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

2

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

Maureen May and Robbie Davis-Floyd

You don't get what you deserve, you get what you negotiate.

—Dorothea Lang, New York CNM

Historically, New York state has been a generative source for Certified Nurse-Midwives (CNMs) and for both of the two new types of direct-entry midwives—the Certified Midwife (CM) and the Certified Professional Midwife (CPM). Our focus in this chapter is on the creation of the CM through the enactment of a significant piece of legislation, the New York State Professional Midwifery Practice Act of 1992. The history we recount here provides background and context for the enactment of the legislation. This history opens a window into the development of the culture of nurse-midwifery, and seeks to describe how the ideological and political conflicts between nurse- and direct-entry midwives in New York have been primary catalysts for the conflicts, rivalries, and misunderstandings that still plague American midwifery in other states.

Until 1992, New York nurse-midwives were not licensed as midwives (the license they held was that of Registered Nurse) but were given permits to practice midwifery under an archaic 1907 statute in the state Sanitation Code while other professionals were licensed and regulated by the New York Education Department. Direct-entry, homebirth midwives practiced without licensure or legal status. Both groups of midwives worked for ten years on legislation that would grant them full and legal professional status. An additional desire of the New York CNMs was to create a new kind of direct-entry midwife (DEM) with the same training as the CNM but without the nursing requirement. The existing DEMs in New York thought that this new kind of midwife certification would and should include them and the training they valued—a training that focuses on homebirth and occurs either through apprenticeship or in one of the independent midwifery schools in the United States that exist outside of the university and medical center milieu (see chapter 1).

Those CNMs working for the legislation were certain that the New York state legislature would never pass a bill validating anything short of a university education for midwives. From their perspective, the legislation had absolutely nothing to do with the homebirth DEMs, but was about legitimizing CNMs and the new kind of DEM they envisioned. The eventual legislation, passed in 1992, did not give the CNMs everything they wanted but did achieve a number of their goals, and did lead directly to the creation of their new kind of midwife, later named the Certified Midwife (CM). It did not include the already existing unlicensed homebirth DEMs in any way except to turn the legal definition of their practice from misdemeanor to felony. This legal

redefinition was not intended by the CNMs, but rather was put into the law by government staff because it is mandatory in any law creating and defining any licensed profession in New York.

While generating new opportunities and challenges for midwifery within New York state, the legislation has also had profound ramifications for midwifery throughout the country as the debate engendered by the creation of the CM has spilled over into political and legislative arenas in other states. In some states, efforts on the part of homebirth direct-entry midwives toward decriminalization and licensure have been actively opposed by some CNMs, with the unofficial support of the national ACNM leadership. In other states, CNMs have attempted to introduce legislation similar to that in New York, which would establish the ACNM-created Certified Midwife as the only legal direct-entry credential. In short, the New York situation set off a classic professional turf battle between midwives.

While to date there are only fifty CMs, what would appear to be something of little consequence is in fact a development of long-term consequence for American midwifery. The political, legislative battles over licensure, credentialing, education, and clinical preparation, as well as place of practice, are really about who has the right to legally practice and to claim the title *midwife*, which is, of course, ultimately all about identity—midwives' social, cultural, and historical identity.

METHODS AND FRAMEWORK

The research on which this chapter is based includes lengthy interviews conducted by the authors with fifty New York DEMs and CNMs, as well as with various government officials and consumer activists, between 1996 and 2000. Maureen May is a CNM with a Certificate of Midwifery from the Frontier School of Midwifery's Community-based Nurse-midwifery Educational Program (CNEP), and a Women's Health Nurse Practitioner with a Masters of Science in Nursing (MSN) from the University of Rochester. She is a homebirth midwife, a member of the ACNM who supports unity within the midwifery community, and is presently working on a PhD in social science with an emphasis on ethnography. Robbie Davis-Floyd is an anthropologist who has studied American midwifery since 1991 and supports both organizations and their philosophies of care (see Introduction, this volume). In addition to our interviews, we attended numerous professional and governmental meetings and investigated primary sources, including minutes from ACNM chapter meetings, the legislative jacket, and journal articles.

Ethnography is both a framework and a method of research. As a framework, ethnography holds as a core value the concept that there are real parts of the world and the human experience that cannot be quantified. Ethnographic research involves back-and-forth dialogue and close relationships between researchers and informants. Through this process, the ethnographer is able to access information unobtainable through other methodologies. Standard methods for data collection include interviews, observations, field notes, and the use of primary documents. We have utilized all of these in the process of our study. Ethnography recognizes that "facts" are not only contested, but are reflected in the richness and details of the informant's own words, and thus requires that the voices of the individuals under study be heard to the greatest extent possible. To that end, we have incorporated extensive quotes into our text from key interviewees on both sides, in order to offer our readers the feel and flavor of their experiences and thoughts. Consent has been obtained for all quotes from interviews. We name the quoted individuals when we have been given permission to do so; any quotes from unnamed individuals reflect their expressed desire to remain anonymous or the fact that the quoted words were repeated by various individuals.

At the onset, the goal of our research was to understand the development and ramifications of the New York midwifery legislation. During the coding of interviews, data on the professional culture of New York nurse-midwifery became so salient that we decided to include it in this chapter, in part because it breaks new ground in the anthropological study of midwifery, but primarily because it brightly illuminates the sociocultural context out of which New York CNMs created the law. For the same reasons, we highlight significant moments of time in the history of New York midwifery because this history is essential to a full understanding of how the culture of New York midwifery developed, why its members have always had a strong sense of specialness within American nurse-midwifery, and how their values came to include the licensing of midwives without nursing training.

Many discussions of present-day American midwifery drift into comparisons based on a binary framework. Analyzing American midwifery through professionalization or social movement theory leads to a focus on the structural and cultural changes (usually criticized by such theorists as negative or co-optive) that occur in a given group during its process of professionalization. Such analysis can easily result in labeling certain players *wrong* and others *right*. For example, if we view the CNM, the new CM, and ACNM as occupying an oppositional space in relationship to the direct-entry homebirth midwife, the Certified Professional Midwife (CPM), and MANA, we inevitably miss the reality, which is that

in practice many midwives are occupying a space in between, both ideologically and in practice. Davis-Floyd (1998a; chapter 1 this volume) has documented the blurring of professional lines between these two types of midwives, demonstrating that within the grassroots of midwifery there is increasingly common ground. Our research has supported this analysis. Some nurse-midwives identify as professionals and as part of a social movement, and some direct-entry midwives continue both to embrace the social movement and engage in professionalization (as Betty Anne Daviss describes in further detail in chapter 12).

Concomitantly, we desired in this chapter to avoid a binary approach in an effort simply to tell, and to analyze, how the New York legislation came about—a story that in its full complexity has never before been written. But the core of this New York story revolves around professional rivalry between two groups of midwives. And so we found a binary approach impossible to avoid. There are two sides, and only two sides, to this New York midwifery story. During the writing process, we have often doubted our ability to tell both sides in a way that both groups will recognize as true. It has been a tremendous challenge to our ability as ethnographers to undertake this task. Early drafts of this chapter sent to midwives and others on both sides of this story for review resulted in responses that included desires to emphasize their parts of the story and discount the other side and accusations that we, the authors, were biased toward one side or the other. We have taken all comments into account in this final version, remaining determined to tell both sides of this New York story accurately and without bias. We have done our best to explain events, philosophies, and actions as both groups perceived and experienced them, and can only hope that in our final words both groups involved will find a fair and accurate portrayal of themselves and their versions of events.

