness and exclusionary desires.

But in the end, MANA's core ethics of inclusiveness and sisterhood once again prevailed, and the NARM board consensually decided to keep its certification open to all midwives, including CNMs and CMs. While NARM was aware that most nurse-midwives would not want or need NARM certification, its members were also aware that some CNMs would want to become NARM-certified out of a philosophical commitment to MANA and to homebirth and midwifery as social movements, while others might need to become CPMs so that they could practice autonomously outside of hospitals, which in some states their CNM or CM certification might not allow them to do. To date, four CNMs have chosen to also become NARM-certified, and as we shall see later on, NARM certification may come to have particular significance to ACNM's new CMs.

Once NARM decided that CPM certification should be open to ACNM/ACC-certified midwives, there was much discussion among board members as to whether additional requirements should be established for candidates in this educational category. This discussion led to a general philosophical agreement among NARM board members and the CTF that in-hospital experience, which is all that ACNM-accredited programs require, is not sufficient preparation for out-of-hospital practice. So it was decided that CNMs and CMs who apply for NARM certification must document attendance as primary midwife at a minimum of ten out-of-hospital births and three courses of continuity of care, and must pass the NARM written examination. (This exam tests knowledge about birth outside the hospital, where as one NARM member put it, "there is no button to push to call for backup and a midwife must know how to handle sudden emergencies herself.")

With these requirements, NARM both kept its certification process open to and inclusive of nurse-midwives, and held its own conceptual space as an organization dedicated to establishing and evaluating the knowledge, skills, and experience required to attend out-of-hospital births.

NARM's third educational category is legal recognition in states previously evaluated for educational equivalency. This category recognizes the equivalency between some pre-existing state certification or licensure processes and NARM certification. Candidates from these states can, with some exceptions, simply submit a copy of their state license and take the NARM written exam.

The fourth category, and the most innovative and complex, is completion of NARM's portfolio evaluation process, also known as PEP—the route established by NARM to evaluate the education, skills, and experience of midwives trained through apprenticeship and self-study. PEP applicants are divided into two categories: "entry-level" and "special circumstances."[6] Entry-level candidates must document their fulfillment of NARM's General Education Requirements; provide written verification from their preceptor(s) that they have achieved proficiency in the numerous skills listed on NARM's Skills, Knowledge, and Abilities Essential for Competent Practice Verification Form; provide a written affidavit from their preceptor(s) that the applicant meets various other requirements; provide three professional letters of reference; and pass the NARM Skills Assessment (a hands-on exam conducted on a pregnant volunteer and an infant). Because an apprentice-trained midwife may have only one or two preceptors during her entire training (individuals who may be her friends), NARM and the CTF felt a need to establish a mechanism for testing her actual skills. Ideally, such an exam would evaluate the skills demonstrated by the student midwife at a birth, but that would have required the exam administrator, called a NARM Qualified Evaluator, to travel to wherever the midwife lived and wait there until her client went into labor. Cost, logistical, and liability difficulties make this impossible. So instead, NARM board members utilized the list of required skills that stemmed from 1995 *Job Analysis* (Houghton and Windom 1996a), emphasizing the skills that can be demonstrated on a pregnant volunteer and an infant. For each exam, the skills that will actually be tested are randomly chosen from this list by a computer. The Qualified Evaluator asks the applicant to demonstrate each skill and grades her performance. This skills exam has formed an essential part of NARM's success in establishing the CPM as a valid credential, as it helps to resolve the issue of how apprentice-trained midwives can prove that they have obtained the skills that were

identified as necessary for entry-level practice, thus ensuring the requisite degree of uniformity in quality among CPMs.

Within a profession, another major aspect of quality control is what mechanisms exist for taking disciplinary action against members who are accused of malpractice. The creation of an effective peer review process has been a major challenge for the NARM board, as it requires them to sit in judgment of their own, a painful position for midwives operating under an ethos of sisterhood and inclusivity. Due to space limitations, I will not discuss the complexities of this process here, as to date there have been very few cases in which the peer review process has had to be activated (three CPM certifications have been revoked). More important for the issue of quality control is birth outcome, which for midwives is the ultimate litmus test of quality control.

Quantification, Legality, and Midwifery's Market Niche

Quantification A commodity must be quantifiable and measurable. How many are produced, how many are sold, how many are used, how well do they work? And a commodity must be able to tap into an existing market niche or, like the personal computer, create one where none previously existed. Lay midwifery in the United States arose in response to the desires of some women to avoid hospital birth. In other words, the market niche existed and lay midwifery rose to fill it. But as long as midwifery remained primarily a social movement, the numbers of women utilizing lay midwives' services remained miniscule. In the United States, as we saw in chapter 1, out-of-hospital births still account for less than one percent of all births.

Direct-entry midwives have long contended that more women want homebirth than are able to achieve it because of the limitations on their accessibility, imposed by lack of legalization, licensure, and/or insurance reimbursement. Where DEM practice is illegal, it is accessed only by the tiny minority of women so committed to the philosophy and spirit of the homebirth movement that they are willing to go outside the law to achieve it. Where DEMs are legal but not reimbursable under insurance, they are accessed only by women who can pay out of pocket for their services. Where they are legal, licensed, and insurance reimbursed, their accessibility to a much wider clientele is reflected in the higher homebirth rates in Oregon, which are paralleled by rising homebirth rates in Florida, New Mexico, Arizona, Vermont (where the homebirth rate doubled in the two years after licensure was achieved), and Washington state. In certain areas of Seattle, for example, where licensed midwives are easily accessible to large numbers of women and

are fully covered under insurance, homebirth rates have risen to eight percent or more, reinforcing the point Ina May Gaskin made in chapter 1 that the "one percent barrier," as it used to be known, was a reflection not of women's lack of interest in homebirth, but rather of its culturally imposed inaccessibility.

