INTRODUCTION

Why Are Social Scientists Studying the Development of Direct-Entry Midwifery in the United States?: Politics, Identity, Professionalization, and Change

Robbie Davis-Floyd and Christine Barbara Johnson

CNMs think DEMs have copped out, and DEMs think CNMs have sold out.

—Joyce Roberts, President of the American College of Nurse-Midwives, 1999

One group needs to tighten up, and the other group needs to lighten up!

—Katherine Camacho Carr, President of the American College of Nurse-Midwives, 2005

FROM ROBBIE DAVIS-FLOYD: RESEARCH, METHODOLOGY, AND THE NATIONAL CONTEXT

Research and Methodology

This book builds on my twenty years of research on American childbirth, which have included since 1991 a growing fascination with

midwives and midwifery. My first book, *Birth as an American Rite of Passage* (1992, reissued in a second edition in 2004), analyzes the responses of 100 women to their medical and social treatment during pregnancy and birth. In subsequent studies I comparatively investigated the self- and body-images of pregnant professionals and homebirthers (Davis-Floyd 1994 a, b) and the worldviews and values that underlie their birth choices (1992b). This research brought midwives to the forefront of my attention, as they are the only childbirth practitioners who seek to span the spectrum of women's choices, from highly technological hospital birth to relatively untrammeled birth at home. It is that spectrum of choice with which I have been primarily concerned.

In May 1996 I began a study of the politics and problematics involved in the professionalization and legitimation of *direct-entry (non-nurse) midwives.* The two major midwifery organizations in the United States—the American College of Nurse-Midwives (ACNM) and the Midwives Alliance of North America (MANA)—were in the early stages of designing and implementing two different routes to national certification for midwives who do not pass through nursing training (direct-entry midwives [DEMs]). For both organizations, this process is revolutionary: *lay midwives* who had in the past maintained their autonomy largely outside the system were now professionalizing within it, and *nurse-midwives* were seeking to move their profession away from its embeddedness in nursing and toward greater independence and autonomy. The desire of both groups is to move midwifery from the margins into the mainstream of American society.

Both new types of direct-entry midwifery certification will undoubtedly affect the evolution of the spectrum of choice for childbearing women in the United States, shaping the extent and style of midwifery care (read: birth options) that will be available in the future. Thus the investigation of these processes has formed a logical next step in the evolution of my research in the anthropology of reproduction.

My research for this study of the development of direct-entry midwifery in the United States was multi-sited, consisting of participant observation at nine ACNM national and regional conferences, fifteen MANA national and regional conferences, twenty national or international *Midwifery Today* conferences (*Midwifery Today* both publishes an international magazine and puts on conferences that bring together midwives of all types from many countries), and the conferences of numerous other birth-related groups, including the Maternity Center Association, Lamaze International, the International Childbirth Education Association (ICEA), the Association of Women's Health, Obstetrical, and Neonatal Nurses (AWHONN), Doulas of North America (DONA), and the

Coalition for Improving Maternity Services (CIMS). I played multiple roles at these conferences—I gave talks at all of them, served on various committees and one board, attended many workshops and presentations, engaged in countless conversations about midwifery, took copious notes, and conducted extensive tape-recorded interviews with over two hundred midwives.

Seventy of these were leaders and educators in nurse- and direct-entry midwifery; my interviews with these leaders focused on their motivations for developing these new certifications, the practical and philosophical issues that divide them, and the legislative processes in various states. I also interviewed eighty midwifery students (forty-five nurse-midwifery students, thirty direct-entry students in the process of becoming certified professional midwife [CPMs], and five direct-entry students in the process of becoming certified midwife [CMs]) about their educational processes, seeking to understand the relative benefits and disadvantages of each. I traveled throughout New York, California, and Washington state conducting interviews with midwives, consumers, and public officials about midwifery legislation and regulation in those states. To date, results of this work have been published in twelve chapters and articles (Benoit et al. 2001; Davis-Floyd 1998 a, b, c, 1999, 2003 a, b, 2004a, b, 2005; Davis-Floyd and Davis 1997). This volume represents the culmination of this work.

The National Context of My Research

Obstetrics as a medical specialty accounts for a disproportionate share of the rising costs of health care in the United States, as a result of over reliance on costly technological interventions and frequent lawsuits. Fear of being sued and the high costs of malpractice insurance are driving many obstetricians out of the field. Those who remain tend to cluster in cities, leaving many rural areas without obstetrical services. In contrast, midwives are rarely sued, many serve rural areas, and their expertise in facilitating normal birth results in fewer interventions and less costly care (Rooks 1997, chap. 10–11; MacDorman and Singh 1998; Perkins 2004; Johnson and Daviss 2005). In 2002, approximately 6,000 certified nurse-midwives (CNMs) practicing in the United States attended 8.6 percent of U.S. births. Around 3,000 lay and direct-entry (non-nurse) midwives (no one knows for sure exactly how many non-nurse homebirth midwives are out there) attended approximately less than one percent (0.6 percent) of American births. In contrast, approximately 40,000 obstetricians (and some family practitioners) attended ninety percent of American births, ninety-nine percent of which took place in hospitals.