Part of our writing challenge had to do with terminology. As anthropologists, it is our tradition to ascribe to subjects the name they claim, as a matter of respect and the right of people to self-definition. But it is precisely the contested claim to the term *direct-entry midwife* that constitutes the fulcrum around which this New York story revolves. Social scientists writing about midwifery had a much easier time when we could simply distinguish between *nurse-midwives* and *lay midwives*—the term used for themselves by many unlicensed homebirth midwives around the country throughout the 1970s, 1980s, and early 1990s. But then *lay* became politically incorrect as the professionalizing homebirth midwives rejected it for its pejorative connotations, and now is only properly used in a historical sense (a use we follow in this chapter). In the late 1980s, these midwives, especially in New York,

began referring to themselves as *direct-entry*, a more professional term that they saw as more clearly describing their identity as it differs from nurse-midwifery. Concurrently, the New York nurse-midwifery leaders had been using the term direct-entry to describe the new kind of midwife they were trying to create, who would be trained not by any route but in specific, formal, university-based educational programs and would practice primarily in-hospital. So no easy distinctions have been possible in writing this chapter, as the term direct-entry properly includes both types of midwife without a nursing education.

In this chapter we wish to avoid confusion for the reader, while at the same time respecting all parties. So *direct-entry midwives* will, unless otherwise specified, refer to New York's independent, unlicensed homebirth midwives (some of whom formerly called themselves lay midwives). When referring to the new direct-entry midwife established after the 1992 legislation, we will use the full title Certified Midwife or the abbreviation CM.

Our goals in this chapter are threefold: (1) to write the history/herstory of the New York 1992 midwifery legislation from the points of view of both groups involved in trying to create it; (2) to present this history in the context of a sociological and anthropological (comparative) analysis of the motivations and ideologies of both groups; and (3) to extend this analysis to include the influence on both groups of their general marginalization in the American health care system and their subordination to the hegemony of obstetrics. Thus our analysis has been informed by James Scott's (1985, 1990) theory of domination and resistance in peasant societies. Scott's identification of "everyday acts of resistance" by subordinated classes against powerful dominating forces provides a useful framework for understanding the development of midwifery in New York. Our interviews revealed what Scott calls "hidden transcripts"—individual conversations taking place behind a group's public representations of itself.

In the United States, normal pregnancy falls within the professional purview of obstetrics. In most other developed countries, even where hospital birth is the norm, uncomplicated pregnancy falls within the professional province of an independent midwifery; obstetrics is considered a medical specialty called upon to handle cases in which complications have developed. Both professions are recognized as having unique and distinct functions in the organization of maternity care. In contrast, American midwifery as a whole is a subjugated profession and the hidden transcripts that we have collected reflect differing beliefs and strategies on how to best position midwifery vis-à-vis the powerful dominating force of obstetrics.

THE DEVELOPMENT OF NURSE-MIDWIFERY IN NEW YORK

Cultural beliefs regarding health and illness are not isolated from, but are always influenced by, a community's social history. The historical lens we provide here is critical for a full understanding of the significance that events in New York have held for the profession of nurse-midwifery from its early years to the present. In the following section, we touch on key aspects of this history that help explain recent events in New York.

New York nurse-midwives have long held strong influence within the ACNM, due both to their numbers and the quality of individual leaders who emerged early on from New York City midwifery schools and services, as well as to the early and continuing important role of nurse-midwifery in the city's health care system. This section will illustrate why New York nurse-midwives attach such importance and pride to their hospital-based midwifery services,[1] and how the history specific to New York midwifery has led to the sense of exceptionality and specialness held by many New York nurse-midwives—their strong feeling that what is good for New York must be good, and should provide the model for the rest of the country.

On the national level, contemporary nurse-midwives tend to strongly identify with a creation mythology that traces their historical roots from Mary Breckenridge and the Frontier Nursing Service. This creation mythology entails vivid imagery of bold, independent nurse-midwives riding horseback through rain and snow providing childbirth and primary health care to the households of the rural poor of Appalachia. While the Frontier Nursing Service is credited as the first "nurse-midwifery program" in the United States (Shoemaker 1947), its model of independent, rural, clinical practice is far from the reality of contemporary nurse-midwifery and is not the model for what ultimately evolved into the contemporary nurse-midwife. Nurse-midwives continue to practice in rural settings in many states (for example, CNMs now (2005) attend approximately thirty percent of births in New Mexico) and the percentage of births attended by CNMs in general is highest in rural states [National Center for Health Statistics, 1999]); but the type of nurse-midwifery that developed in urban New York also played a formative role in this profession's development in the rest of the nation.

New York City became a hot spot during the national campaign to eliminate the midwife in the early twentieth century. Forty percent of New York City deliveries were by midwives in 1905, all in the home (Harris, Daily, and Lang 1971). Many practicing immigrant midwives

in New York City, referred to as "granny" midwives by public health reformers, were in fact professionally trained in government-approved midwifery programs in their countries of origin. One of the obstacles such immigrant midwives faced was the fact that there was "no provision in the law for examination" (Weisl 1964) of these midwives nor any equivalent type of educational facilities. As this brief history will show, the concept of nurse-midwifery was promoted in New York City by public health reformers who saw public health nurses trained as midwives and the movement of place of birth into the hospital as solutions to the public health crisis facing urban America, namely increasing infant and maternal mortality rates—a crisis associated with "the midwife problem" by a well-orchestrated public opinion campaign waged by organized medicine. Ironically, while traditional midwifery was systematically eliminated by this reform effort, many years passed before nurse-midwives were allowed to take the place of the midwives they had helped to eliminate and establish clinical practice in the hospital. And the professional independence held by midwives in other countries became lost and has yet to be reclaimed by American midwifery.

New York City became the first community to initiate reform aimed at reducing the infant mortality rate. A study of midwives was commissioned in 1906 by the Public Health Committee of the Association of Neighborhood Workers. In its report, Elisabeth Crowell, a nurse, produced a "scathing indictment of midwives which prompted the city to revise its laws pertaining to their regulation" describing the typical midwife as "foreigners of a low grade—ignorant, untrained women who find in the natural needs and life-long prejudice of the parturient woman a lucrative means of livelihood" (Litoff 1978:51). Prior to 1907, New York midwifery was loosely regulated by the state. Practicing midwives were required to register with the registrar of the city within which they provided service and present "certificates of character and expertise from two physicians. No supervision was maintained over their activities" (Weisl 1964:9). In 1907, state legislation gave the New York City Board of Health authority to regulate midwifery within its jurisdiction, placing regulation of New York City midwives within the Bureau of Child Hygiene. Section 196 of the Sanitary Code was enacted, establishing minimal regulations. In 1913, the Board of Health set up a Midwifery Division and the Bellevue School for Midwives was established along the lines of the European schools of midwifery (Weisl 1964). In 1914, as a further attempt to regulate and standardize the profession of midwifery, the New York City Health Code was altered so that permits to practice midwifery would be granted only to those

midwives who had graduated from a recognized school of midwifery (Harris, Daily, and Lang 1971)—an effort fostered by those physicians who were supportive of the training and incorporation of midwives. But regulation of midwifery in New York City did not serve to strengthen the position of midwives within the health care system. By 1915, midwife-attended deliveries had dropped from forty percent (in 1905) to thirty percent (Corbin 1959; Harris, Daily, and Lang 1971). Hospital births at the time were also at thirty percent. (Regarding the other forty percent of births, it can only be assumed that doctors were taking over more of the home deliveries in New York City, that some mothers were delivering without official attendants, and that unlicensed midwives continued to attend births.)