Over the past decade, this inaccessibility, which was nearly universal in the United States in the 1960s, has given way to wild variation in the legal status of (and thus consumer access to) DEMs from state to state (see chapter 1). For midwives, issues of quantification, measurability, and marketability in terms of their public image center primarily on outcome. Over time, MANA had accumulated a database of the outcomes of 14,000 births, but this data was not considered epidemiologically valid because it was voluntarily and retrospectively submitted, leaving the results open to the charge that midwives had simply not sent in any bad outcomes they may have had. In 1999 the NARM board decided to address this problem by requiring that every CPM submit a prospective form for every client she accepted in the year 2000, and then account for the outcome of each of those births. Participation in this endeavor, which became known as the CPM2000 Statistics Project, was made mandatory for recertification as a CPM (which must be done every three years). The outcome forms had to be verified by the client whose birth they describe. In this way, the members of the NARM board and the MANA statistics committee intended to generate outcome data for CPMs that meets epidemiological standards for validity. In a sense, they "bet the company" that the outcomes would be good; if they were not, the public image of the CPM and her value as a health care commodity would suffer accordingly.

Preliminary results of the CPM2000 project were presented at the 2001 and 2002 meetings of the American Public Health Association (Johnson and Daviss 2001) and the 2001 and 2003 MANA conventions, and in 2005 were published in the *British Medical Journal* (Johnson and Daviss 2005). Three hundred fifty CPMs sent in data on over 7,000 courses of care. The transport rates from homes (or birth centers) to a hospital were 12.1 percent, meaning that out of every 100 women who started out intending to give birth at home, eighty-eight did so successfully and twelve were transported. Half of the transfers were for failure to progress, pain relief, or maternal exhaustion, and the midwife considered the transfer urgent in only 3.6 percent of intended homebirths. (When a homebirth mother lives thirty minutes from a hospital, the time from start of transport to cesarean is that same thirty minutes. Inside the hospital, the time from "decision to

incision" is also about thirty minutes.) The cesarean rate was 3.7 percent, and the perinatal mortality rate (PNMR), which is the most critically scrutinized figure, was two in 1,000 (1.7 in 1,000 without breeches), equivalent to what it is for nurse-midwives attending homebirths and for physicians attending low-risk births in hospitals. This study shows that planned homebirth attended by a CPM is as safe as hospital birth for low-risk women, and a good deal less interventive. These good outcomes, which demonstrate safe and effective care, will now be included in every legislative package and will become a major marketing tool.

As I have tracked the evolution of the CPM, I have wondered with fascination at what point, if ever, MANA would evolve into a professional organization requiring CPM certification for voting membership. Conversations about creating a separate organization representing CPMs began around 1997, but were usually squelched with the argument that such an organization would generate a further fracturing of an already over-fractured midwifery community. With only 882 members, MANA could hardly afford to lose one-third or more of them to a separate organization. In 1999, yet another problem became visible. While ACNM's membership was growing by 500 or more a year, as new students graduating from the forty-five existing nurse-midwifery programs became full voting members, MANA's membership had hovered at between 700 and 1,000 for years. Part of the problem, it turned out, was that only about one-half of the new CPMs belonged to MANA. All the members of the NARM board are longtime members of MANA and were concerned by this trend. So the NARM board decided to run an ad in the spring 2000 edition of the CPM News; here is how it read:

Numbers Matter!

MANA is the only national organization that is open to all midwives. The ACNM's membership has surpassed 8000 while MANA's membership has held steady at around 1000 for nine years. In order to continue to provide an effective counterbalance to the medicalization of midwifery, and to promote the Midwifery Model of Care and the CPM, MANA must grow! Only half of all CPMs currently belong to MANA.

JOIN MANA, SO THAT WE CAN STAND TOGETHER AND BE COUNTED!

Benefits of membership include:

The MANA News—a primary source of information about political issues affecting CPMs.

Ensuring that MANA represents the interests of CPMs.

Being part of the Sisterhood of Midwives.

Fostering midwifery as a social movement.
Helping to preserve out-of-hospital birth.
Being counted in the national tally of direct-entry midwives.
ASK NOT WHAT MANA CAN DO FOR YOU—
ASK WHAT YOU CAN DO FOR MIDWIFERY BY JOINING MANA!!

It is an ironic twist that its concern with numbers has placed MANA, whose members created CPM certification, in the position of having to market itself to CPMs. Querying those CPMS who hesitated to join MANA, I found that many of them preferred to pay membership dues to their state associations, which represented them as regulated professionals or were lobbying to make them so; they did not perceive membership in MANA as relevant to their concerns as professionals. This situation represents a further transformation in American direct-entry midwifery, demonstrating that a significant portion of CPMs are more committed to the professionalizing enterprise than to the social movement (see Daviss 2001, and chapter 12 of this volume) and/or to local political struggles over national issues (Christa Craven, personal communication, 2005).

