15. Therapeutic value of human presence
16. Collaboration with other members of the health-care team

Excerpted from the ACNM Core Competencies for Basic Midwifery Practice

The midwife provides care according to the following principles:
Midwives work as autonomous practitioners, collaborating with other health and social service providers when necessary.
Midwives understand that physical, emotional, psycho-social and spiritual factors synergistically comprise the health of individuals and affect the childbearing process.
Midwives recognize that a woman is the only direct care provider for herself and her unborn baby; thus the most important determinant of a healthy pregnancy is the mother herself.
Midwives synthesize clinical observations, theoretical knowledge, intuitive assessment, and spiritual awareness as components of a competent decision-making process.

Excerpted from the MANA Core Competencies for Midwifery Practice

This book has focused on the historical relationships between nurse- and direct-entry midwives, on the creation of two new direct-entry midwifery certifications during the 1990s—the CM and the CPM, on the political struggles of direct-entry midwives for legalization and licensure, and on the fractures and fissions within American midwifery that have complicated those struggles, most especially the ideological differences among midwives over appropriate types of education and practice. We hope that our analyses of these divisions will lead to a deeper understanding of the real and reasonable motivations for the actions of various individuals and groups of midwives as they have struggled to mainstream their marginalized profession. In this concluding chapter, we wish to clearly identify the reasons why, no matter what their struggles, we believe that *midwives should become the primary caregivers for most American women throughout pregnancy and birth.* We base this statement on both qualitative and quantitative data. In *Midwifery and Childbirth in America* (1997: Chapter 10), midwife and epidemiologist Judith Rooks thoroughly documents the many quantitative studies demonstrating the excellence of nurse-midwifery care, as did, among others, a comprehensive study published in 1998 by MacDorman and Singh and a smaller study (Davidson 2002) on the outcomes of high-risk women cared for by CNMs. Generally speaking, these studies show that CNMs both in and out of hospital achieve outcomes equal to or better than those of physicians attending

low-risk births. The only thorough and methodologically sound study conducted to date of the outcomes of CPM-attended births is the CPM 2000 study, conducted by Canadian epidemiologists Kenneth C. Johnson and Betty Anne Davis (2005). Its results definitively show the good outcomes achieved by CPMs and are presented in chapter 3. In this chapter, we will take the excellent quantitative outcomes of midwifery care as a given, and will make our argument through an ethnographic analysis of the common and unifying qualitative elements that make midwifery care so precious and meaningful to the women who receive it (see also Kennedy 1995, 2000, 2004).

Much has been written about the theory and ideology of the midwifery model (see chapter 3 for a discussion of the difference between "midwives" and the "midwifery model of care"), but often this work focuses on comparing the midwifery model with the medical model, and thus cannot give full attention to the unique merits of the midwifery model. In this chapter, we examine the midwifery model per se by focusing on the elements of care common to almost all midwives in the United States, making clear *why midwives matter*, and describing the unique characteristics of their invaluable contributions to the care of mothers and babies. Purposefully, we make as few distinctions as possible between home- and hospital-based midwives; they are all *midwives*, and the elements we identify below are common and crucial to the care midwives in general seek to provide.

This chapter is based primarily on the seventy interviews that Christine conducted with midwifery clients from 1999 through 2003, and more peripherally on the many interviews Robbie has conducted with birthing women and midwives as described in the Introduction. In the first section of the chapter, we describe how the midwifery model creates an ideological and practical space within which what Grace Clement (1998) terms an "ethic of care" and an "ethic of autonomy" can emerge as interdependent elements of health-care interaction. Christine has adapted these concepts to elucidate their interdependence and how they form essential elements of the midwifery model of interaction between the midwife and the woman she is serving (Johnson 2001). Her adaptation of these concepts forms a unique analytical contribution to explaining the benefits of midwifery care. We give special attention to how pregnancy and birth are actively constructed on an ongoing basis as normal life events in which the midwife cares the pregnant woman into a sense of autonomy, which culminates in an embodied sense of power following the act of birth.

FOSTERING AUTONOMY THROUGH AN ETHIC OF CARING

Christine has identified seven major elements of what she terms "the ethic of midwifery caring" that foster a strong sense of autonomy in women; this is initially established during prenatal care visits (Johnson 2001). The *ethic of midwifery caring*, as Christine defines it, acknowledges that midwives:

1. realize that context is not neutral but rather sets the stage for connection or disconnection;
2. build a personal dimension into the professional relationship;
3. recognize that emotional well-being is as important as physical well-being;
4. offer concrete, particular information as an essential criterion for creating a shared knowledge base;
5. encourage critical thinking in their clients;
6. promote the woman's belief in body efficacy and body integrity through conversation;
7. value and respect the woman's desires and definitions of the situation, and honor her intuition and their own as important adjuncts to rational knowledge.

During labor and birth, midwives add three further dimensions to this ethic of caring. They:

1. hold a conceptual space within which the woman can give birth according to her desires and needs;
2. keep the woman center stage as the main actor, supporting her in remaining there even when she doubts her ability to continue;
3. *normalize uniqueness* (Davis-Floyd and Davis 1997)—that is, within the parameters of safety, midwives affirm that what is happening in the labor in question is normal for that particular woman in that place at that time in her life, thereby helping the woman to avoid perceiving individual peculiarities of her birthing process as pathological and thus maintaining her sense of ability and self-confidence.

Christine's in-depth interviews revealed that midwives' application of this ethic usually "cared women into autonomy" by generating in them a sense of *embodied power*, which has four major components:

1. The mother's body image, if previously negative, shifts toward a more positive view and an enhanced sense of intrinsic self-worth.

2. If the mother chooses to labor without pain relief, even for only part of the labor, she is facilitated by the midwife to understand pain in many dimensions of life as potentially transformational—as not necessarily to be avoided but rather to be used as a guide to obtaining a level of consciousness and power she had not previously realized.
3. The mother develops a strong sense of confidence in her mothering skills.
4. The mother learns to take more responsibility for her own health-care choices and for those of her family.

Of course, the midwifery model of care as practiced by individual midwives does not always fulfill these potentials. A woman may not be cared into autonomy with a resulting sense of power for various reasons. The emotional bond between the pregnant and/or birthing woman and the midwife may be insufficiently developed (e.g., within a hospital, the woman might have been arbitrarily assigned to midwifery care and thus may come to the care experience with expectations that do not include this kind of relationship; within home care, the mother might have come to the midwife late in the pregnancy); a home to hospital transfer (or a transfer of care within the hospital) may result in the midwife being discounted or discredited; the midwife or midwives with whom the mother has a strong relationship may not be available to attend her labor and birth; or there may be a disconnect between the mother's desires and the midwife's responses to them. Like other professionals, midwives can have their off days; act in a petty, self-serving, self-centered manner; or simply be exhausted and stressed out during any given client encounter. Midwives are not perfect, but their standards of care and aspirations for relationship-centered caring are very high. In our many interviews with mothers, we have found that while a few of them were disappointed by or angry with their midwives, the vast majority did feel cared into autonomy and embodied power by the midwives who attended them. In the following section, we describe their experiences of this process.