Midwifery and homebirth were under increasing pressure from a variety of changing social patterns. Among these was the developing concept of prenatal care as an essential maternity service, a concept promoted through the work of the Federal Children's Bureau (established in 1912) and the Sheppard-Towner Maternity and Infancy Protection Act of 1921 (Corbin 1959; Rooks 1997). During this time a vision of nurse-midwifery began to take hold among public health reformers. The concept of midwifery as a clinical specialty of nursing was first discussed publicly in 1912, the same year as the influential and historic Federal Children's Bureau report. Clara Noyes, the Superintendent of Training Schools at Bellevue and Allied Hospitals in New York City, proposed in a speech to the International Congress of Hygiene and Demography that:

> if the midwife can gradually be replaced by the nurse who has, upon her general training super-imposed a course in practical midwifery, which has been clearly defined by obstetricians, it would seem a logical economic solution to the problem . . . we should be able to provide better teaching, better nursing and eventually better medical assistance to the less highly favored classes." (Quoted in Shoemaker 1947)

Two years later in 1914, at an annual meeting of the National Organization of Public Health Nurses, Dr. Fred Taussig endorsed the concept of establishing schools of midwifery limited to "graduate nurses" (Shoemaker 1947; Harris, Daily, and Lang 1971).

And so it was within the public health reform movement that today's nurse-midwifery was born. This movement's roots go back to the turn of the century and the Progressive Era—a time of public health

reform and the urban settlement house movement with its mission to serve the underserved in large urban communities. Key reforms of the Progressive Era involved the establishment of a public health system serving the growing urban population. This is where nurse-midwives gained their initial toehold—in the public health clinics of the urban centers, in the northeast and New York City in particular (Dye 1987; Harris, Daily and Lang 1971; Howard 1994; Kobrin 1966; Litoff 1978; Reagan 1995).[2]

In 1917, the Women's City Club of New York City, an organization of 2,000 influential women, citing its concern for the extreme maternal and infant mortality rates evident in New York City and the United States, established the Maternity Protection Committee to take on a special project, a maternity center, which would provide both clinical and social service to mothers lacking adequate maternity care (*Bulletin of the Women's City Club of New York*, 1(6) October 1917). The goal of the maternity center was to "give adequate medical and nursing care to every woman" and to provide "thorough coordination of all the work of all the agencies" in the community (Stevens 1918). Within a year the center achieved success beyond hopes and expectations, with over 2,300 women asking for assistance, far more than the 1,000 women they initially hoped to reach (Women's City Club of New York. February 1919. *Summary of the First Year's Work. Preliminary Report to Club Members on the Maternity Center. From Its Opening September 15, 1917 to October 1, 1918).* After little more than two years, the Maternity Center Project could claim the following gains in a pamphlet entitled *Our Hopes Justified.*

> Results of Pre-natal Work carried on for more than two years show: 1. Where three babies die in the entire city only one dies when under our care. 2. When ten are still-born, we have but three. 3. Where five mothers die under ordinary conditions, only two die when under our supervision. Is this not worthwhile? (Women's City Club of New York, *Our Hopes Justified*)

In May 1920, the center project was turned over to the Maternity Center Association (MCA). Formed in 1918, MCA held as a primary goal the establishment of maternity centers throughout New York City. Its mission was to facilitate pregnant women's access to health care so that "every pregnant mother in the City of New York" could be "brought under medical and nursing supervision" (Stevens 1919). This goal was to be accomplished by training "a limited number of selected public health nurses who can find a place to use their training in the

new order; not to work as private practitioners or midwives, but as instructors and supervisors for the untrained midwives and for nurses with only an elementary, deficient training in obstetric nursing" (Hemschemeyer 1962:7). This developing vision of a new type of midwife "contained essential differences from the system of midwifery practice in some countries in Europe and Great Britain and [provided] the guidelines for establishing an American system of nurse-midwifery" (Hemschemeyer 1962:7). A clear—and pragmatically necessary—acquiescence to physicians was evident. These early activities of the MCA, while not directly aimed at the elimination of the midwife, encouraged women to avail themselves of medical care and discouraged the use of midwives in childbirth. Eventually, however, these negative attitudes toward midwives were changed by the excellent results of the Frontier Nursing Service in Hyden, Kentucky (see chapter 1). Its highly successful and well-documented outcomes were noted in New York, to such an extent that by 1931 the MCA had established an educational school of nurse-midwifery,[3] "appropriately so since recognition of the concept of midwifery and the responsibility for its standardization had early precedence here" (Harris, Daily, and Lang 1971:65).

Shoemaker (1947) documents the Manhattan Midwifery School, associated with the Manhattan Maternity and Dispensary and existing from 1928 to 1932, as the first U.S. school of nurse-midwifery. However, the founding in 1931 of the Lobenstine Clinic and School of Midwifery, affiliated with the MCA, was of greater significance (Shoemaker 1947, Lang 1977). According to Rooks (1997), the establishment of this school was an organized effort by individuals within the MCA and Mary Breckenridge.

> In 1921, MCA decided to concentrate on a single demonstration center that could provide complete maternity care. In 1923, MCA tried to arrange for the Bellevue School for Midwives [in New York City] to instruct its public health nurses in midwifery. The plan was rejected by a city commissioner. In 1930, a group of MCA board members and others, including Mary Breckinridge, incorporated themselves as the Association for the Promotion and Standardization of Midwifery. After much work, the two affiliated organizations opened the Lobenstine Clinic, the nation's second nurse-midwifery service and, in 1931, the Lobenstine Midwifery School, the first nurse-midwifery educational program, in New York City. (Rooks 1997:38)

The decision by MCA to establish a midwifery training program and a clinic was controversial, extending beyond its original mission: "It violated a principle to which it had long subscribed; namely, that antepartum and postpartum clinics should be part of an obstetric service in a general hospital. MCA acted because of the immediate, urgent need for public health nurses, equipped not only with theoretical knowledge of obstetrics but with actual clinical knowledge. Midwifery, like any art, can only be learned by doing" (Corbin 1959:22). The objectives of the Lobenstine School and clinic were substantially different from the type of midwifery practiced by European midwives and the nurse-midwives at the Frontier School of Midwifery in Kentucky.

> First, the nurse-midwife trained at the Lobenstine School would accept the responsibility of maternity care of normal patients delegated to her by the obstetrician after a complete physical examination had been given. And secondly, the nurse-midwife would not be a private practitioner as was the principle of work in Kentucky. These differences made it necessary that nurse-midwives be employed only where medical care and medical consultation services are available. Their principle work would be in the field of supervision and instruction. (Shoemaker 1947:30)

The willingness to compromise professional independence in order to gain that primary toehold within the mainstream maternity care system is seen early on in this New York experience.

Rose McNaught, a nurse-midwife from FNS, was sent by Mary Breckenridge to lead the clinic. McNaught, Hattie Hemschemeyer (a public health nurse), and a physician were the initial staff (Shoemaker 1947). The first class of six student nurse-midwives "gave priority to public health nurses from states with high infant mortality and many untrained granny midwives" (Rooks 1997:38). These nurse-midwifery students at MCA, the first of whom graduated in 1934, attended births in women's homes during training. Upon graduation most went to work within the public health system, taught in nursing schools, or did mission work abroad. "Wherever they worked, the level of maternity care improved . . . The demand for their services outran the supply" (Corbin 1959:188). Yet growth in numbers was slight and job opportunities in active clinical midwifery practice were not forthcoming. The effort to eliminate the traditional midwife was very successful. As the number of traditional midwives with practice permits dwindled, nurse-midwives did not take their places.

The following table is from Bernard Weisl's 1964 article "The Nurse-Midwife and the New York City Health Code," published in the *Bulletin of the American College of Nurse-Midwifery* (forerunner of the *Journal of Nurse-Midwifery*, later renamed the *Journal of Midwifery and Women's Health*, see references). It illustrates an efficient and thorough elimination of the traditional midwife through the efforts of physicians, public health reformers, and New York nurses and nurse-midwives. Many years passed before the nurse-midwife would be allowed to take the place of the traditional and immigrant professional midwives these groups worked to eliminate.