Potential need for a separate organization for CPMs became manifest during the attempt that nurse- and direct-entry midwives are currently making for legislation in Massachusetts (see chapter 9), a move intended to heal the breach created in New York by regulating both types of midwives under the same state midwifery board. Legislators understand professional organizations and the official standards they set. The Massachusetts CNMs could point to national practice standards set by ACNM, but CPMs could not because although MANA had set practice standards similar to those of ACNM, MANA is not a professional organization that requires certification for membership. So the direct-entry midwives of Massachusetts felt the need to create a national organization requiring CPM certification for membership that could set specific standards for CPMs. (Not only are such standards reassuring to legislators, but they also help midwives themselves retain control over their profession—a better situation than having standards set for them by regulatory groups with non-midwife members.) A new CTF meeting was held at MANA 2001 in Albuquerque, New Mexico; the discussion revolved around whether the new CPM organization should be independent or should be a section of MANA, albeit with its own independent governing board. At the time, consensus crystallized around the latter option. The thirty or so midwives at the task force meeting wanted to honor the need of CPMs for their own organization and representation without fracturing MANA. But many interested parties were not present at that meeting (it occurred shortly

after 9/11), so the discussion continued, ultimately resulting in the creation of a CPM section within MANA *and* an independent organization, the National Association of Certified Professional Midwives (NACPM).[7] Their strong and inclusive consensus tradition led MANA members to form both, and then see which one would receive the most grassroots support. This interesting development reflects the identity struggles of the new CPMs—are they primarily invested in the professionalizing/commodifying processes of certification and licensure that the NACPM represents or in the social movement of midwifery and its inclusivity that MANA represents? Or will they accomplish and support both simultaneously? As of the date of this writing (May 2005), the NACPM had only about 100 members, but its board, with the help of an advisory committee, has completed national standards of practice for CPMs (www.nacpm.net), which have already been of help in successful legislation in Utah and Virginia and proposed legislation in Wisconsin, as well as in Massachusetts. The CPM section of MANA appears to have few members; time will tell if it will continue to exist.

Legality, Illegality, and the Price of Licensure The multibillion-dollar international drug trade makes it clear that it is not absolutely necessary for a commodity to be legal to be successful in creating and reaching its market niche. Where consumer demand exists, entrepreneurs will try to fill that demand even if it means breaking the law and risking jail. In most such cases, there is nothing noble about this enterprise; it's simply about money and power. In contrast, the early "lay" midwives and contemporary "direct-entry" midwives (many of whom are the same people) flouted the law and continue to do so in some states, not out of a quest for money and power, but out of the moral imperative they feel to keep the homebirth option open to the women in their communities. Members of social movements regularly break the law in the name of their cause; part of the point is to get the laws changed to reflect the realities the social movement is trying to generate. Commodification forms a major part of the strategy midwives and their consumer allies employ to obtain legality.

In many such states, groups of midwifery supporters, often called Friends of Midwives (as in Massachusetts Friends of Midwives), work to help direct-entry midwives gain legal status. At the national level, a consumer group called Citizens for Midwifery (CfM) has generated a number of helpful publications, from brochures on the Midwives Model of Care (MMOC) to information on lobbying and working with media (www.cfmidwifery.org). CfM focuses on networking, sharing information and resources, promoting the MMOC, encouraging public

education efforts, and helping state organizations with legislative initiatives. CfM's stated vision is "to see that the Midwives Model of Care is recognized as the optimal model of care in all settings and available to all women" (Susan Hodges, personal communication, 2003). Through such consumer support groups, direct-entry midwifery's market niche loudly proclaims its existence in highly public ways. For example, when DEMs are arrested or persecuted, or are actively promoting legislation or trying to change an unfavorable bill, they are often helped to win their cases by the public demonstrations consumer groups sponsor and the press coverage they generate.

When lay practitioners become professionals and obtain the benefits of legalization and licensure (which include not only insurance reimbursement, but also not having to worry about being arrested), there is usually a price to be paid. Licensure means regulation, and regulation means restrictions on one's decision-making power and thus on one's autonomy. When DEMs practiced illegally, they did pretty much everything they wanted to do—it was all illegal, so what was the difference? Thus their practices often included attending women choosing homebirth who would be classified in the hospital as high risk, most especially women with babies in the breech position and women giving birth to twins. While most entry-level DEMs would themselves consider these to be high-risk conditions meriting transport, some highly experienced DEMs have gained special expertise in attending such births and are often more skilled at it than most physicians. (Increasingly, vaginal birth after cesarean (VBAC) is considered high-risk in hospitals; some DEMs do not consider them so and continue to attend them at home.)

Nevertheless, getting state legislatures to legalize DEMs and state boards to regulate them in ways that actually allow them to continue to practice almost always requires certain compromises; most often it is these three kinds of births (VBACs, breeches, and twins) that midwives must give up the right to attend out-of-hospital. Before regulation, attendance at such births was a matter of a midwife's individual choice; after regulation, they would be breaking the law to do so, and in danger of losing their license. So midwives seeking commodification have had to decide which is more important: full autonomy or being able to sleep at night instead of lying awake in fear of a knock on the door.[8] Most of the time they compromise and accept these sorts of restrictions in return for the benefits of licensure; in other words, most of the time they are willing to pay the price of commodification.