The United States and Canada are the only two industrialized nations in which professional midwives do not attend the majority of births. As the direct result of a campaign by physicians, nurses, and public health officials from the early 1900s on, by the 1960s midwives in North America had been almost completely eliminated. During this period, birth moved into the hospital and became medically managed and technologically controlled as the obstetrical branch of medicine developed (Oakley 1984; Leavitt 1986). It is therefore quite remarkable that midwives have generated their own renaissance since that time. In achieving this rebirth, midwives have undergone a transformation from the illiterate grannies and rural midwives who served specific ethnic groups in bounded communities (Susie 1988; Logan and Clark 1989; Fraser 1992) to full participants in the postmodern world. Thousands of midwives across North America have become educated, articulate, organized, political, and highly conscious of their cultural uniqueness and importance—a phenomenon that I have labeled *postmodern midwifery* (Davis-Floyd and Davis 1997; Davis-Floyd 2005).

> With this term, I am trying to highlight the qualities that emerge from the practice, the discourse, and the political engagement of a certain kind of contemporary midwife—one who often constructs a radical critique of unexamined conventions and univariate assumptions. Postmodern midwives as I define them are relativistic, articulate, organized, political, and highly conscious of both their cultural uniqueness and their global importance. . . . Postmodern midwives are scientifically informed: they know the limitations and strengths of the biomedical system and of their own, and they can move fluidly between them. These midwives play with the paradigms, working to ensure that the uniquely woman-centered dimensions of midwifery are not subsumed by biomedicine. They are shape-shifters, knowing how to subvert the medical system while appearing to comply with it, bridge-builders, making alliances with biomedicine where possible, and networkers . . .[with a sense of mission around preserving and growing midwifery] and an understanding that *for a midwife, the professional is always political*: midwives and their colleagues must have an organized political voice if they are to survive. So postmodern midwives work to build organizations in their communities, join national and international midwifery organizations, and work within them for policies and legislation that support midwives and the mothers they attend. (Davis-Floyd 2005:13)

This book brings together various social scientific analyses of the efforts of postmodern American midwives and their consumer supporters to achieve sociocultural recognition and acceptance for the two new types of direct-entry midwifery created by their national organizations almost simultaneously in the mid-1990s.

Postmodern American midwifery is far from constituting a unified social movement. Disparate factions have emerged, each of which employs competing discourses of desire for, appropriation of, and resistance to the authority of technomedicine and mainstream professionalization. These separate factions provide an opportunity for the ethnographic tracking of multiple conflicting relationships to each other and to medical authority from within what is still widely regarded by American consumers as a culturally marginal, "alternative" practice. In the United States, the two major organizations that represent the majority of practicing midwives constitute the sometimes competing, sometimes cooperating factions addressed by my research.

The ACNM represents certified nurse-midwives (CNMs), who are recognized in all fifty states; in some they may operate independently in hospital and private practice, while in others they must work under (or cooperatively with) physicians. Their training consists of nursing plus one or two years of in-hospital midwifery (sixty percent of nurse-midwifery programs also offer some out-of-hospital clinical experience for their students, usually in birth centers [Katherine Camacho Carr, personal communication, 2005]). ACNM also now represents the new certified midwife (CM), who receives both midwifery education and "the equivalent" of nursing training as it relates to midwifery (see chapter 2).

The Midwives' Alliance of North America (MANA) primarily represents direct-entry midwives, who were formerly known as lay midwives—an appellation they came to resent as their commitment to professionalization increased. Founded on ideals of "sisterhood" and "inclusivity," MANA welcomes as members all midwives who support its nonmedicalized, holistic approach to birth, including CNMs and both new types of direct-entry midwives—the CM and the certified professional midwife (CPM), a designation created by the North American Registry of Midwives (NARM), a sister organization of MANA.

Members of ACNM and MANA often sharply disagree over the nature of midwifery and the definition of what constitutes appropriate midwifery education and competent care. Most divisive is the issue of apprenticeship, which many CNMs devalue because they believe that not tying midwifery to a college degree is disempowering to women and that university education is fundamental to becoming a healthcare professional. On the other hand, the members of MANA highly

value apprenticeship for the connective and embodied experiential learning (Jordan 1989) it provides, as well as for the deep trust in women and in birth that apprenticeship training builds (see chapters 1 and 3). Accordingly, the new national direct-entry certification process developed by NARM honors "multiple routes of entry," including apprenticeship, to becoming a CPM. In contrast, ACNM's new process of direct-entry certification (the CM) recognizes primarily programs affiliated with universities. ACNM recognizes the value of apprenticeship learning—indeed, the *preceptorship* is an integral part of ACNM-accredited training programs—but insists that it be only one component of an education that should be equally grounded in formal university-type didactic training. MANA members link university training to medical/technocratic co-option of the midwifery emphasis on the normalcy of pregnancy and birth, insisting that apprenticeship training, private vocational direct-entry schools, and small direct-entry college programs provide a less medicalized, more holistic, and more woman-centered approach to care—one that is not based on a sense of danger and risk in birth, but rather on trust in the birth process and the birthing woman. They affirm that an attitude of trust on the part of the midwife fosters and facilitates the mother's ability to trust and believe in herself, noting that many hospital-trained midwives prefer to rely on the information generated by the electronic fetal monitor and the sense of security that if a crisis arises, full-scale assistance is right around the corner.