As the table shows, in 1934, "granny midwives" held 1,997 permits to practice in New York City while nurse-midwives held six. Five years later in 1939, granny midwives held only 270 permits to practice and in

Table 2.1 Permits in Force, New York City, December 31, Annually

Year	Total Midwife Permits	"Granny Midwives"	Maternity Center Midwives
1934	1203	1997	6
1939	276	270	6
1940	235	229	6
1942	170	162	8
1943	151	142	9
1944	129	119	10
1945	113	97	16
1946	47	31	16
1947	36	7	29
1948	26	6	20
1950	24	9	15
1951	21	6	15
1952	21	6	15
1953	22	6	16
1954	18	5	13
1955	19	4	15
1956	19	4	15
1957	13	2	11
1958	17	2	15
1959	13	2	11
1960	25	2	23
1961	2	2	0
1962	1	1	0

	Nurse-Midwife Permits		
	Total	Original	Renewal
1960	5	5	0
1961	15	10	5
1962	21	8	13

1940 had declined further to 229 permits. In 1941, citing a lack of granny midwives to regulate, New York City's Midwifery Board eliminated itself and midwifery became regulated under what became the Bureau of Child Health. By 1957 there were only thirteen midwifery permits in New York City, eleven of which were held by staff of the MCA. By 1962, New York City nurse-midwives held twenty-one permits to practice (Weisl 1964). All were educators or new graduating midwife interns (Dorothea Lang, personal communication 2005).

Professional recognition for nurse-midwives was nonexistent for decades, and clinical positions were scarce. Many graduate nurse-midwives left the United States to work in international settings where they could practice full scope clinical nurse-midwifery (Lang 1977:94–95). This small profession sought out ways to meet the needs of women. "Much of the credit for the pioneering work toward prepared childbirth education and family-centered care goes to these CNMs" (Lang 1977:94–95). However, as hospital birth rapidly replaced homebirth, the doors to providing midwifery care in the hospital remained closed to nurse-midwives. In 1963, a national study of nurse-midwives carried out by the United States Children's Bureau under the Department of Health, Education, and Welfare (HEW) documented that only thirty certified nurse-midwives out of 535 residing in the United States at the time were providing the scope of care for which they were trained (Lang 1977:97).

The Hospital-Based Nurse-Midwife in New York City

New York City cannot lay claim to the first urban nurse-midwifery deliveries. That honor goes to Johns Hopkins Hospital where a nurse-midwife was invited in 1953 to deliver on an experimental basis, followed by a similar experiment at Columbia /Presbyterian Hospital in New York City (Lang 1977). In subsequent years, CNMs began gaining entrance to the New York City hospital system, although not yet at the clinical level. In 1956, Columbia University Teachers College established the first masters-level program available to nurse-midwives, a Masters of Nursing Education. The City of New York Health Code was amended in 1959 making both RN licensure and nurse-midwifery certification a requirement for a midwife permit (Weisl 1964). New York City was the second locale to grant legal status to CNMs. (New Mexico granted state licensure to CNMs in 1945.) Following this Health Code modification, in 1960 five nurse-midwives were given a permit to practice in New York City and by 1968 a total of sixty-seven permits to practice had been obtained by CNMs (Harris, Daily, and Lang 1971).

In 1958, obstetrician Louis Hellman asked the MCA school of Nurse-Midwifery to come to Kings County Hospital in Brooklyn, where the first hospital-based nurse-midwifery class began. In 1961, New York City made a commitment to nurse-midwifery services by making nurse-midwifery educator salaries a budget line in the Department of Hospitals (Hellman 1971:75). In 1963, as an experiment, Cumberland Hospital and Harlem Hospital offered employment to CNMs (Cumberland Hospital, three CNMs; Harlem Hospital, two CNMs) serving mothers in the hospital labor and delivery unit (personal communication, Dorothea Lang, 2005).

In 1962, the Panel on Mental Retardation created the opening nurse-midwives had been waiting for by drawing a connection between inadequate maternity care and prematurity and brain damage. "The report led to legislation which authorized the Maternity and Infant Care Projects under Title V of the Social Security Act beginning in 1963" (Lesser 1972:111). Fifty-six projects were quickly funded through this legislation, two of which hired nurse-midwives, resulting in a new source of employment for graduates. The Maternal and Infant Care (MIC) Project of New York City, responsible for community-based maternity and infant care clinics throughout the city, came out of this federal effort and played an important role in propagating midwifery services throughout the city's hospital system.

In 1970, the MIC project established the first hospital-based nurse-midwifery service in New York at Delafield Hospital's Obstetrics and Family Practice Center, with permission to attend births at Columbia/Presbyterian Hospital. At the same time, the MIC published a guide for the development of nurse-midwifery services for twelve hospitals affiliated with the MIC project. A unique relationship developed between the MIC project and the twelve affiliated hospitals. Nurse-midwives hired by MIC for each hospital provided both community and hospital-based services; half of their time in intrapartum care and the other half in pre- and postnatal care at the community-based clinics. Nurse-midwives expanded their scope of practice as they began to staff family planning clinics (Hellman 1971). By 1971, 100 nurse-midwives at eighteen hospitals had attended the births of 3,650 babies in New York City (Lesser 1972).

Under this unique organizational scheme, New York midwifery services grew in number and flourished. By 1981, CNMs were providing care and managing labor and delivery services at five hospitals and nine prenatal clinics. Although initially a pioneering strategy allowing for a degree of independence for nurse-midwives, this unusual organizational framework with its multiple lines of institutional accountability

and corresponding responsibility to multiple authorities became increasingly unworkable for nurse-midwives. The confusion this framework created and its limitations for long-term practice and identity led directly to the push to separate midwifery from nursing at the clinical level, an underlying motivation for nurse-midwifery to have its own legislation in New York state.

In 1981, nurse-midwives attended four percent of deliveries in New York state, most of which took place in hospitals. Six midwives—five CNMs and one lay midwife—attended homebirths in New York City. One freestanding birth center existed—the MCA Childbearing Center in Manhattan (Wolfe 1982). This was the first urban birth center in the United States, becoming a prestigious role model for independent midwifery and seen by its leaders, at its creation, as an alternative to homebirths attended by lay midwives (Judith Rooks, personal communication, 2004). It also became "an alternative to nurse-midwife-attended hospital births where strict regulation of practice and lack of family-centered care prevailed" (Katherine Carr, personal communication, 2005). The number of hospital deliveries attended by CNMs steadily increased to eight percent by 1994 (New York State Department of Health and New York State Education Department, 1997).

PRAGMATISM, IDEOLOGY, AND EVERYDAY ACTS OF RESISTANCE

> In order to be able to function as best we can in whatever system we're in, we find ourselves in the constant, and tiring, position of having to negotiate, balance, and compromise; be skilled politically and in interpersonal relations; and take put-down with a smile, coolness of response, and outward negation of pride. . . .
>
> Maternity care is a political issue and our purpose [is] one of identifying recommendations, which would address the redistribution of power pertaining to maternity care. . . . Now I, like most of you, am for progress and against impotence; but I do not believe in annihilation. There must be a way. When I was a student nurse I frequently heard a great deal of pride given to an attribute, which was presented as characteristic of nurses. This attribute was ingenuity, i.e., figuring out how to create necessary items out of materials not before considered for that purpose. As we are *nurse-midwives* [italics in original] I call upon us, individually and collectively, to create the modes of practice that will take us out of our binds and conflicts without destroying ourselves in the process.
>
> **—Helen Varney Burst, Presidential address to the ACNM 23rd Annual Meeting, 1978**

Pragmatism has been of high value and is a fundamental cultural characteristic within nurse-midwifery (May 1999). The nurse-midwives in New York state had a practical vision and a long-term strategic plan that culminated in the Professional Midwifery Act of 1992. They had a "dream," as do many pragmatists, but the tactics and strategies they use to achieve their goals are influenced by the pragmatic nature of their thinking. As opposed to the idealist, the pragmatist is more likely to settle for less in the short run in order to stay "in the game."