Some midwives, however, refuse to pay that price. In Pennsylvania and other states, such midwives call themselves "plain midwives," to

differentiate themselves from the professionalizing direct-entry midwives. Few such midwives belong to MANA. Often they are members of religious groups; in general, they just want to serve their communities according to their particular customs and beliefs, preferring to remain completely outside of the system. Although they run the risk of being arrested for practicing medicine without a license, in actuality they are so few in number and so adept at avoiding publicity that they are usually left alone; to them that seems better than the closer scrutiny that comes with legalization and regulation. In other words, content to remain in the cultural margins, the plain midwives reject both professionalization and commodification, while their direct-entry colleagues actively seek, through both of these strategies, to enter the mainstream. After sometimes bitter rhetorical battles with plain midwives in their states, DEMs often decide to accept or actively generate a fissioning of their social movement by clearly differentiating themselves from midwives who do not want any kind of licensure or regulation. Mary Lay has documented this process in detail for Minnesota, a state in which the professionalizing DEMs formed a midwifery guild and eventually won state licensure based on NARM certification. One of the rhetorical strategies they employed was actively distancing themselves from their nonprofessionalized colleagues. Lay (2000:78) notes that during the legislative hearings:

> the Minnesota direct-entry midwives made clear that the midwifery community was divided, and to some extent took advantage of that division. As those involved in the hearings struggled to define the "good midwife," they did so by acknowledging an "other" midwife who seemed not to rely on medical knowledge to screen her homebirth clients and who was in essence silenced in the hearings.

Such silencing is not atypical of the results of successful commodification processes. Midwives who succeed in professionalizing and obtaining licensure often find it both ironic and intensely distressing that their mainstream status results in the establishment of exclusionary hierarchies in a community where before, there were none. In Washington state, for example, in the early 1980s DEMs succeeded in gaining legalization and licensure via an old law on the books that allowed for midwives to be licensed if they graduated from a formal vocational school. The Seattle Midwifery School (SMS) thus became the first, and is by now the best-known three-year DEM vocational

program. Its founders were countercultural self-help feminists who thought they were going to end up in jail for practicing midwifery, but ended up founding a school instead. The downside was that no DEM could become legal and licensed in Washington without graduating from this school, which takes three years and costs over $25,000 in tuition. The result has been the hierarchization of non-nurse midwifery in the state: SMS graduates, who call themselves direct-entry midwives, are legal, licensed, regulated, and insurance-reimbursed. The "other midwife" thus created is called a *lay midwife*; she can practice legally only if she does not accept any money in payment for her services. Thus the victory of some has been the defeat of others. Because this result was never their intention, the directors and staff of SMS have been trying for years (and have recently succeeded) to get the legislature to open other routes to licensure in Washington state. In one sense, opening such routes is like shooting themselves in the foot, as it may limit the number of applicants they receive, but their commitment to the spirit and inclusive ethos of the social movement remains strong, and they would prefer to qualify, even compromise, the success of their commodification rather than continue to live with the exclusions and hierarchies it has created.

This respect for and appreciation of nonprofessionalizing lay or plain midwives is one of the primary reasons MANA members voted at their Florida convention in 2000 to keep their membership open to all midwives. Licensed midwives responsible to the state often find themselves torn between parents' wishes and regulatory protocols. They stand to lose their licenses if they accept out-of-protocol home-birth clients (e.g., VBACs, breeches, or twins). Sometimes licensed midwives take such cases anyway; other times they refer such clients to the unlicensed, illegal, or alegal "lay" midwives nearby (if they respect those midwives' skills), who are often termed "renegade midwives" because they do not follow peer group protocols, but rather consider the wishes of the parents to be primary (see chapter 11). The professionalizing members of MANA, who used to have the same priorities, regard these lay midwives with an odd combination of distrust and wistfulness, but they would never want to exclude such midwives from membership in MANA. Having to turn away certain clients one has the skills to attend is the price many pay for licensure, and there is a great deal of respect within MANA for skilled and responsible unlicensed midwives who are unwilling to pay that price and so will serve the clients licensed midwives are supposed to refuse.

Purchasability, Marketing, and Brand Name Recognition

> Certified Professional Midwives (CPMs) are skilled professionals qualified to provide the Midwives Model of Care, which is appropriate for the majority of births.
>
> —**NARM brochure, *The Certified Professional Midwife***

Commodities are sold and bought. This kind of purchasability came after the fact to many lay midwifery pioneers who began their work out of an ethic of service to women. Over time and across the country, these early pioneers evolved into seasoned professionals with set fees, bookkeeping systems, and a desire for insurance reimbursement. But to be bought, commodities must be readily available. In states where direct-entry midwifery remains illegal, their practice is very much underground and they can be extremely hard to find. In contrast, in states where they are fully legal, licensed, and regulated, midwives' advertisements often appear in bold letters in the yellow pages. For example, an ad for the Austin Area Birthing Center in Austin, Texas, reads as follows:

> Create an Ideal Birth for You and Your Baby:
>
> With Gentleness and Individual Care in a beautiful, warm, homelike environment!
>
> - Staffed with Certified Professional Midwives and Licensed Nurses
> - Medical backup
> - Covered by most insurance
> - Spacious birthing rooms with fire place & waterbirth tub
> - Complete care from prenatal through birth
> - Over 1800 successful births since 1981
>
> Childbirth the Way It Should Be!