After the creation of the CM (described in chapter 2), the ACNM's Division of Accreditation (DOA) immediately set about establishing a framework and set of guidelines for the creation of university-affiliated CM training programs. These could potentially have included schools (such as the Seattle Midwifery School) that are already formally accredited by MANA's other sister organization, the Midwifery Education Accreditation Council (MEAC), but the DOA set its standards beyond the reach of such schools (the major impediments are university affiliation and the requirements that key faculty members be CNMs or CMs), clearly intending to keep these two direct-entry certification processes separate and distinct.[1] Larson (1979) identifies the core of the professionalizing project as the attempt to secure a structural linkage between education and occupation; between *knowledge* as the negotiation of cognitive exclusiveness and *power* in the form of a market monopoly. While ACNM members have sought to create and strengthen such linkages, homebirth midwives have tried to weaken them, ensuring that midwifery knowledge is available to anyone who wishes to attend births as

an apprentice, and rejecting monopolistic moves that tie the necessary knowledge to a particular form of education.

Professionalization is a contentious issue not only between these organizations, but within each of them. Although the CPM national certification process enjoys strong support from most members in MANA, it is a source of tension and polarization for others who have found great benefit in uncertified, nonprofessional, unregulated status. To professionalize is to accept a level of regulation and bureaucratic conformity that can compromise independence of practice (Torstendahl and Burrage 1990; Witz 1992). For example, in every state where direct-entry midwives seek licensure, they find that along with the benefits come limitations (including prohibitions on attending certain kinds of births at home, such as vaginal birth after cesarean [VBACs], breeches, and twins). Some in MANA fear that even the self-regulation that accompanies self-designed national certification will be too constraining. Likewise, in ACNM there is ongoing tension between those who wish to preserve nursing as the primary route of entry to midwifery and those who dream of being freed from the restrictions placed on nurses and of "getting out from under the thumb" of state nursing boards, to be regulated instead under newly established state midwifery boards.

Central to many professionalization processes (in addition to credentialing, the development of practice standards, a code of ethics, and accredited educational routes) is the attempt to gain legalization and state licensure (MacDonald 1985; Witz 1992). NARM and many MANA members have been actively lobbying in various states for recognition of the CPM credential and for state adoption of the NARM exam as the state licensing exam for direct-entry midwives; these efforts have been successful in twenty-one states to date. Active lobbying of state legislatures by local ACNM chapters in favor of their own direct-entry certification (the CM) and adoption of their exam and their standards has but recently begun or is yet to materialize in most states; there is no national plan. In some places the local chapters of ACNM and the state organizations of homebirth midwives (many of whose members belong to MANA and/or have become CPMs) are coordinating their lobbying efforts; in others they have been or may become directly opposed. New York state constitutes the clearest example to date of the bitterness and havoc that can be created by such opposition, as Maureen May and I describe in chapter 2. In contrast, the nurse- and direct-entry midwives of Massachusetts are working together on joint legislation in a very conscious effort to counteract the divisive and distrustful legacy of the New York legislation, as Christine Barbara Johnson describes in chapter 9.

A dangerous set of problematics arises from these new kinds of professionalization, which includes not only internal dissensions and divisions and legislative turf wars between MANA and the ACNM, but also very real possibilities for the co-option of homebirth midwifery, including the chance that the autonomous niche in the system that midwives are seeking to establish through licensure and certification could backfire into increased dependence on physicians (Reid 1989). (Indeed, in the 1990s this became a danger in New York and California, where current legislation requires that midwives have practice agreements with physicians.) An enticing set of possibilities accompanies these problematics, including the growth and expansion of both organizations and thus of midwifery itself, mutual cooperation between them to create a birth care system in which CNMs and CMs work in tandem with CPMs, offering more options and a more complete range of choice to birthing women, and pooling of resources and efforts in state legislatures around the country to work for bills that benefit both CMs and CPMs. There is much to recommend this sort of cooperative approach; whether or not it develops will depend to a great extent on the motivations of the prime movers in both organizations—motivations I have tried to identify and clarify through my research.

My specific objectives have been: (1) to identify the goals and motivations of those women[2] in both organizations who are most influential in setting future-oriented directions and policies in the brand new field of non-nurse midwifery certification; (2) to examine the dynamics of the relationships between the ACNM and MANA; (3) to identify and analyze within each organization the tensions generated around the direct-entry certification process, as well as its design and implementation; (4) to study the attitudes of key members of both organizations toward professionalization and all that it entails; and (5) to synthesize a clear and useful holistic overview of the future directions in midwifery now emerging in North America and their implications for birth care and women's reproductive choices. (A part of this endeavor has been my editorial participation in the recently published volume *Reconceiving Midwives*, which describes the development of direct-entry midwifery in Canada [Bourgeault, Benoit, and Davis-Floyd 2004]).

As an anthropologist, I have made every effort to maintain a neutral stance toward the political differences between MANA and the ACNM, so that I can work fluidly with both groups. I fully support midwives who practice both in and out of the hospital; my focus as a birth activist has always been on keeping open the full spectrum of choice for birthing women, and I see midwives as absolutely essential to that endeavor. (While it is not hard to find an obstetrician who will willingly schedule a

cesarean at his and the mother's convenience, it is almost impossible to find an obstetrician who will attend a homebirth—there are probably only about fifty in the country.)