Fostering Autonomy through the Ethic of Caring during Prenatal Visits

The following sections describe the multiple ways in which midwives foster autonomy in their clients through their ethic of caring and the ways in which they implement that ethic.

Context is not neutral but rather sets the stage for connection or disconnection. Most midwives attempt to arrange the prenatal examination room to meet the woman's needs as well as the needs of the institution, if any. In the following quote, a blind woman describes how the environment felt to her and how it helped her feel cared for and increased her sense of safety.

> My midwife . . . has a day bed and she gives you these pillowcases and sheets and there are designs that you pick. Each time you visit her you use your own personal pillow and sheet. And I can't even see these things and [my husband] describes them to me—she tries to make it so comfortable and a loving experience. She tells me, "I really want you to look forward to coming here."

A personal dimension is interwoven into the professional relationship. Prenatal visits with midwives almost always involve more than the clinical details of the pregnancy. The nature of the interaction offers a personal dimension in which mutual disclosure can take place. When asked what one word they would use to describe their relationship with their midwife, the overwhelming majority of woman use the word *friend.* Often the visits are family affairs with the spouse and/or children present. Many women note that they feel a loss when they do not go to prenatal visits anymore. They miss the relationship they have built with the midwife over the past nine months. The following quote demonstrates not only how personal and intimate the relationships can become, but also how the interaction contains mutually revealing elements. This personal relationship establishes the trust that will be necessary during the birth, when the woman needs to rely on the midwife's assessment of the birth process:

> Sometimes we would be talking in prenatal visits about something that had nothing to do with childbirth. We would be talking about some other medical issue or some other social event that was mentioned in the paper that day. You get to know each other as people. This is important because then when you are in the middle of labor this person is standing by your bed—you believe what they tell you because you know them. I knew her children's names, I knew her experience and how she had come to where she was practicing, I knew her as a person.

Often the relationship gets established with other family members who have participated in the prenatal visits. In many cases even the

husbands note that they will miss their visits with the midwife. For example, "When I went in for my checkup, my husband took the morning off from work to go with me. He said, 'I am going to miss the midwife. What are we going to do when we don't go visit her anymore?'" In many cases, this meaningful relationship can remain over a lifetime, as the woman can continue to visit the midwife for further pregnancies or for the well-woman gynecological care that many midwives provide.

The woman's emotional and physical well-being are equally promoted through her encounters with the midwife. During prenatal care visits, many things are talked about and the woman's overall well-being is considered an important part of having a healthy pregnancy. For this reason the midwife administers emotional as well as physical care:

> It is a wonderful feeling to walk into the prenatals and have them say, "Hello, how are you feeling?" and not just how am I doing physically but how am I doing emotionally—"How is your other child adjusting, how are your days going, how are things with your husband?"

The following quote illustrates how far this emotional care can extend:

> I felt very comfortable with my midwife. I told her we were going to a funeral and I was feeling emotional— my pregnancy brought waves of emotionalism. I was nervous going to a funeral and I was afraid it would harm me in some way, but my husband really needed me there. And I told [our midwife] this. I cannot believe the difference she made for me in this instance. She said, "You know that one way I look at it is that a birth is very similar to a funeral—you have a lot of people around and you are celebrating that person's life in a sense and there is a lot of commonality." That perspective really helped me and I told her later, "You helped me go there and have it be okay."

Concrete, particular information is an essential criterion for creating a shared knowledge base. The midwife makes a decision based on particularized knowledge of each woman rather than making decisions based on statistical normality alone. The following account demonstrates how the midwife uses this knowledge to interpret the definition of risk in a way that the mother can understand and work with to help her combat the fear of childbirth that is pervasive in this culture.

> In prenatal visits, I told my midwife how scared I was that something would go wrong during the birth and that I wouldn't have enough information to know what to do—that the hospital would just start doing stuff to me as they had done before. Then during labor, when I started feeling the urge to push, a lot of meconium started coming out and my husband got worried that this was a sign of a serious problem, so I started to get scared as well, and I just kind of shut down and the urge to push went away. I did not understand what was happening or what it meant—I just felt this overwhelming terror. The midwife explained to me that the meconium was thin, watery, that the baby's heart tones were good and strong, and that there was time for me to go ahead and give birth if I would just go for it. She was so clear and straightforward that my fear just vanished and I pushed with my whole will and within minutes the baby came out. There was thin meconium everywhere, and the midwife continued to explain that she was aspirating the baby and that she would not cut the cord until she was sure the baby's lungs were clear so that the baby would get plenty of oxygen until he was ready to breathe. And sure enough, he breathed and cried a little, and my feeling of confidence returned and I just held him and talked to him and then I realized that I knew he was fine, he was *fine*. And then I realized, I did it! I was scared, but I did it, I gave birth to a healthy baby on my own. No one took my power away like the time before. It was the clear information the midwife gave me that got me through my fear.

Critical thinking by the client is encouraged. Ensuring that women and their families understand the details of the situation is key, and often this takes a lot of critical thinking. As illustrated in the previous quotation, rather than try to brush over difficult issues, midwives tend to openly address them on both rational and emotional levels until the matter is resolved. Most of their clients highly value the midwife's veracity as a part of the trust-building process. In the following exchange, the woman's husband is with her as they put some tough questions to the midwife regarding a document the mother needed to sign, which clearly stated that in some situations a planned homebirth might have a better outcome in the hospital, while in others a planned hospital birth might have a better outcome at home:

> We read through the legal document she asked us to sign. Unfortunately my midwife had to deal with my [being] upset

> about this and I am glad that this was told to me because this is the truth. We are still discussing this—it was brought up last time and we just started discussing it. What I am learning is that there is a balance about when to use medical technology and when to not use it. We felt very satisfied with our midwife's competence and signed the document. I actually found it very truthful. I felt that my midwife's honesty about the letter put more trust in her rather than less.

Through conversation, the woman's belief in body efficacy and body integrity is established and reestablished. The following quote illustrates how interaction with the midwife transformed this woman's body image. Note how she stresses that her encounters with the midwife changed her self-talk and hence her own subjective meaning of giving birth:

> My main midwife, instead of saying, "This could go wrong or that could go wrong," she was saying, "The likelihood is that everything is going to go well. The high percentage is that everything is going to be fine"—nobody had been saying that. She did a physical exam and said, "How beautiful you look!" and all these positive things about my body. For somebody who had always felt that their body was inferior and didn't do things right, this was very empowering. And I started thinking, "Maybe my body is going to really work, maybe I can really do this." So there was that real paradigm shift and the focus was not on the process of birth as a physiological mechanical event, the focus was on me, on me giving birth. It wasn't that the midwives were saying, "We have to work hard to get you prepared," it was that they provided an atmosphere and a supportive place where I could grow into being ready to give birth and I could ask them questions.

This woman illustrates how midwives put themselves in the supporting role, give the woman the starring role, and in so doing, encourage the woman to take responsibility for herself. The following encounter communicated to the client that she had authority over her own body:

> Just the level of respect of having you put your clothes back on [right after the exam] like a human being so there was not this authority person—that just made such a difference to me—and it was very clear that she was saying, "I am not in charge here. This is *your* body, I am here to support *you*."