Fees for midwifery services vary widely from rural to urban areas. For a quick example, in Austin, direct-entry midwives charge $3,000 for one entire course of care, including prenatal care, labor and delivery, and postpartum follow-up. Although their fees are markedly lower in most areas than those charged by obstetricians and CNMs, DEMs remain at a disadvantage because in most states their fees must be paid out of pocket, a fact that often limits their client base to the middle class. Lack of insurance reimbursement has in some places been a powerful motivator for midwives to obtain NARM certification and to drive for legislation recognizing the CPM as a legitimate health care provider. In this endeavor, cost-effectiveness is one of their major supporting points. Because DEMs employ few technological interventions

and practice out of hospital, from a governmental perspective they are a cost-effective alternative to highly expensive obstetrical care. But the costs of state testing and licensure are high, so the expenses of the boards that must regulate licensed midwives can be prohibitive. Thus one of NARM's most effective marketing strategies has been pointing out to state agencies how much money they can save if they let NARM do the testing and credentialing instead of the state. A fact sheet developed by NARM, dated August 12, 1999, reads as follows:

HOW CAN THE CERTIFIED PROFESSIONAL MIDWIFE (CPM) CREDENTIAL SAVE GOVERNMENT AGENCIES MONEY ?

When the CPM is used as the state credential for midwives practicing in out-of-hospital settings, government agencies can:

1. Avoid expending valuable staff time to validate the education of direct-entry midwives who practice in primarily out-of-hospital settings;
2. Avoid test construction and maintenance costs associated with the creation of a licensure examination;
3. Save the costs of test administration;
4. Save the costs of continuing education monitoring for re-licensure.

IT'S A GOOD DEAL FOR THE MIDWIVES! IT'S A $$ SAVER FOR THE STATE!

Through such promotional literature, NARM seeks to demonstrate not just its cost-effectiveness, but also its user-friendliness to state agencies, whose beleagured workers are often delighted to be relieved of some of their administrative burdens.

Of course, user-friendliness has become a buzzword for accessibility in technology; likewise, brand name recognition is often an essential ingredient of a commodity's success. User-friendliness has been a central distinguishing feature of midwives' practices from the beginning, one that they have long branded *woman-centered care* in order to contrast their approach to that of physicians, who often place their own needs or the requirements of the institution above those of the mother. Another identifying phrase, a sort of generic label adopted by all American midwives, has been "the midwifery model of care." These two phrases are universally used by both nurse- and direct-entry midwives. But as NARM crystallized its certification, its members and many others worked for months to develop and copyright their own "brand name," which turned out to be a definition of what they originally called the Midwifery Model of Care (adding the capitalization to distinguish its wording as uniquely theirs).

This focus on the model of care rather than the midwife was a contribution from consumers, as Susan Hodges, president of the national consumer group Citizens for Midwifery, recounts:

> When representatives of MANA, MEAC, and NARM began having regular phone calls (spring of 1996), one of the first things that came up was the need for some way to succinctly describe what we were all working for. The idea was to come up with a definition of *midwife*. It was Citizens for Midwifery that suggested a definition of a kind of care rather than of a midwife. As consumers, we were very aware that the kind of care you get is much more important than the letters after someone's name. [We knew] that there was tremendous variation among midwives in terms of how they practice. So it was the consumers who strongly suggested a definition of the model of care, which has turned out to be much more useful than a definition of midwife. (Personal communication, 2003)

As MANA, NARM, MEAC, and CfM began to organize their marketing strategies around this model, they were increasingly disconcerted by the fact that the word "midwifery" was not user-friendly: many people, including legislators, had a problem pronouncing it, which often resulted in embarrassment and a general turnoff on the legislator's part. On the advice of a professional marketing organization they had hired to help them revamp their public image, they changed the name to "Midwives Model of Care," trademarking the label and the brief description of that model on which they had all agreed:

> The Midwives Model of Care is based on the fact that pregnancy and birth are normal life events.
>
> The Midwives 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. (NARM, *How To Become a CPM*, 2002:2).

This description was originally copyrighted in May 1996 by the Midwifery Task Force (a nonprofit corporation), under the title "Midwifery Model of Care." It was recopyrighted in 2000 with the new title

"Midwives Model of Care." This brief description of the MMOC appears in all NARM literature, including its consumer brochures and legislative lobbying packets. A much more detailed description of what a woman should expect from a practitioner promising this kind of care is published in CfM brochures. Many thousands of copies have been distributed in the United States and around the world. As the brochure points out, any practitioner, including physicians, can provide this model of care. This focus on a user-friendly and consumer-oriented brand name—the Midwives Model of Care—instead of on the midwives themselves, is an intentional strategy suggested by consumers and agreed on by midwives. This consensus arose to focus more attention on the pregnant woman as the deserving recipient of a certain kind of care, and less on the self-promotion of midwives who seek to provide that kind of care (even though the ultimate effect may be the same). Through this brand name choice, CPMs remind themselves, even through their self-marketing, that their primary mission is to mothers.