At present, the status of direct-entry midwives fluctuates wildly from state to state. In some states, like Missouri and Alabama, direct-entry midwifery is explicitly illegal. In others, such as Pennsylvania, it is *alegal.* This is a misleading term that means that the practice of midwifery is not legally secure. When alegal, midwifery is not specifically addressed in statutes, but the actions involved in midwifery practice are considered the practice of medicine and/or nursing; these midwives are left vulnerable to criminal prosecution whenever anyone cares to pursue such action. (For a full discussion of *alegality,* see www.fromcallingtocourtroom.net.) In others states, such as Florida, Washington, and New Mexico, midwifery is completely legal and even supported by the system; licensed midwives in these states can obtain not only medical backup but also third-party insurance reimbursement. Many are now looking to these states to see what kind of market will be generated over time by the increased availability of homebirth. Any significant jump would generate awareness nationwide of the availability of a huge new market niche for insurers and HMOs. (But where these institutions are deeply involved with hospitals, they often act to stop midwifery and out-of-hospital birth because these take income away from hospitals [Hodges 2004]).

Planned, midwife-attended home and birth center births have been repeatedly shown to be as safe as hospital birth. Such births are far more woman-empowering, and far more baby- and family-friendly. They are also much cheaper—a homebirth and home midwifery care cost an average of one-third that of a hospital birth. If this information, third-party reimbursement, and professional midwives were widely available around the country, many women who now enter alternative birth centers in the hospital might wish to choose freestanding birth centers or homebirth instead.

In 2005, the newly created CMs could be licensed in three states (New York, New Jersey, and Rhode Island), while the newly created CPMs are licensed in twenty-one states. Now the consumer must deal with CNMs, CMs, CPMs, LMs, and RMs (many homebirth midwives are licensed in their states and called either Licensed Midwives or Registered Midwives) and "plain" midwives who refuse to professionalize. Are you confused yet? You would think it would be simpler for the ACNM and MANA to work something out together—one type of professional non-nurse-midwife that everyone could agree on. They tried for three years during the early 1990s, in intense meetings of the

Interorganizational Work Group (sponsored by the Carnegie Foundation for the Advancement of Teaching), during which ACNM did agree with MANA's establishment of NARM and that NARM-certified midwives and CNMs would have similar scopes of practice (a similarity that later vanished as CNMs moved into gynecological care). But that's as far as they could get; their differences over the issue of higher education were just too deep. ACNM insists that midwives have college degrees and graduate from formal training programs; effectively, their programs require a master's degree (see chapter 1). MANA insists that degrees do not a good midwife make. While many MANA members do graduate from formal training programs, the membership agrees that apprenticeship should remain a valid route to midwifery.

So for the foreseeable future, there will be three national certification processes for midwifery, with three titles obtainable—CNM, CPM, and CM. And there will be five kinds of midwives: CNMs, CMs, CPMs, midwives licensed in their states who have no national certification (such as LMs and RMs), and the plain midwives who work and wish to stay completely outside the system. Many bridge-builders want to make midwifery into one profession with one flexible set of educational standards on which everyone will (eventually) agree. But those on opposing sides insist on the utter impossibility of that. ACNM will continue to insist on formal educational programs leading to advanced degrees. NARM and MANA will continue to insist that a college degree has nothing to do with one's competence as a midwife,[3] and will go on validating multiple routes of entry into their profession, including apprenticeship, self-study, private midwifery schools, and university programs. In some states these groups may fight each other in the legislatures for legitimation of their version of direct-entry midwifery, when their energies would be much better spent fighting the medical system and the insurance companies for greater public access to midwifery care. The public will have to deal with five kinds of midwives. And the future of homebirth and of freedom of choice for the childbearing women of North America—which only midwives can guarantee—will hang in the balance. In some states members of both MANA and ACNM will cooperate to write legislation that legitimates both certifications, as some midwives belong to both organizations and are aware of the benefits of making common cause. When they do fight each other, it will likely be because their differences are real: many CNMs see homebirth as irresponsible and think that other midwives are poorly trained; many MANA members see CNMs as sellouts to the medical establishment—"physician extenders" more interested in making money than in serving women. ACNM is determined to set the standard for midwifery

in the United States. MANA and NARM are just as determined to set a strong standard for nonmedicalized midwifery and their independent Midwives Model of Care™ (see chapter 3).

I was thrilled when I met Christine Barbara Johnson, informally known as Barbara, who is an experienced and accomplished sociologist and has been a birth activist for many years. She lives and breathes the cultural treatment of childbirth and of midwives and midwifery politics as deeply, on a daily basis, as I do. Her outstanding editorial skills have contributed substantially to the excellence of every chapter in this book, and her deep and lengthy involvement in midwifery politics in her home state of Massachusetts has given her not only local ethnographic understanding but also a broad and informed perspective on the national midwifery scene. It is that broad and informed perspective that we try to bring to you, our readers. *We declare our complete support for the survival and prospering of all types of midwives and midwifery models of care in the United States*, and we refuse to take sides in the debates and disagreements between midwives of differing philosophies and educational backgrounds. Midwives in general give more nurturant, more woman-centered, more compassionate, and often more effective care than obstetricians (see Rooks 1997; Davis-Floyd 2004c; chap. 13 of this volume), and so we wish to make clear from the beginning that *our bias is in favor of midwives*, period. We contribute this analysis of the philosophical, practical, and political divisions and disagreements, as well as the areas of accord among American midwives, not in the interest of tarnishing midwifery's image in any way, but rather in the spirit of social scientists who wish, through their critical and comparative analyses, to contribute to healing the traumas and pain and political prices of the divisions that we analyze in these pages.