The woman's subsequent experience is indicative of how the process of prenatal care is as important as the content. She specifically comments on the midwifery technique of respectfully asking permission rather than giving orders:

> My midwife asked permission to do things—"May we?" instead of just telling me to stick my arm out. And it is things that you don't realize that you have a choice about in a conventional practice because they just say you are expected to submit to these things. They were very careful to say, "This is why I'd like to do this but if you really don't want to there are other options. Asking your permission before they touch your body—it just made me glow almost—"May I take your blood pressure now?" "I am going to touch your belly, is that okay—may I start now?" I thought, "Wow, my body is my own body, they are letting *me* decide."

The midwife values and respects the woman's desires and definition of the situation, and honors the woman's intuition as an important adjunct to rational knowledge. We previously gave an example of how the concrete information a midwife provides can change a woman's perception of danger, giving her the courage to go forward. Here we call attention to the ways in which midwives can use the woman's own definition of the situation and her intuitions about her condition to facilitate her birth process. This midwifery approach includes acknowledging intuition as an important adjunct to rational knowledge. Some women are accustomed to validating their feelings and intuition as important aspects of their everyday lives. Others, like the woman quoted below, take longer to define feelings and intuition as legitimate complements to rational knowledge. Her case is instructive for two reasons. First, her account illustrates the general manner in which the midwife can validate a woman's knowledge. Second, her experience gives insight into how the midwife, in this case also a neighbor, can help the woman make the paradigm shift from the medical-rational model to trusting her own definition of the situation:

> My neighbor, who later turned out to be my midwife, supported me in my intuition—she gave me faith in myself, she trusted me, she validated my voice, my internal voice that was emerging as a woman in this pregnancy. When they told me at my HMO where I was doing my prenatals that I had to take a genetic screening test, I thought, "I am just beginning to establish trust

> in my body that I am normal. What will taking this test do to disrupt this trust?" [My midwife encouraged me to research the pros and cons of the test, and based on this research I decided not to have the test because it has a high rate of false positives, which can lead to further testing or to a decision to abort a baby that is perfectly healthy. I was at very low risk of having this condition and my intuition was strong that my baby was fine]. This was a very important step for me and as the pregnancy progressed, I continued with that assertive self. I started reading books and I started learning about birth and I started discovering what it was that I wanted for birth experience and my neighbor midwife was right there with me all the way. I found my voice and found myself. I saw a new side of me. My neighbor midwife—she was right there for me the entire time.

As many social scientists have shown (see for example Browner and Press 1995, 1997), the mere existence of genetic screening tests generates a cultural expectation that women should have such tests in order to give their babies "the best care." Yet as this woman's words acknowledge, such tests can undermine a woman's confidence in the integrity of her pregnancy and her baby, and the test results can be misleading. Her midwife's encouragement to do the research and make the decision for herself empowered her to think critically and at the same time to factor her intuition into the final decision.

Fostering Autonomy through the Ethic of Caring during Birth

Midwives hold a conceptual space within which the woman can give birth according to her individual desires and needs. By *conceptual space* we mean an ideology of flexibility that allows the woman room for variation in her movements, the progress of her labor, and her desires. Many women doubt their ability to give birth, yet find that ability enhanced when external cues convey that birth is not a medical condition but rather a normal life event. Some examples of this are when women are able to walk about, labor in the hot tub, and respond to their body messages:

> I remember laboring in the hot tub. My husband was in the tub with me. I felt like my birth was being sanctified in a natural environment where other people care. Candles and music were present. . . . Then I started waking up every couple of minutes because I was having contractions every couple of minutes.

> Finally, I got up and started walking around. This gave me a needed sense of freedom.

Midwives themselves often experience a steep learning curve with respect to their ability to hold this conceptual space for normal birth. One of the student midwives Robbie interviewed described being sent in to attend the hospital birth of a woman she had not previously met. She said,

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

The student went on to say that if she had felt more confidence, she would have "held the woman, soothed her, gotten her up, given her something to drink, helped her take a shower or walk around." But, she continued, "The circumstances didn't allow it—there was no space for me to connect with her at that level." In contrast, another midwifery student in a similar situation did do all of the above because her preceptor encouraged her to follow the midwifery model and to have confidence in what we would call its ethic of caring. She said, "My preceptor backed me up—she held a space for me as a student within which I could trust myself, my intuition, and the woman's ability to give birth when she felt safe and supported. And it was a beautiful birth, and it taught me, when I was on my own, how to hold that space myself, that precious space in which the woman can do what she needs to because she has the support she needs." In our terms, the preceptor fostered a sense of autonomy in the student so that the student could foster that same sense in the mother.

Midwives keep the woman center stage as the main actor, supporting her to remain there even when she doubts her ability to continue. Midwives make a very clear point: The woman is the one giving birth. Although they are often tempted to talk about the babies they "delivered," when they really think about it, they change that language into "catching the baby" or "assisting" or "attending" the birth—their way of acknowledging that the mother is the one who does the hard work of labor and delivers the baby to the world. One woman was filling out a

form after the birth with a space that required her to fill in who delivered the baby. She thought, "Well, that would be me," and she put her name on the dotted line. The woman is center stage and the midwives are there to support her and provide guidance or care as needed. One of the forms this takes is remaining in tune with the birthing woman and being conscious of her needs at all times. The following quote shows how all interactions are centered on the needs of the birthing woman rather than those of her caregivers.

> And one of the things that I really distinctly remember was the two midwives would be talking about things. Then, when I was having a contraction, everybody could tell and the talking stopped and nobody moved and that was so important to me because anything was really distracting to me. But because they did that, I was really able to stay with my contractions. And they were very intense and it was like a volcanic energy—those contractions were such that I just had to go with them, I couldn't resist them, if I resisted them it was terrible.

Most birthing women can manage the contractions if they can get into and sustain a rhythm. Such a rhythm can be easily disturbed and is contingent on the birthing woman's needs remaining paramount:

> I could almost see the contractions like waves. I saw myself body surfing over them. I remember at the peak it was so intense I just kept thinking, "This is almost more than I can stand, but this means that it is almost over." And I just got into this rhythm. I didn't want anybody to talk with me. I didn't want anybody to touch me or touch the bed or move anything. I wanted nobody to move around in the room. I wanted no stimulation whatsoever and my friend was really great, she was really protective, if the midwives came in she would say in a whisper, "She doesn't want anybody to talk to her."

The following midwife explains the importance of artfully navigating the boundary between care and autonomy to achieve a woman-empowering outcome when the birthing woman loses faith in her ability to accomplish the birth. In this case, rather than take it as an indication of failure, her birth team cares her into remaining autonomous and reminding her that she has everything she needs to complete the process. Her personal care is intimate—even when she is falling down, she has a group of people who care enough about her to help her

come back up again and get through it. The mother and midwife we quote, speaking jointly, use a sports metaphor to help them express how the homebirth team loves the woman into fully manifesting her power:

> If you want to be an Olympic skier, or if you want to be on the basketball team in high school, you get this drive to do it and you wind up with a support system. When you fall down and you miss a basket or you blow it on the ski slope, your support team rallies around you and gets you together and gets you back out there to do what you need to do to be at your best. When you miss a basket, your support team would never think of saying, "You are really losing it, here let me get a ladder to help you make the basket." Rather, your support team rallies around you. Homebirth is that way.