Design and Redesign: Commodities as Responsive to Consumer Demands and Market Trends

> The term "midwifery consumer" . . . implies a certain agency and choice on the part of women having midwifery care that has always been important to midwifery. Indeed, the consumer-based campaign for choices in childbirth was a key factor that fueled midwifery as a social movement over the last several decades. The idea of the midwifery consumer, however, is not simply a result of the self-conscious feminist agenda of woman-centred care and the critique of biomedicine. It also speaks to the political economy of reproduction . . . in the context of late capitalism and demographic transition, specifically, the trend towards having fewer children later in life and the trend towards treating pregnancy and childbirth as valuable experiences.
>
> **—Margaret MacDonald, "The Role of Midwifery Clients in the New Midwifery in Canada: Postmodern Negotiations with Medical Technology"**

Successful commodities in today's market frequently shape-shift in response to technological advances, consumer trends, and market demands. Computers were beige and boxy until the iMac set new standards for attractiveness in computer design, reshaping consumer expectations for how computers should look. The ugly but functional toaster from Target is elegantly redesigned; the software upgraded; the dishwasher computerized. The "redesign" of direct-entry midwives in response to consumer trends has, to date, been most obvious in Ontario, where

the legalization of midwifery in 1993 was accomplished through an alliance of nurse- and lay midwives who united behind a model of midwifery practice based on the principle that "the midwife follows the mother." In other words, women select their site of birth—home, birth center, or hospital—and the midwife will attend them there. As a result, Ontario's former lay midwives, who practiced only outside of the hospital for two decades when midwifery was a social movement and not yet a profession, have had to familiarize themselves with hospital protocols and technologies. And, as documented by MacDonald (2001), Sharpe (2004), and Daviss (2001), Ontario midwives' client base has shifted from homebirthers dedicated to the holistic principles of the midwifery and homebirth movements to consumers who have had no involvement in these movements and may simply want more personalized care.

In particular, Margaret MacDonald (2001) points to the agentic role midwifery consumers are playing in reshaping the nature of Ontario midwifery. North American consumers display increasing familiarity with and respect for information obtained through high technology; when they choose midwifery care, they add to this familiarity the midwifery principle of fully informed choice. The result is that even when midwives themselves recommend against certain technologies, such as repeat ultrasounds or certain kinds of genetic testing (e.g., the triple screen), consumers often choose them anyway, and midwives find themselves the go-betweens in a game they are very uncomfortable playing. As Canadian midwife and social scientist Mary Sharpe (2001) expressed it:

> Midwives felt that the requirement to offer testing shifted their care towards a focus of verifying rather than assuming that pregnancy is normal, and were concerned that midwives themselves might be moving away from a wellness model towards a pathology-oriented model, relying on ultrasounds and an increased use of the system and spending less time on woman-generated discussions relating to the woman's feelings, questions, and circumstances.

In addition to the shape shifting they are undergoing in response to consumer demands, Ontario midwives find themselves changing even more as they attend more births in hospitals. In other words, the market for midwives to attend hospital births, which is larger than the market for midwives to attend homebirths, is slowly but inexorably

reshaping the nature of Ontario midwifery. Sharpe describes their experiences at the beginning of their entry into the hospital.

> [M]idwives. . . . were on a steep learning curve with respect to orientation to hospital procedures, protocols, equipment and paperwork, as well as client admission and discharge. While attending their first hospital births as primary caregivers following legislation, it would take two midwives up to four hours following the birth to accomplish the usual postpartum care and the new paperwork. . . . Comments from midwives expressed how they felt their practices were ruled by these new procedures.
>
> > "The hospital is the most disturbing situation to me because I'm finding it difficult to feel like I'm both fulfilling my expected role as a health care professional in the hierarchy of the system in the hospital as well as just being with someone which is what I feel my primary role is." (Anna)
>
> Some midwives felt closely monitored and scrutinized in hospital, and that the hospital staff was testing them, waiting to assess their level of competence. There was great pressure to be very careful about what they did. . . . In exchange for hospital privileges, some midwives felt compromised, now required to comply with certain hospital rules with which they didn't agree. Some midwives implied that they had to "behave like good girls" and "move into line" in order to get what they wanted for their clients in the hospital setting and to maintain their credibility. . . . The definition of being a good midwife in the hospital had changed for one midwife: before the legislation it had to do with her labour supporting skills, now, with her clinical care and charting. Another noted that experiences in the hospital were influencing how she worked at homebirths in that she didn't have as much hands on caring for the woman in either setting. . . . The client of one midwife who previously appreciated the spiritual aspect of her work, hired a "spiritual midwife." She wondered if she was now the "clinical midwife."

Decades of hospital practice have also clearly had their effect on American nurse-midwives; an examination of birth certificate data shows that CNMs' use of some technological interventions, such as electronic fetal monitoring, has been rising at the same rates as that of physicians (Curtin 1999). My interview data indicate that nurse-midwives' use of hospital technologies is influenced by the degree to which they are taught to rely on such technologies during their midwifery education, by pressures placed on them by other hospital personnel to utilize high technologies, and by the choices and demands of their clients, many of whom feel reassured by the application of high technologies to their births and actively choose their use (see Davis-Floyd 2003). This brief glance at the influence of hospital practice on Canadian midwives

and American nurse-midwives clearly illustrates how the market and its consumers can reshape the nature of the commodity.

Predictably, American DEMs are often heard to suggest that CNMs have sold out to or been co-opted by the medical system, noting that while out-of-hospital practice certainly limits DEMs' accessibility as a health care commodity, it also significantly limits the extent to which they can be co-opted into overmedicalization. While they have done some shape-shifting themselves in response to market trends and consumer demands, as long as they remain outside of hospitals, DEMs may be able to successfully limit the degree of change they undergo as they professionalize and commodify.