FROM CHRISTINE BARBARA JOHNSON: RESEARCH, METHODOLOGY, AND FINDINGS ON HOMEBIRTH CONSUMERS

Research and Methodology

My contributions to this book have been shaped by over twenty years of experience (Johnson 1987, 2000, 2001; Johnson and Galvin 2001), including extensive interviews with homebirth consumers. I have been actively involved in studying and supporting midwifery since 1983 and became so engrossed by the subject that I decided to focus my Ph.D. thesis entirely on midwifery in Massachusetts, *Normalizing Birth* (1987, unpublished). The themes that captivated my interest at that time and have continued to mature and evolve over the years involve, first, the

relationship between the individual/small groups and institutions, micro- and macro-configurations, structure and agency. In particular, I have been fascinated to uncover the process through which nascent and pioneering social movements gain social legitimacy and widespread public acceptance while maintaining their identity and autonomy. With regard to midwifery, I have been most interested in how this model of care, through networking and public outreach, has the potential to transform medical, legal, and political institutions. Second, I have been equally interested in the chasm between the reality of who the homebirth consumer is and the public misperception.

From the beginning, the more I studied the homebirth consumer, the more I became amazed at the conscientious and well-thought-out research most of them undertook in deciding to have a homebirth. In addition, their willingness to be proactive birthgivers, and the level of responsibility they were willing to assume constantly impressed me. The more I have learned about the homebirth consumer, the more I have become dedicated to doing everything I can to correct the erroneous public image of homebirth consumers as irresponsible and reckless. In addition to my research on homebirth consumers,[4] I have interviewed over one hundred midwives and have presented and advocated the midwifery model of care in talks around the country, as well as throughout the New England region.

In my dissertation I observed firsthand how homebirth midwifery in Massachusetts was transformed almost overnight. One moment it appeared very likely that this option would be deemed the practice of medicine and thus outlawed. The next moment homebirth had the support of all three branches of state government: judicial, administrative, and legislative (see chapter 9 on Massachusetts midwifery, "Creating a Way Out of No Way"). This series of events made a lasting impression on me with respect to how individuals can change the fabric of our societal institutions through their sustained and committed actions. This realization in turn has fostered in me an avid interest in exploring how institutions are transformed and altered at their core through social action.

As a social activist I served many years on the board of directors of the Massachusetts Friends of Midwives (MFOM) and was one of the six original members of the Massachusetts Coalition for Midwifery (MCM), a group dedicated to representing the interests of certified nurse-midwives, direct-entry midwives, and homebirth consumers. This coalition was created in large part to support the Massachusetts midwifery legislation effort. This is a joint legislative bill, the first of its kind in the United States that would license both CNMs and CPMs

under a single board (see chapter 9). In addition to these activities, I have publicly supported midwifery in university classrooms, professional conferences, state houses, courtrooms, and on many occasions have agreed to meet with couples wanting to learn more about midwifery so they could evaluate it as a viable option. My evolving research has been motivated by my social activist concerns and the desire to use a disciplined and grounded research methodology to further investigate viable ways to disseminate information about the midwifery model of care to the wider public.

To this end, I jumped at the chance to be an "expert consultant" on the prenatal care module of the United States National Library of Medicine's Information Infrastructure Program (contract NO-LM-6-3539) and write a report based on these findings (Johnson and Galvin 2001). This project explored how the dissemination of online health care information creates new health care spaces by influencing ideas and behaviors. In addition, I have completed in-depth interviews with seventy homebirth mothers and over 100 direct-entry midwives, with the express purpose of writing a thoroughly researched and accessible book conveying an accurate profile of homebirth consumers and their midwives. Findings from this research have been incorporated in this book in chapters 9, 11, 12, and 13. Findings from the National Library of Medicine's Information Infrastructure Program are encapsulated below.

Informing the Public about Midwives through the Internet: Results of the National Library of Medicine Study

The National Library of Medicine Information Infrastructure Program was set up to fund empirically-based evaluations assessing the impact of Internet-based health care information. Prenatal care was one of the five preventive health-care topics that were targeted for in-depth study. The research team agreed that I could include a research component assessing the effectiveness of the web for disseminating midwifery information to the wider public. Previous to this, I had hypothesized that the web would be an effective tool for informing the public about the midwifery model of care. Here was my chance to find out how powerful the web could be as a communication tool for disseminating information not usually available through official channels.

Our health-care research team produced a specially designed webpage and the respondents answered two online questionnaires, one taken before viewing the prenatal care (PNC) webpage and the other after exploring the PNC site. In addition to the questionnaires (both closed and open-ended questions were included), we designed and

facilitated three focus groups to gain more in-depth data about process, especially to determine whether women change their ideas about using midwives when they learn more about them. When the PNC webpage went online, the midwifery portion of the project had not yet been completed. As soon as this section was finished, we e-mailed all participants offering this information along with extensive links explaining the philosophy behind the midwifery model of care. In addition, two types of midwives were described: the certified nurse-midwife and the direct-entry midwife. Extensive links describing the philosophical tenets of the midwifery model in general and the specific differences between the two types of midwives augmented this information. Our Information Infrastructure sample consisted of one hundred women of childbearing age at a prominent Northeastern university who were pregnant or planned on a future pregnancy and had ready access to webpage technology. The sample included representative members of the staff, faculty, graduate students, and a selected subset of undergraduate students.