From its inception, nurse-midwifery has occupied a position on the margins between midwifery and medicine, having to balance these two traditions. Since the 1960s, its focus has been on: (1) hospital-based midwifery; (2) education within universities; and (3) the carving out of a sustainable niche within the medical system, the culture of which is often hostile to the midwifery model of care. These early sustainable niches were often in areas where few, if any, physicians were available or willing to provide care to those women who were underserved.

Many nurse-midwives describe their practice as occupying a space along a continuum of care, with ideal midwifery care on one end and obstetrical (interventive) birth at the other. As nurse-midwives began positioning themselves in hospitals and operating along this continuum of care, survival depended on the ability to negotiate care processes filled with tension and dichotomy. Flexibility, the ability to compromise, a comfort with ambiguity, and a distrust of extreme viewpoints are key values within the nurse-midwifery profession. Such flexibility has proven so helpful that the nurse-midwife is often loath to adjust her pragmatism for idealism. From her standpoint, the ability to survive within a hostile environment depends on these cultural characteristics, which empower her to serve a far greater number of women than would otherwise be possible, as well as to bring humanistic care to disadvantaged women.

One nurse-midwife, who no longer delivers babies but instead cares for women with AIDS, calls herself "a poverty worker." This commitment to serving women comes through in the words of another New York City nurse-midwife, Ronnie Lichtman (personal communication, 2005):

> The decision to practice as a midwife in a hospital, particularly in the inner city, can be seen as both an ideological and an idealistic choice. It isn't merely that this is where we are hired, or where we have a regular salary—those issues, of course, are real. Nor is it merely because of the numbers of women who birth in hospitals—which is, of course, most American women. It is because of

> the "who" we wish to serve and our desire to make the midwifery model of care available to underserved, undereducated, oppressed women—who do not have the wherewithal, for whatever reasons, to even consider a homebirth, let alone carry it out. It is to make midwifery available to these often-disenfranchised women that we choose to work in hospitals. Sometimes, the best we can do is offer a kinder approach—despite the hospital's policy of routine use of technology. We can, at the very least, provide physical and emotional support that otherwise would not necessarily be available to the woman in our care. Moving along the continuum of midwifery practice, we can frequently avoid some of the interventions that would make the woman high risk or lead her down the slippery slope to complications and cesarean birth. At the most positive end of the continuum, we can influence practice and make substantial change . . . .
>
> [T]he discussion is not only about higher or lower skills, or whether a given salary is worth the sacrifice of the midwifery model of care. I'm trying to point out that the reasons (for some of us at least) behind the choices we make are for equally idealistic reasons—only different ones—as the reasons to become a homebirth midwife.

Lichtman's words provide us with a deeper understanding of the value placed on altruism and the care of women by nurse-midwives. These values are the context for the pragmatic nature of nurse-midwifery's survival strategies.

Scoggin (1996) documents the growing professional identity of nurse-midwives as unique and separate from both nursing and medicine. She also identifies five fundamental concepts and core values of nurse-midwifery: (1) advocacy—supporting and protecting clients, (2) normalcy of the birth process, (3) a high regard for competence, (4) authority—the ability to command respect, and (5) autonomy—the ability to practice independently within the CNM's area of expertise. As the obstetrical technocracy spirals out of control in the United States, holding true to these values while continuing to negotiate the midwifery–obstetrical continuum both strains and renders more essential the coping values of CNMs—patience, flexibility, negotiation, and comfort—with ambiguity. We find evidence of all these values in the voices of our informants.

The ingenuity—the ability to create "necessary items out of materials not before considered for that purpose"—referred to above by Varney is a form of nurse-midwifery resistance to the overwhelming presence of the technocratic model of childbirth within which nurse-midwives,

against great odds, daily find themselves working. Within the unavoidable (in the hospital) constraints on the midwifery model of care, nurse-midwives look for small and subtle means of subversion to bring midwifery care to mothers and babies. This daily resistance runs as a thread in the voices of the New York nurse-midwives we interviewed during our research.

For example, one nurse-midwife who has been in practice in New York for several decades described how she used carefully worded "informed consent" (a legal and ethical responsibility of all health care professionals) as a means of subverting the actions of an aggressive on-site anesthesiologist who wanted to give as many epidurals as possible to laboring women. It became well known that when she was on the schedule, the anesthesiologist could expect to be called for fewer epidurals because she made sure that her clients understood the role that epidurals play in the cascade of events that can ultimately lead to an unnecessary cesarean. In her hands, informed consent also became a form of everyday resistance. "I didn't buck the system," she said. "I just did what clients asked me to do. If they wanted that epidural then I made sure that they understood benefits, risks and alternatives to it and I wasn't going to dissuade them in any way. But if they wanted that natural childbirth, they got it. I never went out of my way to provide epidural service to people because I viewed birth as normal." It mattered not a bit to this nurse-midwife that at Christmastime, the anesthesiologist let it be known that she was the only staff member who would not be receiving a gift from him. Laughing, she said, "The anesthesiologist was passing out the bottles of wine to the staff and he said, 'You don't get one.' And he smiled and laughed. And I said, 'Why's that?' He goes, 'Because your patients never have epidurals.'" This CNM went on to describe her impact on her labor and delivery unit: "Here's a statistic for you. . . . [when] I went out on a leave . . . he told me that the epidural rate on evenings . . . I was a permanent evening shift . . . went up by ninety-five percent while my foot was broken."

Time and again nurse-midwives describe how they employ the skills of patience, negotiation, and subtle manipulation of the technocratic obstetrical model to bring the midwifery model of care to the many women who give birth in a hospital. One nurse-midwife described her relationship with "my guy," her term for the obstetrician for whom she worked. At first their relationship was difficult for her because he "micromanaged my care. But over time he came to trust my judgment, and I now can do pretty much what I want without his interference. When I want to do something that I think he might not go along with,

I know how to handle my guy. I can call him and talk him into going along with just about whatever I think is best."

This strategy (establishing a relationship with an obstetrician who then backs off enough to allow the midwife room to practice her model of care) is repeatedly expressed by nurse-midwives as key to survival in the hospital setting. The danger they note is that the instinct of flexibility and compromise, so intrinsic to nurse-midwifery, can turn into its opposite—hesitancy and a fear of rocking the boat. Another nurse-midwife, in a late 1990s interview, described her frustration with her CNM colleagues who were unwilling to support her attempts to confront what she felt was a sexualized work environment because of their fear that it would jeopardize the arrangements that had been worked out over the years.

> It's an issue of power and control. As long as we're good little girls . . . [To be told] "Oh you just don't know how to deal with these people." What [I'm really being told is] "You're not willing to play the nurse game." Because that's what we were taught as nurses . . . play the nurse game, how to manipulate the doctors to get what we wanted. [There were] twelve OBs in the group that we worked with. . . . And I had issue probably with eight of them who would think that they could either touch you or talk to you in an inappropriate way. Like, "sweetheart, honey, dear, darlin'" . . . hug, kiss or touch me in any way inappropriate. And when I'd say to my other midwife colleagues, "I want to bring this issue up at the next staff meeting with the OBs," [none] were supportive. "We understand what you're saying. We don't like it either. But we're going to pick our battles and this is not key or important."
>
> If the way we conduct ourselves with each other is not key or important to us moving things forward, I don't know what the hell is. I don't know what else would be more important than communicating to these physicians that we were not an object that they could slap on the ass when they felt like it. . . . [But] I was told I should cut them a little slack because they're in their fifties and sixties and seventies and of a generation when that was appropriate. I don't buy that line either. A lot of [my CNM colleagues said] "Tolerate it because after all, we're not going to change them." But do you know what I found out personally? Probably all but one of these eight that I eventually had opportunity to interact with and confront on my own, I felt I had better relationships with them when I stood up to them. Most of

> them understood because . . . I turned it around. I said, "It isn't appropriate for *me* to call *you* 'honey,' or 'sweetheart,' or 'dear,' or to come up and start touching you." And [when they stopped] I would comment to them, "I appreciate you respecting that I don't want you to touch me, that I don't want you to call me these certain names."
>
> By the way, these other midwives—I was by far younger than all of them. These are midwives who are in their fifties, who have been practicing for years . . . and [it was] like, "You're a little neophyte about this but you'll learn too that this is something to tolerate." I'm not ignorant about male-female relationships. But I'm establishing myself and midwifery.