Commodities as Embedded in the Global Political Economy

American DEMs respect Ontario's former lay midwives for their success at achieving full integration into the Canadian health-care system and American nurse-midwives for being there for women who choose hospital birth, but DEMs are simultaneously aware that their purely out-of-hospital independent midwifery system is unique. Recently I coauthored, with a group of international scholars, a chapter comparing midwifery education in the United States, Canada, and Europe (Benoit et al 2001), which we organized around the three basic models of midwifery education: apprenticeship, vocational training, and university education. As I worked on the sections on the United States, I was fascinated to note that because of the American DEMs, the United States is the only Euro-American country in which all three basic models of midwifery training are alive and flourishing. All over the developed world, I have heard American direct-entry midwives extolled as examples of "holistic midwifery," "pure midwifery," and "real midwifery." Many long-professionalized midwives in the United Kingdom, Italy, Australia, and other Western countries consider American direct-entry midwives to represent the heart or essence of what midwifery should be, and engage in long discussions about how they might try to recapture some of the spirituality and woman-centeredness that they feel they have lost in their professionalism. Thus American midwives feel a special responsibility not only to themselves but also to the world to preserve what they have created. Their sense of the value of their independent midwifery system and out-of-hospital knowledge base, in relation to midwives everywhere, has led the members of the NARM board to make the CPM an international certification, available to midwives in any country who might choose to adopt it. Some beginnings have been made: the Canadian province of Manitoba recognizes NARM certification, and at present there are forty-five CPMs in practice in Canada. Four midwives

in Mexico have become CPMs (Naoli Vinaver, Alison Bastien, Marian Tudela, and Laura Cao Romero; see Davis-Floyd 2001). One CPM per country is in practice in France, Ireland, South Africa, Namibia, and Hungary. While there is no government recognition of the CPM in these countries, the fact that it is an American-created credential gives it some authoritative status. In addition, as I mentioned in chapter 1, NARM has created a streamlined route for British midwives to be able to obtain CPM certification (which includes documenting attendance at the requisite ten out-of-hospital births and passing the NARM exam). If this process continues, the CPM may become an option for all European Union midwives who wish to practice in the United States attending out-of-hospital births.

CONCLUSION: MAINTAINING A TIRELESS VIGILANCE

> With legislation, midwives are learning new texts and engaging in new rulings. Are these rulings slowing us down, fixing us gradually and inexorably into new relationships and new ways of acting and being? Or do these rulings provide structure and support and free us? . . . The bottom line for midwives is: can legislation enhance creativity and expand possibilities for women and midwifery or limit them? . . . We need continuously to hold our behaviour in question. . . . We require a tireless vigilance to maintain what some would say are midwifery's gains, and others would call our compromises. And we must continue to examine our practices in order to recognize how we, for better or for worse, are implicated in the rulings of our profession.
>
> **—Mary Sharpe, "Exploring Legislated Ontario Midwifery"**

I have often heard members of NARM and MANA echo Sharpe's words as they work to maintain a tireless vigilance over the gains they achieve and the losses they suffer in their professionalizing and commodifying enterprises. What I have observed over and over is that every time these midwives face a choice between enhancing their public image as health-care commodities and compromising their values, their practices, or their training programs, they let go of image and concentrate on what works and what, in their eyes, preserves the essence of who they are. Speaking for all those who participated in the development of CPM certification (during a 1997 panel discussion), direct-entry midwives Pam Weaver, Elizabeth Davis, and Alice Sammon exclaimed, "We did it! We actually managed to develop a certification that encompasses everything we hold dear!"

To be sure, many midwives who have struggled to fill out NARM's detailed forms, to come up with the required documentation, or to pay NARM's fees, have done their share of complaining about the number

and complexity of the hoops they are asked to jump through, as have those who failed the NARM exam on their first and even second attempts and had to take it again. But I have watched this process long enough to be awed by the lack of controversy now surrounding it among MANA members, who have moved from initial deep suspicion of any standardizing moves to acceptance of the CPM as a credential that supports them far more than it gets in their way. As longtime homebirth midwife Sharon Wells put it, "the CPM is the only ground we have to stand on." Even the thirty direct-entry students I have interviewed, instead of complaining about NARM requirements, were happy to have specific goals to work toward. Several of them noted to me that apprentice-trained midwives are often not sure at what point during their training they can actually start to call themselves midwives instead of students. The arrival of their CPM certificate in the mail has become a concrete marker for them that they have earned the right to say, "I am a midwife."

Nevertheless, debates continue in various states between midwives willing and unwilling to compromise in order to gain a toehold in the technocracy, with one group accusing the other of selling out to get in. Many midwives mourn some of their lost freedoms to serve their clients as they saw best (see chapter 11) while they rejoice in their legal status and the many new clients who are seeking them out because they are legal and insurance-reimbursed.

When I focus on the big picture, what I see, all things considered, is that American direct-entry midwives, even as they professionalize and commodify, are simultaneously striving to maintain themselves as the woman-centered, family-serving, intuition-honoring, birth-trusting, and system-flouting guides and guardians of birth that they have always been. Clearly, commodification can be more than a means of selling out to capitalism. When qualified according to the values of a particular group newly perceiving itself as a commodity, it can also be a creative way of generating needed services that offer consumers a rich array of alternatives, precluding homogenization and facilitating the heterogenization of individual choice.