When asked if their ideas about midwives had changed as a direct result of viewing the webpage, a significant minority (twenty-eight percent) said "yes." When the respondents were asked to elaborate on how their ideas about midwives changed, the women answered that they were more positively inclined to think of midwives as a viable option. This sample population highlighted three major dimensions that they felt were involved in creating a new health-care practitioner narrative—in this case, a new midwifery narrative. First, clear and easily understandable information must be available to counteract stereotypes and vague, uncertain knowledge. Second, this information must contain enough substance to directly challenge negative images. Third, the source of the information must be viewed as legitimate. When these three criteria were satisfied, the respondents become more open to redefining who is and is not an appropriate health care professional.

The focus group participants provided more in-depth access to their redefinition process. The following quotes illustrate this reconstruction process:

> Before [reading the webpage] midwives didn't seem as reputable as being in a hospital, so it was really interesting to see that some insurance does cover it and it is an option, not that I'm personally ready to have this baby now, but [using a midwife] actually became an option and before [the webpage] it wasn't. Midwifery was demystified on the webpage. I have had no other

experience of midwifery except through this webpage; it would definitely be an option now whereas before I don't think I would have used it.

The webpage answered a lot of questions that I had that I wouldn't necessarily ask anyone just because everyone starts assuming that you want to get pregnant. For example, the thing I would call the most [enlightening] was the whole issue of the midwives vs. the doctors and the hospital, it really opened my eyes and made choosing a midwife something that I want to do.

Through the midwifery links I learned about all the categories of prenatal care providers—physicians and midwives. I found this very useful because I didn't know anything about that. Usually, you just go to the physician and that is it. Now I have more options.

I found the part of the webpage on midwives the most interesting. It has really opened my mind, something I've never had to consider before, especially the differences between them and the physician. Whether the physicians are male or female, it just blew me away. It is definitely good to know that midwives exist.

As a direct result of the website I would consider using a midwife now; I never would have considered a midwife before.

I'm probably a little more aware of questions I should be asking. For me it was just that everyone in my family has always used a physician. I have never even considered a midwife. It was always something that other people do, alternative people do, people that do alternative medicine. It wasn't something that I would necessarily do…so I have never really investigated it. And perhaps it makes me more comfortable with asking the question, is using a midwife an option that I want to choose?

After viewing the webpage I think I do know more about midwives. I think I have an open mind to probably learning as much as I can when I do become pregnant or when I want to become pregnant. I think it is good that the information about midwives is out there because I think people will be more open and curious, including me.

> Now as a result of the webpage I am more curious about midwives. Although it probably won't be an alternative that I would pick in the near future, it could be. I would probably ask more about it, especially when I hear people say that they have used a midwife. I will be more interested to hear their decision making process and what went into it, rather than writing it off. It's like you have a certain predisposition almost and the webpage might lead you to question your position and what you feel comfortable with more than before.
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> The webpage made me rethink the idea of using midwives (this woman has had two children with doctors).
>
> The webpage made me open to midwives; it just gave me another cue to be open when I get to that point in my life.

Despite extensive information detailing the difference between certified nurse-midwives and direct-entry midwives, the women in the study were not able to discriminate between them, but rather combined them into one indistinguishable category. We found that the idea of actually using a midwife was so novel that the difference between the two types of midwives described on the prenatal care webpage was not retained. This was a big surprise to us since our study population was highly educated and able to readily grasp conceptual information. We hypothesized that the novelty of seeing midwives as a viable option caused the majority of women in our study to reach saturation at this point, and the differences between the two kinds of midwives became excess data.

As the United States moves increasingly toward a market-driven managed health-care industry, health-care consumers will turn to the Internet with greater frequency as they are required to act more as consumers than as patients. Under these conditions the Internet will become an innovative medium for constructing new narratives about midwives. In fact, a little over one-fifth of the seventy women I interviewed for my forthcoming book reported having based their choice to pursue a homebirth on information gleaned from the web. In this environment it becomes more important than ever for midwives to settle their differences. If *two* types of midwives were confusing to a highly educated segment of the population, then *five* types of midwives will most certainly confuse the wider public about the midwifery model of care. Resolving the midwifery differences of opinion at this historical juncture will do much to promulgate the proliferation of midwifery.

Our ardent hope is that this book may contribute in some small measure to midwifery unity.

OVERVIEW OF THE BOOK

Part I, Developing Direct-Entry Midwifery in the United States

The three chapters in Part I of this book take a national perspective on the development of direct-entry midwifery, offering a comparative overview of MANA and the ACNM and descriptions of the creation of the CM by ACNM members and of the CPM by MANA members.

Many midwives have questioned the existence of two national midwifery organizations in the United States, suggesting that unifying under one organizational banner would do a great deal more to promote midwifery and improve women's health. In chapter 1, the comparative overview of ACNM and MANA, Robbie analyzes points that could have led to convergence, explains the very real reasons (some of which were briefly described above) why they have not, and points to some very positive contemporary convergent trends that hold promise for mutual respect and effective collaboration between these two national organizations—one large, the other small, but both equally committed to growing midwifery in the interests of better care for women.