This woman eloquently describes how she was supported both physically and emotionally during the birth:

> When the contractions got really intense I [wondered if I could really do it]. At these times I was sitting on the side of the bed and the apprentice midwife was sitting behind me so her back was up against mine and supporting my back. My husband would be sitting in front of me holding my hands or holding my head and the apprentice midwife had her back right up against me so I didn't fall backwards—I didn't have to use any of my muscles to hold myself up—I was literally being held up by everyone around me instead of trying to hold myself up and get through a contraction. I could completely relax and let my body go limp and everybody else made sure that I was supported—not just emotionally supported but they physically supported me through all of this. This was demanding on all of them—they were up all night long.

This woman discusses how she was having trouble dealing with the pain—it felt overwhelming to her, and her midwives' response altered her internal experience of the pain in such a way that it became manageable:

> The contractions got really intense. At that point, the midwives were gathered around us singing songs to encourage me. It was music. This helped me to see that the pain was not just pain—it

was a special kind of happening. It was something very unusual and very sacred.

This woman's experience of midwifery care illustrates how midwives negotiate the boundary between care and autonomy by providing full-on, attentive care without taking autonomy away from the mother. Rather, their care enhances her ability to remain autonomous.

Midwives normalize uniqueness. Within the parameters of safety, midwives affirm that what is happening in the labor at hand is normal for that particular woman in that place at that time in her life, thereby keeping the woman from identifying individual peculiarities of her birthing process as pathological (if they are not), and thus maintaining her sense of ability and self-confidence:

> I experienced tremendous pressure during my homebirth to "do it right" because I felt a responsibility to midwives and the entire birth activist community to prove that they were right. I wanted to be the exemplar of everything that they were saying and that I also believed in. I think that's why I needed to have such a long labor—three days! At any point after the first twenty-four hours the midwives could have said, "That's it, it's been too long, you are way out of protocol, you've been at four centimeters forever and we need to transport you. But they didn't. Instead, they asked me, "What do you think is going on?" And I said, "I think I just need time—this birth is making me process my previous cesarean, and I'm trying so hard to prove something, and I think I just need time to get beyond all that and just get into this labor and birth on its own terms. I want to do this, I believe that I can do this—I just need time." They were monitoring the baby's heart tones, and he was fine the whole time. And so they said, "Then that's normal for you, that's what you need to do, and we are here for you—take the time you need." And their trust and support were fundamental—once I knew in my bones that they weren't going to take this birth away from me the way the doctor had before, I relaxed, forgot about the pressure, got into the experience, and ended up doing it all on my own, the way that I had hoped, dreamed, prepared, and planned that I would. I knew that a three-day labor with a VBAC was way out of protocol for them, but they understood that it was normal and right and necessary for *me.* And it worked, and I gave birth, and their faith in the abnormal as normal and right for me at that time in my life was right on!

Embodied Power

Midwife-attended women develop or reaffirm a positive body image. A very common experience for women who receive midwifery care during birth is the development (or reaffirmation) of a positive body image—one not based on cultural ideals but on the personal power they experience from discovering that their bodies are capable of such feats:

> I had not felt that great about my body before that—it was not the conventionally attractive body. And through this experience I fell in love with my body! Bearing children has changed my whole feeling about getting older—having babies is a huge and important experience that I wouldn't trade for anything. And my body shows I did this and my body can do this, and the more I do things like this the more wise I get and the more powerful I get and the more competent I get. And every wrinkle and gray hair and everything else I get says, "I am becoming wiser and stronger."

"If I gave birth I can do anything": Midwife-attended women learn to experience pain as transformational. This woman's experience is illustrative of the majority of women in Christine's sample who gained a great deal of personal empowerment from giving birth. For her, the empowering value of the experience has not diminished but has grown stronger over time:

> When the baby came out of me, I thought, "I can do anything!! I did this, my body worked, my body is wonderful and I am strong and I can do *anything*—that incredible sense of empowerment of almost being bigger than life. And since that time I still get energy from remembering that experience. My birth experience has built on itself. That kind of intense purpose and conviction and that kind of inner power—that comes from giving birth. That feeling that nothing is going to stop me is from giving birth and it carries over into my work life. I am accomplishing things in my work life that I would never have attempted prior to birth.

Most women say they have gained an enormous sense of personal power from the knowledge that they gave birth themselves rather than having someone else do it for them. As a result of this experience, they have a new way of being in the world—knowing they possess the power to accomplish difficult tasks. This woman sums up the general feeling:

> You come out in a different place after birth. It felt like a major life change was occurring and I was being present for it. *I* was going through it. I was walking that path and I hadn't been carried. I *walked*—I hadn't been drugged or I hadn't been cut open. I walked that path and came out the other end conscious and fully present. And that felt good. It wasn't like waking up on the other end wondering how I got there, and I knew very well how I had gotten there. And there was a lot of support to get there—it wasn't a one-woman show.

Many women consciously invoke the birth to talk themselves into knowing that they can accomplish other difficult tasks. For example,

> A couple of weeks ago I was jogging. I hadn't jogged for ten years and I was starting up again. I found myself thinking, "I don't know if I can do this." Then I thought, "Wait a minute—I went through that long birth. My body did this incredible thing. I can do this! I can do any physical thing that I put my mind to."

Another woman said,

> About a year after giving birth to my daughter in hospital with a midwife, with no drugs and no episiotomy and twenty hours of labor, I went skiing again. And when I got off the lift, I took a wrong turn and ended up on a really difficult slope full of moguls. At first I freaked out, and thought about retracing my steps. And then I thought, "Hey, I gave birth even in the face of pain and fear—this is nothing compared to that." So I tackled those moguls, and I'm sure it wasn't the most graceful of descents, but I found myself surrendering to the realities of the mountain the way I surrendered to the realities of labor—I kind of just flowed with those moguls, down and around, down and around, my knees swallowing their eddies, my body leaning into the strength of the mountain while swaying with its flows and depths. I discovered that I could trust the mountain to be there the way I had ended up trusting that the pain of labor would be there as long as I needed it. I had never been an athlete, and every muscle in my body was aching and I almost cried from the pain, but somehow that mountain and I became one, just exactly the way the equally reliable pain of labor and I became one. And I made it to the bottom and had lots of thrills doing what would have absolutely terrified me and taken me down before I gave birth.