Of course, such issues and struggles are not unique to nurse-midwifery practice; they are the same issues confronting women in many other professional arenas dominated by men, and also by new professions trying to make inroads into established hierarchies. This CNM did eventually tactfully and successfully negotiate nonsexualized professional relationships with the obstetricians, yet lost her job when she encountered an issue unique to hospital-based midwifery. She participated, on her own time, in a homebirth that was entirely legal and for which she had a written medical agreement. Her participation in this birth was known by only a small number of people. Nonetheless, she was fired by her midwifery service director, a CNM. When asked if she believed that liability was at issue in the firing, she responded:

> That was the fear but they didn't use that word. They used philosophy. "There is a difference in philosophy and we do not want to discuss it." There was so much damage to my self-esteem to be fired. I felt so alone. [Those midwives I felt were my colleagues—not one] talked to me for three months. Not a phone call, not a card, not one word, because they'd go down too for the association with me. . . . But they knew what kind of a midwife I was.

From the mid-1960s until the early 1990s, nurse-midwives gained their first experiences in the labor and delivery room milieu. (For many years, nurse-midwifery programs required labor and delivery experience as a prerequisite for application.) There they learned what nurses viewed as the necessary survival skills of negotiation, compromise, and flexibility—skills that can also take the form of manipulation, evasion

and passive resistance. Significantly, this New York CNM entered nurse-midwifery school without labor and delivery nursing experience. The culture of pragmatism often does not come easily to those newer CNMs, who unlike their veteran colleagues, do not have the years of labor and delivery nursing once thought essential to becoming a nurse-midwife. This CNM has now found her place in a successful homebirth practice—she is one of approximately twenty CNMs who legally practice homebirth in New York State and who are consciously blurring the line between home and hospital birth midwifery.

The relationship between survival and change remains a central theme in the discourse of CNMs. Veteran nurse-midwives defend their culture in terms of surviving in order to bring about change. Their words echo throughout our interviews. In order to bring about change one has to still "be here, and being here involves shifting and survival." Future midwives need to be prepared for the "reality that they must be better than" and that reality involves having a clear view of "what one has rather than acting like you have what you don't."

NURSES OR MIDWIVES? AN IDENTITY CRISIS WITHIN NURSE-MIDWIFERY

In keeping with its beginnings as a clinical specialty of nursing and an alternative to traditional midwifery, nurse-midwives made a point of emphasizing their distinctness from traditional midwifery. A 1987 ACNM brochure entitled *What Is a Nurse-Midwife?* stated, "For centuries, women who assist at births have been called midwives. But other than a shared tradition of caring for mothers and infants, today's certified nurse-midwives have little in common with their historical counterparts."

In contemporary nurse-midwifery we witness a growing identification with a model of independent practice unlike that of American nursing and akin to that of some European professional midwives. This identity crisis has been fueled in part by the evolution of homebirth midwifery (see chapter 1) whose practitioners held as a central philosophical tenet a radical critique of nurse-midwifery as being dominated by, identified with, and subordinated to the obstetrical profession. Central to this critique has been the viewpoint that nursing education is not only unnecessary for midwifery training, but has tied American midwifery to a highly technocratic model of childbirth. The identity crisis within nurse-midwifery has also been fueled by the growing power of the technocratic obstetrical model (bringing with it increased control

over both women and midwives) along with a growing discomfort among nurse-midwives with their identity as advanced practice nurses.

Throughout the 1980s, the relationship of nurse-midwifery to the profession of nursing became a point of intense debate among CNMs, even as they began to grow in numbers and make inroads into hospital practice across the country. Arguments for separation from nursing have originated from two different standpoints, one ideological and one pragmatic: (1) nurse-midwifery's position within nursing has led the profession to turn away from the midwifery model of noninterventive birth; and (2) in the interests of autonomy and establishing itself as a recognized and identifiable profession, nurse-midwifery should separate from nursing to avoid being regulated under evolving state legislative initiatives as advanced nursing practice.

During the decade or more of debate on the professional identity of nurse-midwifery, growing numbers of women identifying with this alternative vision of midwifery entered nursing school for the sole purpose of jumping through the necessary hoops to gain admittance to nurse-midwifery school. These new nurse-midwives held little loyalty to the nursing profession and shared a common sense of purpose with direct-entry midwives. Many held (and still hold) dual loyalty to both the ACNM and MANA (see Davis-Floyd 1998a and chapter 1, this volume). And so the critique of nurse-midwifery's relationship to nursing became internal as well as external to the profession.

The influence of these internal and external debates was summed up well in 1978 by Helen Varney Burst in her President's Address to the ACNM's 23rd Annual Meeting in Phoenix, Arizona. "In many very real ways," she states, "we are beset upon from all sides, pressured simultaneously by medicine, lay midwifery, the alternative childbirth movement, and nursing" (1978:11). Burst's warnings regarding nursing did not involve rejection of nursing education as a prerequisite for midwifery, but rather expressed many nurse-midwives' fears of being subsumed organizationally and structurally by nursing. With regard to physicians, Burst noted, "On one side we have some physicians whom we threaten either economically or professionally or both. They fear our entry into private practice and attempt to restrain our practice to the indigent and/or rural underserved as well as to restrict us to always be in the role of an employee." Additionally, Burst noted, physicians feared being relegated to the role of high-risk obstetrical specialists as midwives laid claim to normal childbirth. Nurse-midwifery has always believed in "the philosophy of a team relationship" but "in self-defense will have to get competitive vis-à-vis the obstetrical profession—exactly what they don't want" (1978:11).

"Lay midwifery," Burst continued, "threatens us and in other instances scares us." While admitting that some lay midwives "are serving the consumer well," she stated that nurse-midwives are "frightened for the consumer" by those lay midwives who are "unprepared, unread, inexperienced, unsupervised. . . ." At the same time, nurse-midwives are threatened by lay midwifery "because they claim a population we thought we were serving: the consumer population. . . . We may also be jealous of the lay midwife because of her freedom from the professional restraints which sometimes frustrate us" (1978:11).

Early lay midwives and the alternative childbirth movement critiqued the merging of nursing and midwifery, asserting that this encouraged the medicalization of midwifery. They also questioned whether nursing education was necessary for training competent midwives. A growing number of nurse-midwives shared this critique. In contrast, the earlier questioning by ACNM leadership of its relationship to nursing had focused not on this radical critique but on awareness of the danger of becoming subsumed, absorbed, and controlled by nursing.