Another central question often posed by midwives has been, why would ACNM, an organization whose members took twenty-five years to attend one percent of American births (by the late 1970s), and another thirty years to reach close to ten percent and to get its members legal, licensed, and regulated in all fifty states, challenge its own gains with a new certification not based on nursing, which at least is already a culturally accepted and respected profession? Maureen May and Robbie Davis-Floyd seek to answer this question in chapter 2, which describes and analyzes the creation of the CM. It might seem more logical to have separated this chapter, which is by far the longest one in the book, into two, one describing the national creation of the CM and the other focusing on the legalization of the CM in New York. These chapters would have most properly fit into Part II of this book, which consists of state-based case studies in the legalization of direct-entry midwifery. But the CM's national creation and state legitimation are inseparable: they are really one story and that story is all about the history, politics, and culture of nurse-midwifery in New York.

New York was formative in the development of both nurse- and direct-entry midwifery in the United States, and an understanding of that history is essential to an understanding of why the CM was created

and the ramifications of the law that allowed its creation, the 1992 New York Midwifery Practice Act. The development of direct-entry midwifery is our main focus in this book, and the history, culture, and politics of nurse-midwifery have been intimately tied to this process. Much of this history unfolded in New York, along with a particular kind of midwifery politics and a particular type of culture, which the authors characterize in that chapter as one of pragmatism, showing how that culture influenced the political decisions the New York nurse-midwives made as they created and fought to legalize the CM. This hefty chapter must also treat the history of MANA-style lay and direct-entry midwifery in New York—a history that unfolded sometimes in synchrony with, and sometimes in opposition to, the efforts of the New York CNMs to create their own version of direct-entry midwifery, the CM. The battles fought in New York over the type of direct-entry midwife that should exist in that state have had long-standing national ramifications, both for relations between CNMs and DEMs in other states, and for the creation of the CPM described in chapter 3.

Thus we ask our readers to stick with the authors through all the pages of the New York story because it is so central to understanding (1) the creation and legalization of the CM; (2) the history, politics, and culture of nurse-midwifery in the United States; (3) the history, politics, and culture of direct-entry (formerly lay) midwifery in the United States; and (4) the essence of the differences and struggles between these groups as they were played out on New York's political terrain. The New York story is told and retold among midwives around the United States, usually as a story of betrayal and exploitation of one side by the other, and as an example of why the groups don't trust each other and what was so awful about one group or the other, with little understanding of what really happened there and why. We hope that you will find the information in this chapter enlightening, the stories fascinating, and the politics revealing, and that you will become engaged as you read in understanding the motivations and ideals of the two competing groups—the group that lost the battle (homebirth DEMs) and the group that won.

Another question midwives sometimes pose is: Why would lay midwives, who fought hard and long to stay independent, autonomous, and often, unregulated, drop the term "lay" in favor of "direct-entry," create a national certification for direct-entry midwives who practice out-of-hospital, and work extremely hard to get it legalized (entailing licensure and regulation) in most states? Robbie addresses this question in chapter 3, in which she describes the creation of the CPM in terms of what she calls *qualified commodification*—a successful effort to commodify

and market midwifery within the legal system without compromising its essential ideals of autonomy and woman-centeredness.

Part II, State-Based Case Studies in the Legalization of Direct-Entry Midwives

The six chapters in Part II document the efforts of direct-entry midwives (successful and unsuccessful) to become legal, licensed, and regulated in six states: Florida, Minnesota, Colorado, Virginia, Iowa, and Massachusetts. Although we wish for more, in this book we cannot hope to deal with the complexities of midwifery politics in every U.S. state. Because this book is a work of social science, our decisions about which states to include as case studies stemmed from our discoveries that particular social scientists were actively engaged in studying midwifery politics in their states, and that the states they were studying provided the full spectrum of the legal struggles and situations of homebirth direct-entry midwives in the contemporary United States.

We were fortunate to find that Melissa Denmark, at the time an anthropology masters' student at the University of Florida (and now a graduate of Seattle Midwifery School), was willing to conduct an extensive study of midwifery history and legislation in Florida. Rhetorician Mary Lay had long been both participating in and observing the proposed direct-entry midwifery legislation in Minnesota and had formed a professional friendship with Kerry Dixon, a direct-entry midwife who became chapter coauthor. A similar relationship formed between anthropologist Susan Erickson and midwife Amy Colo, coauthors of the Colorado chapter. Anthropologist Christa Craven spent years studying and participating in midwifery legislative efforts in Virginia, as did Carrie Hough (also an anthropologist) in Iowa, and Christine Barbara Johnson (sociologist) in Massachusetts. Collectively, these six chapters offer profound lessons about what works and what does not in attempts to legalize midwifery.

With enormous effort over several years, DEMs had achieved legalization in Florida before Melissa Denmark began her research. In Minnesota, they achieved it toward the end of Mary Lay's research process through combined legislative and grassroots efforts, as also happened for Susan Erickson and Amy Colo in Colorado and Christa Craven in Virginia, who had to rewrite portions of her chapter to record legislative success shortly before this book went to press! Legalization efforts remain ongoing in Iowa and Massachusetts. Salient successful strategies that emerge from the analyses in these chapters include organization, communication, savvy lobbying, education of consumers and legislators, collaborative efforts among midwives and related groups,

cultivation of particular officials and physicians, effective consumer support, perseverance over many years, and occasional serendipitous doses of luck. (We offer much more detail about successful strategies in the Introduction to Part II.) The foundational basis of the success of all of these strategies is the midwives' documentation of, and the consumers' testaments to, the excellent, evidence-based, and woman-centered care they provide.