Midwife-attended women tend to develop confidence in their competence as mothers. Many of the women Christine interviewed noted that they often found that their response to a crying baby evoked the birth experience. To the extent that they experienced themselves as competent and powerful, they had immediate access to this feeling as a foundation for exploring how to care for their child. To the extent that they felt frustrated and disempowered, these feelings translated into uncertainty and frustration in dealing with their child. In these cases they had to work hard to overcome the negative birth experience. Usually, a positive birth experience was sufficient to reinterpret the first birth and heal a parenting style with the first child that had become troublesome. This woman discusses how her second birth, which was midwife attended, allowed her to redefine and reinterpret the meaning of the first birth:

> This homebirth was my way out of that first birth, and I did it beautifully and I know that I have a fabulous relationship with my new baby. This birth changed my relationship with my oldest son. It sounds weird to say but I forgave him for his birth. I feel closer to my oldest son after this birth, and I also feel like I can handle it. He would throw these temper tantrums before and I would just get so frustrated and now it is like, "I can do this." My first baby came into the world with my sense of frustration attached—my anger, my frustration, my feeling of being out of control. From the time he was a newborn and started crying—the first place I went was, "I am frustrated, I am angry, I can't handle this"—this is absolutely how I felt at the birth. . . . From the moment this second baby was born the tape in my head says, "This is fabulous, this is beautiful, I can do anything. I can handle anything. I am strong enough and I have the tools and if I don't have the tools I know who to call." My work colleagues, my friends, and husband tell me that I am different after the birth—that I am not the same person that I was before the birth. They say that there is something calmer, gentler, more laid back. The consensus is that I have turned a corner somewhere—I have passed a milestone, on a spiritual level.

Midwife-attended women learn to take responsibility for their own health-care choices and for those of their families. In the technocracy (Davis-Floyd 2004), people in general, and women in particular, are socialized to depend on physicians for health care. Physicians in general are trained in a technocratic model of health care that stresses

aggressive intervention and reliance on drugs and technologies that often cause more harm than good. Moving away from this dependence requires that women develop the sense of embodied power we address here as an outgrowth of midwifery care. While technocratically oriented physicians tend to be comfortable with their authoritative role, holistic physicians, who make a paradigm shift toward seeing themselves as supporters and facilitators of individual choice and responsibility, often express a sense of frustration that their clients come to them for a quick fix that requires no responsibility or informed choice on the part of the consumer (Davis-Floyd and St. John 1998). Like holistic physicians, midwives work hard to foster in their clients that sense of autonomy and individual responsibility that can lead them to making informed decisions on their own. As this woman describes, midwife-assisted births can be transformative in this regard:

> My first birth—an unnecessary cesarean in the hospital—left me feeling disempowered and helpless. I realized this most fully when my baby girl's eye outlets did not open properly and so her eyes would get filled up with gunk. I took her to a pediatrician and I let him strap her down in a Velcro body bag and kick me out of the room while he pierced her outlets and she screamed the whole time. If I had insisted, he would have let me be there with her to comfort her during the procedure. My sense of powerlessness and victimization increased. By the time I was pregnant with my second child, I was determined to have a homebirth as a way of learning the meaning of autonomy. When I pushed out my ten-pound son, I realized that I could in fact do anything—I did not need to kowtow to authorities for my children's care. From then on, every health-care decision I made for myself and my family was well considered, well researched, and was my own. I realized my own responsibility in allowing that first cesarean—I just let it happen—and that I didn't need to just succumb anymore. So I read everything I could about self-help in health care, and from that time on, I made the right decisions about how to heal every time anyone in my family was sick. Giving birth on my own changed my life, and I know that it happened because of me, but also because my midwives held the space in which I could learn and grow into taking responsibility.

In homes or hospitals, urban cities or rural communities, culturally comfortable or disjunctive situations, rich environments or poor, midwives work hard to hold this kind of space for women and to deliver them into their own power and autonomy as they give birth. All of the political, ideological, and personal conflicts that midwives face pale in comparison to what they give to the women they attend.

BARRIERS TO MIDWIFERY CARE AND EFFORTS TO OVERCOME THEM

> More and more the wisdom of midwifery is confirmed by epidemiology, and more important, social and historical research is providing new understandings of the forces that prevent the wisdom of midwifery from being realized. The re-establishment of independent midwifery in the United Kingdom and Canada and the use of nurse-midwives by managed care organizations in the United States are preparing the cultural soil needed to sustain a new obstetric system, a system that is characterized by love and justice, a system that makes prudent use of our resources, a system that supports women, babies, and families.
>
> **—Raymond Devries, Making Midwives Legal: Childbirth, Medicine, and the Law**

The above reasons why midwives matter would indicate that instead of 40,000 obstetricians attending ninety-one percent of American births and around 8000 midwives attending nine percent, there should be 40,000 midwives attending at least eighty-five percent of American births (this figure is based on the WHO [World Health Organization] estimate that even in high-risk tertiary care hospitals, the cesarean rate should not be more than fifteen percent) with around 5,000 obstetricians giving care to high-risk women and attending birth emergencies, as is the comparative situation in most European countries. So why is this not the case in the United States? In the introduction and part I, we discussed some of the historical factors that led to midwives' near-elimination in the United States during the first half of the twentieth century, and the enormous efforts midwives have made to achieve their American renaissance through the growth of nurse- and direct-entry midwifery and the development of two new national direct-entry certifications, the CM and the CPM. The chapters in part II illustrate the struggles of direct-entry midwives to achieve legalization and licensure in various states. And the chapters in part III illuminated some of the complexities midwives encounter in their attempts to practice autonomously and holistically in a technocratic society, and to balance the

competing demands of their social movement and professionalization projects. Here, in summary, we provide a list of the barriers that continue to prevent American midwives from realizing their full potential, along with descriptions of efforts to overcome these barriers.

The first and most salient barrier to women's widespread utilization of midwives is *the general public assumption that obstetricians are the best attendants for pregnancy and birth*, and the concomitant lack of awareness of midwives' knowledge, skills, and competence. Certainly there has been some progress here. When Christine and Robbie first began to study midwifery around sixteen years ago, hardly anyone we spoke to in public arenas even knew that midwives still existed in the United States. Today that situation has dramatically changed—almost everyone we speak to out there in the world at least knows that midwives exist. Some people understand the difference between hospital and home-based midwives, yet many only know about one kind or the other and have little understanding of what midwives have to offer. To address this barrier, both ACNM and MANA, as well as many midwifery state organizations and dedicated consumer groups, have written books and articles; printed and distributed thousands of brochures; given public talks in all kinds of places, including classrooms; held rallies; given interviews to the press; and hired marketing firms and lobbyists—all to increase public awareness of midwives and what they do. (Certainly, national advertising campaigns on television would help, but midwifery budgets do not extend to such endeavors.)

In some places these efforts have begun to pay off, as evidenced by increased utilization of midwives. The percentage of births attended by midwives has increased every year since the National Center for Health Statistics began to gather and keep track of that information from birth certificates, and presently stands at around nine percent. CNMs attend approximately eight percent of all births nationwide, and ten percent of vaginal births. Many practicing CNMs have solid jobs with good salaries, and many DEMs, who attend around one percent of American births, have well-established home or birth center practices (see Davis-Floyd 1998 for a more detailed discussion of the nuances of midwifery economics). But even when midwives are able to find jobs or establish relatively successful independent practices with sufficient client loads to make a living, they are confronted with the other major barriers our technocratic and legalistic society imposes.