ENDNOTES

1. This chapter is a revised version of a chapter that appears in *Consuming Motherhood*, eds. Janelle Taylor, Danielle Wozniak, and Linda Layne (2004). I wish to thank anthropologists Linda Layne, Janelle Taylor, and Danielle Wozniak, CPMs Shannon Anton, Elizabeth Davis, Abby Kinne, Carol Nelson, Holly Scholles, and Alice Sammon; consumer advocates Susan Hodges and Jo Anne Myers-Ciecko; and sociologists Christine Barbara Johnson and Betty Anne Daviss (who is also a midwife) for their helpful comments and suggestions.

2. As Margaret Reid put it in "Sisterhood and Professionalization: A Case Study of the American Lay Midwife" (1989:229), "The first transformation to occur was often an internal one, a change in self-perception or self-image. . . . It was always a significant change, as one midwife's comments illustrate: 'it took me a long time [to realize]—I want some money for this. I'm spending maybe sixty hours a week, I'm away from my family . . . and I want to be compensated.' And with that grew the birth of a professional."
3. At that time, the members of the NARM board, who held primary responsibility for developing CPM certification, included Sondra Abdullah-Zaimah, Shannon Anton, Robbie Davis-Floyd (since 1994, I have served as the consumer representative on the NARM board; my role has been largely advisory), Alice Sammon, Suzanne Suarez, Ruth Walsh, Pam Weaver, and Sharon Wells. Key committee heads included Ann Cairns, Susan Hodges, Debbie Pulley, Abby Kinne, and Sandra MorningStar.
4. I was invited to become a member of the NARM board in 1994, in the position of consumer representative. Before I accepted the invitation, I made it clear that if I accepted, I would want to be studying NARM's work even as I participated in it, a request that was approved by the board members at the time. The members of the NARM board and the Certification Task Force have always been tolerant of, and helpful with, my dual roles as participant and observer, and I would like to express my appreciation to them for accepting me in both capacities.
5. Regarding the IV question, a large majority of survey respondents indicated that IV insertion should not be required for entry-level practice, and so it was not. Another fascinating result of the survey was in the category of Well-Woman Care. Respondents indicated that they did not wish the category as a whole to be required; however, they did wish all the skills listed under it to be required. At first puzzled by this response, the NARM board eventually ascertained that this meant that practicing midwives wanted entry-level midwives to be able to perform all these skills, but not to be required to offer general well-woman (gynecological) care.
6. NARM's inclusivity is perhaps best demonstrated by the Special Circumstances category, which is designed to allow midwives trained in other countries, *grand midwives* who began practice before 1965, or midwives trained through other unusual circumstances to apply. Special Circumstances applicants must document attendance at a minimum of seventy-five births in the last ten years (ten of which must have occurred in the preceding two years) and fulfill an extensive set of further requirements; they are individually evaluated by a special NARM committee. In addition, for the first two years of CPM certification, NARM held open an Experienced Midwife category as a mechanism to quickly evaluate and certify experienced practicing midwives. Qualification for the Experienced Midwife category required being in practice for more than five years and attending a minimum of seventy-five births as primary. Although this move was criticized by some members of ACNM and others as an easy way of granting certification to the "members of the club," it proved to be a critical and viable transition strategy for creating a base of qualified midwives who could then mentor student midwives through their certification process.
7. CPMs are not required to belong to MANA (or the NACPM). CNMs and CMs are not required to belong to the ACNM, but they are intensively socialized during their educational processes to think of ACNM as their professional organization, and the vast majority (approximately seventy-five percent) of them do. In contrast, MANA remains aprofessional, trying to meet the needs of both professionally licensed or certified midwives and those who are not, an increasingly difficult task.
8. Ohio midwife Abby J. Kinne CPM points to another crucial issue regarding midwifery autonomy even where state regulations do not exist. (In Ohio, direct-entry midwifery is not legally defined, but not prohibited.)

> It is not just fear of the knock on the door—for many of us, it is the trade-off for making the midwifery model of care more accessible to the homebirth community at large. Although Ohio has yet to institute regulations (which are quite likely, in the end, to restrict our ability to attend VBACs, twins, and breeches) some of us already are limited in such special circumstances in order to maintain good relations with supportive backup physicians. You can choose to help these moms and risk losing good backup, or you can make a concession to your backup doc so that you can continue to provide good backup to the vast majority of our clients who do not face these rare circumstances. It is a major dilemma for us. (Personal communication, 2003.)

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Fig. 3.1 Committee chairs who worked on the creation of the CPM, Captiva Island, 1995. Photographer: Robbie Davis-Floyd. From left (top) to right: Sharon Wells, Carol Nelson, Ann Cairns, Alice Sammon, Susan Hodges, Pam Weaver, Ruth Walsh, Justine Clegg. From left (bottom) to right: Jo Anne Myers-Ciecko, Marimikel Penn, Abby Kinne, Sandra MorningStar.

Fig. 3.2 Midwives Pam Weaver and Alice Sammon expressing their vision of the CPM as the gateway to the future for direct-entry midwifery, 1996. Photographer: Robbie Davis-Floyd

Fig. 3.3 The NARM Board, March 2005. From left to right around table: Robbie Davis-Floyd, Joanne Gottschall, Shannon Anton, Ida Darragh, Debbie Pulley, and Carol Nelson. Photographer: Robbie Davis-Floyd