As part of her original research project, Robbie conducted extensive interviews in California and Washington state on the history of midwifery in those states, direct-entry midwives' successful legislative efforts in both, and the problematics resulting from their achievement of legalization, licensure, and regulation. She originally intended to include chapters on these states in this volume, but space limitations intervened, along with her discovery that sociologist Bruce Hoffman is actively engaged in an in-depth research project on these issues in California, Washington, and Oregon. His research and subsequent publications will tell the stories of the development of direct-entry midwifery in these key states (supplementing the work of Raymond DeVries [1996], who recounted the early history of the legislative efforts of the California midwives), and we urge our readers to watch for and read the results of his work. Suffice it to say that midwives' legislative success in these states benefited from all of the strategies mentioned above, and that the problems this success has generated are echoed and reflected in the descriptions of these same problems recorded in the chapters we do include in this book.

Part III, Core Issues in Mainstreaming Midwives

The four chapters in Part III of this book treat core issues in mainstreaming direct-entry midwives, from impediments to positive change. In chapter 10, midwife-sociologist Betty Anne Daviss describes the overarching tensions between midwifery as a social movement and its professionalizing enterprise, showing how social movement theory can both illuminate and inspire contemporary American midwives to engage in "social activist moments."

Some of the problems generated by legislative success are encapsulated in chapter 11, which deals with the issue of *renegade midwives*—those who occasionally or regularly reject state regulations or peer protocols to attend the births of women considered high risk. Renegade midwives, more dedicated to serving women's desires than to preserving midwifery as a viable profession, simultaneously preserve essential elements of midwifery knowledge, such as techniques for the home delivery of breeches and twins, and jeopardize the professional

gains made by midwives in their states who are willing to abide by state regulations or peer protocols prohibiting such practices. Thus they constitute both assets and liabilities to contemporary American direct-entry midwives' struggle to enter the mainstream.

Chapter 12 describes the vagaries and successes of home-to-hospital transport, in which the very different worlds of homebirth midwifery and hospital obstetrics either collide or (temporarily) merge. Barbara and Robbie hoped, in writing this chapter, to offer a positive model to hospitals and homebirth midwives alike for the most effective forms of transport, which can constitute magical *mandorlas* (wholes created in small spaces by the merging of separate worlds).

The concluding chapter explains, fundamentally, "why midwives matter" through Christine's work on how midwives "care women into" a sense of autonomy and empowerment through pregnancy and birth. This chapter also addresses the primary barriers to a widely held dream—that midwives become the primary health care givers for the majority of childbearing women in the United States, while specialized obstetricians concentrate on the high-risk care they are trained to give. As Christine and Robbie delineate these barriers, they seek also to indicate the myriad strategies midwives and their many supporters are employing to overcome them.

Further information about the chapters in Parts I, II, and III can be found in the introductions to those parts.

The midwifery story we tell in this book is about politics, professionalization, and positive change; it is also deeply about identity. American midwives are still in the process of deciding and becoming who they want to be, both as professionals and as members of a social activist movement that seeks to change not only American birthways but also the cultural beliefs and values behind contemporary technocratic modes of birth. Collectively, midwives are still so marginal that their profession might vanish tomorrow if insurance companies, obstetricians, and health-care officials should decide to unite against them. Nevertheless, midwives do their best to provide women with birth options they would not otherwise enjoy and with lifetime health care based on notions of the normalcy of women's bodies and a sense of the importance of an ongoing relationship between the client and the practitioner. Legal or illegal, plain or professional, nurse- or direct-entry, American midwives remain dedicated to serving women and babies in woman-centered ways. We contend that in this endeavor they deserve the full support of the society whose need for childbirth alternatives generated, and continues to demand, their existence and their sociocultural, economic, and legal viability.

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The title of this book was adapted from the theme of the 1998 Conference of the Midwives Alliance of North America in Traverse City, Michigan: "Midwifery in the Mainstream."

ENDNOTES

1. This original clarity has been blurred in recent years by the certification and licensure in New York of several CMs who graduated from MEAC-accredited programs, including the Seattle Midwifery School, as described in chapter 2.
2. Throughout this book we use female nouns and pronouns to refer to midwives. But it is important to remember that one percent of American midwives are male, and that many of these men have made important contributions to the development of American midwifery.
3. Indeed, a study conducted by nurse-midwifery researchers clearly demonstrated that higher education did not equal increased clinical competence (Rooks, Carr, and Sandvold 1991). But it does bring research skills, social credibility, and prestige.
4. Christine sought to obtain a representative sample of women who chose homebirth by contacting midwives, their clients, friends of homebirth organizations, and by using the snowball technique to increase the sample size. The sample reflects the profile of most women who choose homebirth—predominantly professional, white, and middle class. However, there is a significant minority of poor and working-class women who also consistently choose homebirth and are also included in the sample. To establish sufficient rapport for an authentic narrative account to emerge, each woman was interviewed using the in-depth, semi-structured interview technique. The interviews took from two to ten hours each, with the average interview running about four hours. To avoid the problems involved when collecting only retrospective data, Christine also located eleven women who were pregnant and were planning to give birth at home. Each of these eleven women was interviewed both before and after their birth experience. Every interview was transcribed in its entirety. Following this, recurring

themes and issues were identified in the resulting data, using a grounded theory approach. This technique is based on the generation of analytically-based categories through the *constant comparative method*, which validates the categories against the data in which they are grounded.

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