One of the most significant and challenging of these barriers is *hospital and physician resistance to midwives*, which is sometimes purely economically motivated, and sometimes motivated by an erroneous belief that midwives are not really competent professionals—at least

not as competent as the doctors themselves. CNMs experience physician or hospital administrator resistance when they are overscrutinized (usually when someone is looking for a reason to get rid of them) or fired outright in large numbers, or when physicians refuse to provide backup for their birth center, homebirth practices, and even hospital practices, and/or harass the few physicians that do. Two recent books—*Critical Condition: How Health Care in America Became Big Business* (Barlett and Steele 2004) and *The Medical Delivery Business: Health Reform, Childbirth, and the Economic Order* (Perkins 2004) thoroughly document the distorted economic priorities of our current health-care system, which fails to support midwives and natural childbirth because the low intervention approach to birth brings no economic benefit to hospitals or doctors. Susan Hodges (personal communication 2005) offers an enlightening metaphor to explain why:

> Midwifery care, with its individualized patience and respect for each unique woman and her birth process, is like the work of an artist—painstaking, patient, unique. Hospital birth is more like a factory, with economic analyses etc. to ensure operating as efficiently as possible to make money. How many factories mass-producing some product for money would consider changing to artisans creating the objects by hand? When we want to have midwives providing midwifery care with the qualities you list above, we are essentially expecting the efficient, mass-producing hospital factory/institution to make space for hand-crafted, one-of-a-kind births that don't get done on a schedule and are not efficient at all from the hospital's point of view. So, besides all the philosophical, power, etc. issues between MDs and midwives, there is also a misfit between hospital culture and value systems and *any* other way of "managing" labor and delivery.

DEMs experience physician resistance in the form of the same refusal of backup care, insulting treatment in the hospital when they transport a patient, investigation of their practices by physicians determined to shut them down in what midwives all over the country refer to as "the witch hunt," and heavy lobbying by professional medical organizations against legislation to legalize and regulate DEMs in various states. In chapter 10, we described three ways in which formerly antagonistic physicians may become midwife supporters; to recap, these are (1) exposure to midwifery care; (2) exposure to midwives; (3) attention to the scientific evidence.

While most CNMs do have liability insurance and insurance reimbursement for their services, those who practice out of hospital, like DEMs, may not be able to obtain them in many states. *Lack of insurance reimbursement and malpractice coverage* often limits midwives' abilities to grow their out-of-hospital practices, as does the *high cost of insurance* when it can be obtained. Like many obstetricians, some midwives are leaving their practices because of liability concerns and an inability to pay increases in insurance premiums (Fennell 2003). Insurance companies may fail to see the overall savings from less interventive midwifery care, focusing only on the fact that if a midwife consults with an obstetrician or a planned midwife-attended birth ends up with a cesarean, the insurance company may be charged for the services of both the obstetrician and the midwife. And CNMs are often not reimbursed for their services at the same rates as physicians. (For example, Medicare reimburses CNMs at only sixty-five percent of the Medicare physician fee schedule, while nurse-practitioners and PAs are reimbursed at eighty-five percent.) The ACNM has been actively promoting national legislation that would redress that situation, and actively seeking to educate insurance companies about the value of midwifery care. DEMs have been able to obtain insurance coverage in several states, and are working hard to do so in others. Yet like many alternative health-care practitioners, many DEMs are able to succeed financially because their (mostly middle-class) clients are willing to pay out-of-pocket for their services.

Lack of educational programs is an enormous obstacle in particular for the new Certified Midwife. While there are forty programs for students who want to become CNMs, twenty or so private vocational schools for DEMs that can help them achieve CPM certification (half of which are accredited by MEAC), and hundreds of midwives who precept apprentices who can then go on to become CPMs, there are only two programs in the country for training the CM (see chapter 1). This situation is unfortunate because one of the goals of the New York nurse-midwives who worked to create the CM was to increase access to midwifery education by eliminating the nursing requirement. Around the country there are probably hundreds or thousands of women who would become CMs if there were laws in their states legitimizing the CM and educational programs to meet the demand. But passing such laws requires money, effort, and time, as demonstrated by the ten-year process the New York CNMs went through to pass their legislation legitimizing the CM (see chapter 2), and by the chapters in part II of this book, which show how hard and how long DEMs have had to work to achieve their own laws, with variable success. With so many other

problems to deal with, CNMs in most states don't give high priority to legalizing CMs, given the expense and effort required to create new statutes and new educational programs for them. Judith Rooks (personal communication 2004) notes that:

> Many CNMs would like to get out from under nursing, but some think nursing is just fine and few have the time and energy, consensus and leadership, to prioritize this issue in any state. States are also likely to resist the CM, as her legal existence would require the development of a separate midwifery board, and most states adamantly refuse any new professional boards because they are expensive. Most states require the members of the regulated profession to pay for the costs of regulation through their licensing fees, which can be exorbitant.

Thus we cannot expect any kind of rapid growth in the number of CMs in the near future, in spite of the fact that the CM represents an important opportunity for the future of American midwifery, and that she is an ACNM (ACC)-certified midwife qualified to provide both maternity services and primary health care who does not have to spend the years (and the psychological toll) it takes to become a nurse first. From any educational route that entails a baccalaureate degree, she can go on to become a midwife qualified to practice in hospitals, where the vast majority of American women chose to go for birth. Her services are needed across the nation, and we fervently hope that someday the vision of the nurse-midwives of New York, who created the CM, will be realized with her legalization and licensure in every state, and with the concomitant creation of educational programs that will be needed to accommodate the many women who would choose to become CMs if that option were available in their states.

Of course, *lack of legalization and licensure in many states also creates a huge barrier for non-CM direct-entry midwives.* Although homebirth direct-entry midwives do practice in all of the states in which they are not legal, their growth in numbers in unlicensed states is often inhibited by fear of persecution and arrest, and their legislative attempts may be limited for the same reasons. (This situation varies by state; for example, in Michigan and Maine, unlicensed DEMs are able to practice rather openly because they are not hunted by state agencies, while in Ohio they are aggressively pursued.) In addition, the lack of visibility resulting from the underground nature of their practice can make them hard to find and thus limit their accessibility. DEMs, aided by consumer groups and others, are addressing this barrier through legislative efforts in

almost every state in which they are not yet legal and licensed, some of which we have documented in part II of this book. They have been greatly aided in this endeavor by NARM's creation of the CPM credential in 1994, NARM's subsequent membership in the National Organization for Competency Assurance (NOCA) and certification by the National Commission for Certifying Agencies (NCCA), and by MEAC's official recognition as an accrediting body for direct-entry midwifery schools by the U.S. Department of Education in 2000 (reaffirmed in 2003). Such national recognition for these direct-entry certification and accreditation processes impresses legislators. Yet MEAC's government recognition brought with it what many DEMs perceive as the danger that some states may accept CPMs only if they graduate from MEAC-accredited programs (as is currently the case in several states), thus threatening the ongoing viability of the apprenticeship learning that the CPM certification was, in part, designed to protect.