One of the earliest calls for separation of nurse-midwifery from nursing was articulated in a 1973 editorial in the *Journal of Nurse-Midwifery*, "Cut the Cord," by Dolores Fiedler, MD, a New York City physician associated with MIC (Maternal and Infant Care Project of New York City). To foster its attempt to demarcate itself from traditional midwifery, nurse-midwifery had needed the status, the image of competence, and the public respectability of nursing. But now, Fiedler argued, separation from nursing was in the interest of nurse-midwifery; her arguments were clinically and structurally based. First of all, nurse-midwifery faced limitation of its growth as only one profession among the variety of midlevel health care professions emerging at the time (which included physician assistants and nurse-practitioners in addition to nurse-anesthetists and paramedics). "The delegation of granting licensure of midwives to the nursing discipline will hamper and stagnate the profession of midwifery. . . . With the advent of the nurse-clinician, nurse obstetrician, paramedic, obstetrical technician, etc. the distinctive role and the unique potential of the midwife will become diminished, diluted, and devitalized . . ." (Fiedler 1973:3). Nurse-midwifery had outgrown its need for nursing; Fiedler notes:

> Midwifery has enough status to be considered and regulated as an independent and distinct profession. . . . Simply stated the question is: Are midwives content to be an extension and expansion of the nursing role, or is it the desire of midwives to become

> completely unique professionals, capable of delivering services to women by a discipline of education and training exclusively developed for a new profession? (3)

Louis H. Hellman(obstetrician, Director of the Ob/GYN department at Kings County Hospital/SUNY [State University of New York] Downstate Medical Center, and leading academic and health care policy spokesperson) was a strong supporter of the developing New York City nurse-midwifery services and the expansion of their scope of practice beyond nursing. In an editorial in the *Bulletin of the American College of Nurse-Midwives* (1971) and again at a 1972 speech given to the International Confederation of Midwives, Hellman critiqued the institutional position of New York City's nurse-midwifery services, which were subject to several lines of authority. Warning that nurse-midwifery's position was untenable, he stated, "I do not believe that the organization of maternity care under a triumvirate of nurse-midwives, nurses, and obstetricians is beneficial or viable" (Hellman 1971:21). He continued, "the organizational system under which nurse-midwifery answered to several lines of authority presents too many interfaces and too much fragmentation of responsibility; academic progression is cumbersome and funding may be impossible to achieve" (78). Insisting that nurse-midwifery should establish a separate place for itself, he stated, "Nurse-midwifery could survive as part of the medical cadre, but it would never achieve its full stature, and achieving academic status for its staff might present difficulties. American nursing has been rigid and inflexible for at least a generation" (78). His proposed solution for resolving institutional conflict with nursing was to make nurse-midwifery clearly responsible for all maternity care; all maternity nurses would be nurse-midwives and all activities and academic positions having to do with maternity nurses would be filled by nurse-midwives.

In New York state, many nurse-midwives work in private medical services. But New York City has been unique because of its large, city-run maternity care program in which nurse-midwives played a major role. Throughout the next decades, the debate over their relationship to nursing persisted among New York nurse-midwives and continued to focus on the need to separate structurally from nursing (e.g., Cuddihy 1984). This discussion was primarily based in New York City; its subsequent legislative efforts culminated in the New York State Professional Midwifery Practice Act of 1992, which we address in the following sections.

THE NEW YORK PROFESSIONAL MIDWIFERY ACT OF 1992: HISTORY AND PERSONAL MOTIVATIONS

Legislative Efforts of the CNMs

In the early 1980s, New York CNMs embarked on a process of strategizing and lobbying to create state legislation legitimizing nurse-midwifery as a viable health care profession. Their legal status was ambiguous. The only statute regulating midwifery was the State Department of Health Sanitation Code, under which nurse-midwives received a permit to practice through the Department of Health. The permit required a physician signature to show "medical direction" and so was usually time-limited, tied to each individual nurse-midwife's employment. A legal midwife in New York was required to hold a nursing license and therefore came under the jurisdiction of the Board of Nursing within the Department of Education, yet as nurse-midwives they were also regulated by the Department of Health.

Throughout the 1970s and 1980s, nurse-midwives around the country, along with nurse practitioners, promoted legislation defining and regulating midwifery as advanced practice nursing. The result has been that in most states today, nurse-midwifery is defined under legislative statute as advanced practice nursing, so that nurse-midwives, nurse-anesthetists, and a wide variety of nurse-practitioners work under the jurisdiction of the State Board of Nursing, which also regulates Registered Nurses (RNs) and Licensed Practical Nurses (LPNs). In New York, at the same time that nurse-midwives were pushing the Midwifery Practice Act, nurse-practitioners were lobbying for advanced practice nursing legislation. Their legislation passed several years before the midwifery legislation also successfully passed. It gave legal recognition to advanced nursing practice, granted licensure to nurse practitioners, established regulations for their practice, and allowed them prescriptive privileges.[4] New York nurse-midwives rejected the opportunity to be included in the New York advanced nursing practice legislation, opting to write and promote their own bill. Unlike their colleagues in other states, the New York CNMs made a decision that not only did they need legislation clarifying the legal status of midwifery, they wanted to be a profession separate and distinct from nursing. Separation from nursing was *the* bottom-line issue on which they would not compromise (Redman 1997). There would be "one type of midwife; one level of midwifery" that would not require a nursing education. The intent of the promoters of this new legislation was to create an "open door" for foreign-trained and other midwives who wished to pursue a career in licensed midwifery

practice without first attending nursing school (Dorothea Lang, personal communication, 2005).

By all accounts, the New York midwifery legislation, while certainly an idea whose time had come and had from its conception included the idea of separation from nursing, was the brainchild of Dorothea Lang, past president of the ACNM and longtime Director of the Maternal and Infant Care Project (MIC) of New York City from 1968 until her recent retirement. During her many years of active practice and administration, Dorothea dreamed of freeing the profession of midwifery from the constraints of nursing. Her own birth in Japan in the 1940s was attended by professional midwives, whose persistent presence at the majority of Japanese births (though they became nurse-midwives after World War II) helped to give that country one of the lowest perinatal mortality rates in the world. A return visit to Japan in 1962 and again during the 1970s further convinced Dorothea of the viability of an independent midwifery.

Another major factor motivating Dorothea's support for direct-entry midwifery was her understanding of the circuitous nature of the nursing route:

> I remember in the early days when I interviewed almost every new graduate [in New York City], I always used to ask them, "Would you have come into midwifery without nursing if there would have been a route?" And ninety percentof my applicants used to say, "Yes! . . . I would not have wasted six to eight years of my life coming before you now as my first job potential. If I had another route I would have been in midwifery four years ago, two years ago, three years ago. It was costly. It was agonizing. It took many years for me to finally be a midwife."

With Dorothea's dream in mind, a committed group of CNMs began to envision and later lobby for a bill that would establish New York midwifery as a licensed, independent profession governed by its own Board of Midwifery (as opposed to the Board of Nursing), prescriptive privileges (which are essential to autonomous practice), and the freedom as independent practitioners to practice without a written physician agreement. Registered nurse licensure and a degree in nursing would not be necessary to practice as a midwife. Embracing direct-entry midwifery became an essential, fundamental piece of their rationale that midwifery in New York state should be separate from nursing, with its own licensing mechanism and its own separate lines of authority at both the regulatory and clinical levels. "This new New York legislation

was a confirmation that New York recognized midwifery as an identifiable profession. . . . This now enables midwives to help guide/control the practice of midwifery and the licensed professional midwife" (personal communication, Dorothea Lang, 2005).

When New York nurse-midwives laid claim to direct-entry midwifery, it was with a different meaning than that of the homebirth direct-entry midwives who had been practicing in New York since the early 1980s. For New York CNMs, "direct-entry" did not mean apprenticeship learning and homebirth practice. Rather, it meant escape from the institutional and structural dominance of nursing—for example, having budget lines separate from nursing in hospitals with midwifery services. Midwifery Service Directors would no longer be answerable to a Director of Nursing, and midwifery staff would no longer be claimed by the Nursing Department. Midwifery salaries and benefits would no longer have to correlate with those of advanced practice nurses. Perhaps most importantly, midwives could lay claim to clinical activities as being distinctly midwifery, which would help protect those activities from encroachment by other professionals (such as the Physician Assistants and Women's Health Nurse Practitioners who were beginning to attend labor and delivery patients in New York under the auspices of employer obstetricians). Direct-entry midwifery education was a fundamental piece of the overall rationale for institutional separation from nursing. It was as much a means to an end as it was a dream.