Further protection for the CPM credential, with all the educational routes it supports, now exists through national standards for CPMs created and adopted in 2004 by the National Association of Certified Professional Midwives (NACPM) (see chapter 1). Until now, CPMs have lacked clear national practice standards. (MANA has had such standards since the mid-1980s, but not all CPMs belong to MANA, and not all MANA members are CPMs.) The codification of such standards constitutes another step forward in the CPMs' professionalization project; the mere fact that these standards were under development has already helped midwives' legislative efforts in the states of Utah and Wisconsin, and has been of immediate benefit in Massachusetts as well, where legislators made it clear to the CPMs that their law stood no chance of passage without such standards. Indeed, it was in response to the situation in Massachusetts that the NACPM was created, so that CPMs could have a national standard-setting organization more structurally similar to the ACNM than MANA. (To recap from chapter 1, MANA is inclusive, requiring only the statement that one is a midwife, any type of midwife, for voting membership; in contrast, the NACPM requires the CPM for membership, just as members of the ACNM must become either CNMs or CMs.) If all or most CPMs eventually come to join the NACPM (the professional organization) and leave MANA (the social movement organization), the NACPM may eventually come to threaten MANA. At present, such an occurrence appears unlikely (see chapter 1). NACPM incorporates its meetings into MANA's annual conferences and urges its members to join MANA as well. For the foreseeable future, it appears that MANA, to which hundreds of DEMs hold a twenty-year allegiance, will continue to serve as the umbrella

organization and the ideological anchor for NARM, MEAC, and the new NACPM.

Ironically, as we showed in chapter 11 on renegade midwives, the very legalization midwives seek in order to avoid legal harassment and increase their public visibility and accessibility, and which NARM, MEAC, the NACPM, and many DEM state organizations and consumers are working so hard to provide, can create barriers to homebirth midwifery care once state laws are passed. *Licensure and regulation can compromise midwives' autonomy* by, for example, prohibiting their attendance at VBACs and breech births, which some very experienced homebirth midwives feel more qualified to attend than obstetricians who nowadays tend to deal with such births by performing a cesarean. In addition, licensure and regulation can result in a requirement that midwives obtain malpractice insurance—another complication, as we have seen. Most of the midwives we interviewed prefer licensure to illegality; they deal with the possible restrictions that can result by doing their best to write their own state regulations (not possible in some states, where regulations for midwives are written by others). Once those regulations are in place, most DEMs who achieve licensure are careful to abide by them, checking themselves and each other through ongoing peer review processes in their states. But as we saw in chapter 11, when confronted with certain situations, midwives must make difficult individual choices about abiding by or choosing to lay aside those regulations to serve a particular mother.

A further barrier to midwifery care has to do with *the negative publicity that occurs almost every time there is a bad outcome at a homebirth.* Deaths in the hospital of baby or mother are rarely publicized because the hospital constitutes the cultural standard for safety, and physicians tend to protect their own from public view. Thus a death at home rings loud cultural alarm bells, sounding the culturally ingrained message that homebirth is an irresponsible choice for mothers, and that homebirth midwives must be far less competent that hospital-based practitioners. The case presentations in our chapter on home to hospital transport, and in the Massachusetts chapter on the harassment that a midwife (who in fact delivered exemplary care) received during transport, highlight this fact. This barrier can only be overcome by increased public education, which as we mentioned above, is an ongoing effort on the part of midwives and consumers.

In some of the states that do offer licensure for direct-entry midwives, where the situation can appear rosy, there is often *insufficient financial support for state midwifery boards.* Most state governments want such boards to be supported financially by the fees the midwives

themselves are required to pay, but realize that there are not enough midwives to sustain the board by paying reasonable fees, and that if the fees are too high, they will put midwives out of business. Thus, some state midwifery boards run deficits that have to be paid from the state's budget—a precarious situation.

This is not a problem in New York, where around 1,000 CNMs and around fifty CMs provide enough income at reasonable fees to sustain the board, but it is a serious problem in other states whose midwifery boards regulate only direct-entry midwives relatively few in number, especially when the board faces complaints or other legal actions for which it must pay, as has happened in Oregon and Washington. A potential solution to this problem is presented by the Massachusetts midwives, who seek to create a midwifery board that would regulate CNMs, CMs, and CPMs; collectively, their numbers should be high enough to sustain the board they want the state to create. Because many CNMs around the United States would like to "get out from under the thumb of nursing," and many CPMs seeking independent licensing boards need greater numbers to sustain their boards, we can hope that future collaborations between such groups in various states might lead to a transcendence of this barrier. If CPMs continue to grow in number and establish successful practices, they might alone become more able to sustain the fees necessary to sustain the boards that regulate them. This, of course, would require more women to choose homebirth—again, the midwives hope, a question of public education.

A barrier particular to the growth of organized midwifery, which midwives can easily eliminate, is the fact that *many midwives do not choose to belong to their national organizations.* Seventy-five percent of CNMs are members of ACNM (some are retired and others don't feel that ACNM supports their individual needs and concerns). About one-third of CPMs belong to MANA (the NACPM is too new for specific numbers to be available); the other two-thirds, who do not, tend to feel that their state organizations do more for them than MANA. ACNM, MANA, and the NACPM are dependent on membership numbers, dues, and active participation for their annual budgets and the projects they aim to achieve. Each national organization is actively campaigning for increased membership, and *we personally urge every midwife to join at least one of them.* As the midwives of Europe discovered some time ago, there is power in numbers and national organizations that cannot be achieved to the same extent at a local level.

A barrier to the ability of CPMs to serve more women is their inability (with a handful of exceptions) to obtain hospital privileges. On this note, let us return for a moment to the Ontario midwives discussed in

chapter 1 of this book, who created ways to evaluate the competence of their direct-entry midwives along with the means to empower those same midwives (who had previously never practiced inside a hospital) to maintain their competence inside the hospital system. American CPMs, who are as knowledgeable about normal birth as CNMs and CMs, could be equally empowered to attend hospital births if medical systems would choose to allow it. Clients choosing CPMs could then also have the choice of a CPM-attended hospital birth. We can find no valid scientific, educational, or ideological reason why such options should not be created in our homeland. The current for-profit, specialized, and bureaucratic structure of health care remains the problem (Barlett and Steele 2004, Perkins 2004).

The following barrier will be controversial among midwives, but the need for its transcendence is made obvious by the *splitting of midwifery care* generated by the fact that most CPMs can only practice outside the hospital and most CNMs and CMs can only practice inside of hospitals. Thus, as we discussed in chapter 1, to choose a particular kind of midwife is also to choose a particular place of birth. In the interests of eventually healing this divide (as the midwives of Ontario were able to do), we suggest that having three national organizations instead of one (or two) entails a splitting of energy and resources, and generates conflicts of interest in which midwives sometimes work against each other. At the very least, it might eventually behoove MANA and the NACPM to merge (if their members can ever agree that the CPM should be a requirement for membership). At the very most, we envision a time in which ACNM, MANA, and the NACPM might, in the social movement sense, unite behind the midwifery model of care to promote all nationally certified midwives. The longer these organizations remain separate in their concerns, the more vital energy may be drained away from the real source of the conflict: the hegemonic obstetrical system. A united American midwifery movement might well gain enough momentum and power to pose formidable obstacles to medical definitions of birth, and to vastly increase birth options available to women.

Midwifery consumer Susan Hodges, president of Citizens for Midwifery, adds the following suggestion:

> My own thought, as an alternative, would be for MANA, NACPM and ACNM to acknowledge the contributions of each to the survival of midwifery—because of the ACNM, at least in part, most people have heard of the word *midwife*, while the DEMs, whose laws for the most part do not require any agreement from any

> doctor in order to practice, have demonstrated that midwives can practice safely and effectively without "permission" or oversight from doctors. DEMs benefit from the generally excellent reputation of CNMs, but CNMs can benefit from the independence of DEMs to make their own case for autonomy. I would think this coming together could happen to everyone's benefits without even entertaining the idea of merging and losing one or more of these organizations, certainly for a long time to come. (Personal communication 2005)

New potential barriers for CNMs come from nursing. There are a number of specialties in advanced practice nursing, and each of these requires program accreditation. The deans of nursing of various schools, impatient with the bureaucracy of these accreditation processes, are considering eliminating them in favor of the same process for advanced practice nurses of all types. CNMs perceive this potential action as a core-level threat to their identities as midwives, as it might take away ACNM/DOA's power to accredit programs, which lies at the heart of nurse-midwifery's identity, in part because the DOA has to date been able to require that nurse-midwives be taught by nurse-midwives. Another potential threat from nursing lies in a decision made by the American Association of Colleges of Nursing (a national alliance of nursing organizations) to require a Doctorate in Nursing Practice (DNP) for all advanced practice nurses by 2015. This would be a clinical degree distinct from, but equivalent in prestige to, the academic Ph.D. (One argument used in favor of this move is that the number of hours earned to get a master's in many advanced practice nursing programs, including nurse-midwifery programs, is not far short of what is required for a Ph.D.) While ACNM as yet has no official position on this issue, many CNM leaders have expressed feelings ranging from "concern" to "dismay" (Deanne Williams, personal communication, 2005), as they are very aware that advanced degrees do not equate to better practitioners (see chapter 1). One ACNM leader proposes a preemptive strike: she suggests that ACNM create a Doctor of Midwifery (a clinical degree like a Doctor of Medicine or a Doctor of Chiropractic that focuses on clinical practice more than academic research) to enable CNMs and CMs to maintain their identity as midwives. These two nursing initiatives are too new for us to be able to evaluate their eventual impact; all we can do here is point to them as potential problems for nurse-midwives that indicate even more sharply some of the reasons why many midwives wish to "get out from under the thumb" of nursing.

To summarize, the barriers to midwives becoming the primary attendants at birth in the United States include:

1. the general public assumption that obstetricians are the best attendants for pregnancy and birth, and the concomitant lack of awareness of midwives' knowledge, skills, and competence;
2. physicians' resistance to the competition midwives present, in combination with the economic structure of U.S. health care, which makes natural childbirth and midwifery care money losers for hospitals and OBs;
3. lack of sufficient insurance reimbursement and malpractice coverage;
4. lack of educational programs and legalization for CMs in forty-eight states;
5. lack of legalization and licensure for DEMs in twenty-nine states;
6. the restrictions on autonomous midwifery practice that can result from legalization and licensure when midwives do not have enough authority to write their own regulations;
7. the negative publicity that occurs almost every time there is a bad outcome at a homebirth, while negative hospital outcomes are often hidden from public view;
8. insufficient financial support for some state midwifery boards;
9. the fact that many midwives do not choose to belong to their national organizations;
10. the inability of CPMs to attend births inside of hospitals and the inability of most CNMs and CMs to attend births outside of hospitals (because of lack of physician backup and insurance restrictions);
11. three national midwifery organizations that do not present a united front to the public in favor of the midwifery model of care, due to their internal differences;
12. recent nursing initiatives to eliminate specific program accreditation and to require a Ph.D. for all advanced practice nurses by 2015.

For every barrier we presented above except the last one, which is too new to fully evaluate, we also presented possible routes for overcoming these barriers that midwives and their consumer and legislative supporters are trying, or might try in the future, to create. Their struggle is ongoing and deserves the support of every American citizen and resident who cares about better birth for mothers and babies.

CONCLUSION: INTEGRATING CARE AND AUTONOMY

As we have seen in this chapter, the midwifery model provides both an ideology and a method through which care and autonomy can become integrated. Without the ethic of care, the client may have a difficult time remaining or becoming autonomous. Without a sense of autonomy, the client has little chance of developing an embodied sense of power through the birth process. Our analysis of these interrelationships, which we offer as an important subject for further research, suggests that care and autonomy should not be conceptualized as competitors but rather as inseparable allies for building new professional models that are equally conducive to excellent outcomes *and* to human well-being. Midwives matter because they are specialists in the conscious development of these interrelationships between care and autonomy, paving the way toward the kind of integral health care that must come to characterize and facilitate the human future.

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Fig. 13.1 Midwife-assisted water birth in hospital. Photographer: Kenneth C. Johnson.

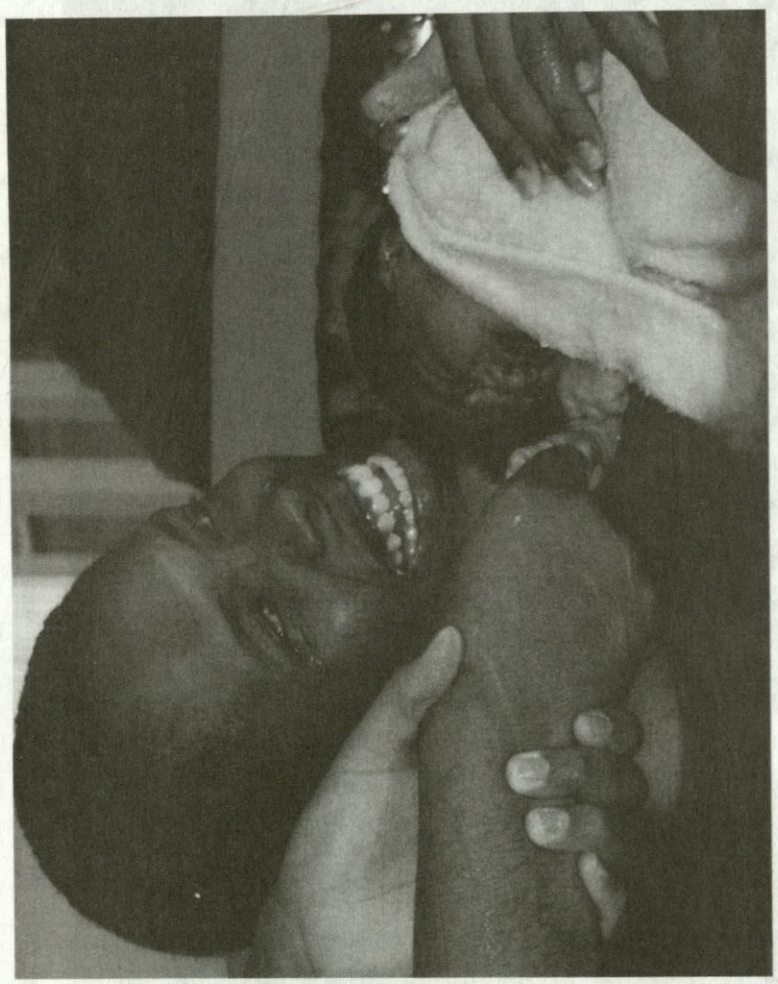

Fig. 13.2 Midwife-assisted water birth in hospital. Photographer: Kenneth C. Johnson.