In 1983, the initial draft of what was to become the Professional Midwifery Act of 1992 was supported through the Legislative Committee of the New York City chapter of ACNM Region II. Funds from the legislative committee were used to hire a lobbyist. Meeting in the lobbyist's office, four nurse-midwives wrote the initial draft—Nancy Cuddihy, a nurse-midwife at the state Health Department in Albany, Sue Piening from SUNY Downstate, Beth Cooper from Rochester, and Elaine Mielcarski from Syracuse (personal communication, Elaine Mielcarski, 2004). The legislation was promoted strongly by the New York City ACNM chapter's Legislative Committee. The Midwifery Council, representing midwifery service directors in New York City, became actively involved behind the scenes after its formation in 1984. Richard Gottfried, a Democratic State Representative from Manhattan, chair of the New York State Assembly Committee on Health, and a powerful player within the Democrat-controlled New York Assembly, became the House sponsor of the Midwifery Practice Act, ultimately known as the Gottfried-Lomardi Act; once enacted, it became the Professional Midwifery Practice Act of 1992.

Through the persistent lobbying efforts of Elaine Mielcarski, State Senator Tarky Lombardi of Syracuse became convinced to take over sponsorship of the midwifery legislation in the New York State Senate. Lombardi, at the time, was a powerful Republican in the Republican dominated state Senate serving as Chair of the Senate Committee on Finance, Health and Public Authorities, and Chair of the Governor's Council on Health Care Financing. His sponsorship and personal support of the bill became instrumental in its eventual successful passage. With two powerful sponsors combined with the massive efforts of nurse-midwives Dorothea Lang, Pixie Ellsberry, Nancy Cuddihy, and others, Elaine's ten-year lobbying effort, and as we shall see, the support of the direct-entry midwives who believed that they would be legalized, resulted in legislation establishing a Board of Midwifery within the State Education Department that would license and regulate midwives in New York state. CNMs in upstate New York, fewer in number and more widely dispersed geographically, were nevertheless heavily involved in the early stages of developing and supporting the legislation. Elaine Mielcarski was an early key proponent of the legislation and one of its primary drivers. Already certified as a nurse-practitioner, Elaine had been inspired to become a midwife by Dorothea Lang. She felt that the training she received at the Medical University of South Carolina with a poor, high-risk population well equipped her to practice in New York. But on her return to New York, she faced the realization that the midwifery statute was outdated and that the circumstances for nurse-practitioners were changing.

> When I came back to New York state and looked at the original [1907] statute and the Sanitary Codes governing midwifery practice, I realized that it was a very old, archaic law. It said that we had to have "clean nails, clean aprons, clean minds" and we delivered babies, but there was nothing there that spoke to how we did it and what types of—It didn't codify our practice at all.

She went on to explain:

> Nursing became very upset when the nurse-practitioners tried to break away and become licensed as nurse-practitioners and not just under the Nurse Practice Act in New York state. . . . The Board of Nursing sent around a memo to the hospitals, to nursing services, and told them that nurses could not take orders from nurse-practitioners anymore. And they were legally right in doing that because there was nothing in the statute that

allowed them to write on an order sheet and give them [nurses] orders [without a physician signature]. So therefore there was nothing legally supporting nurses who took those orders. . . .

And when they sent that memo around . . . the labor and delivery nurses were standing at the counter, where I was also standing. And they said, "We can take orders from nurse-midwives. Why can't we take orders from nurse-practitioners? Elaine, we can take orders from you, can't we?" Well, I wanted to sink right onto the floor because I knew there wasn't anything in our statute either that we could prescribe medication. . . . An anesthesiologist, who was very anti-midwife, happened to be in the utility room and overheard the conversation. He went to the administration of the hospital and told them that there were no legal grounds for my practice, that I could not write orders on the order sheet or could not give phone orders. I could not admit patients to the hospital. And he was smart enough before he did this to look up the act and he was absolutely right.

This was in 1982 when my hospital privileges were suspended by the hospital. I had been practicing since 1979 at PHP [an early HMO in the Syracuse area with its own clinics] in Baldwinsville. It was a tremendous blow to our patients. It was a tremendous blow to the center in which I practiced. Not to even mention that I had moved with three children to another state and had worked two jobs to earn the money to do that prior to becoming a student, and then took out loans at thirteen percent interest to pay for my education.

Elaine saw New York City as more insulated from this threat: since 1907 the Sanitary Code had legalized the practice of midwifery in New York City, midwives there were providing thirty-five percent of prenatal care and attending twenty-five percent of births for the Health and Hospital Corporation, so that "New York City could not just wipe out midwifery without major catastrophes." But the larger threat was that "as the competition between midwives and obstetricians became more keen, the existing law would be enforced throughout the state." Elaine called Dorothea to alert the New York City midwives:

that we had to band together to begin legislation to codify the practice of midwifery. And Dorothea asked me to come down to the next chapter meeting in New York City, which I did. And that was in December of 1982. I went down and . . . started a lobbying fund. . . . And so we hired a lobbyist through the dues

that the upstate chapters of the American College of Nurse-Midwives had put together. We each went to our chapters and asked for lobbying funds.

It was entirely clear to the New York CNMs that if they had not been so committed to creating their version of direct-entry midwifery, they could have either joined the nurse-practitioners, or passed their own bill legitimizing their profession, granting them prescriptive privileges, and giving them autonomy from physicians, at least five years before they actually achieved passage of the 1992 bill. Why did they fight so hard for that five extra years to create a new kind of midwife who would then have to struggle for legislation and licensure in the other forty-nine states?

Elaine: Initially we wanted to codify the practice of *nurse*-midwifery. [The initial language of the bill] talked about the American College of *Nurse*-Midwives. I always was in favor of being totally separate from nursing and developing a profession, a professional language, and licensure in our own right as midwives.

Robbie: Why? I mean here you were trained as a nurse and a nurse-practitioner. Why would you, of all people, want to separate from nursing?

Elaine: Because midwifery is not nursing. Nor has it ever been promoted as nursing in the College. When I became a nurse-midwife, if you looked at the language in the documents from the American College of Nurse-Midwives, and you looked at the definition, it said that nurse-midwives are trained in the two disciplines of nursing and midwifery.

Robbie: Which implies that midwifery is a separate . . .

Elaine: A separate profession. And if you look in the documents that further expand and explain that, they talked about midwifery not being nursing. That we're colleagues and it's an interdisciplinary teamwork approach. . . . But that midwives do not do nursing. That's how I was educated. My knowledge of midwifery at that point purely came from the American College of Nurse-Midwives. The ACNM did not ever consider themselves to be practicing nursing.

And as nursing saw the positive legislation that midwifery was getting all over the country and the positive laws for midwifery and the number of dollars that legislators were setting aside for midwifery education . . . the feeling by nursing of being an underappreciated and demeaned profession. . . . I think that they looked at this golden egg as something that they wanted to hitch their star to. . . . I saw at the Medical University of South Carolina totally separate units. I saw the nursing division try to put more and more tentacles into nurse-midwifery.

> And if Dorothea and I didn't have the brainstorm that we actually pushed until all nurse-midwives accepted it in New York state. . . . remember that we had a hard sell, not just to the legislators, but we had a hard sell to nurse-midwives, to open . . . to expand the law beyond nurse-midwifery, to expand the language in the legislation. Because nurse-midwives knew the safety of nurse-midwifery practice and they had strong feelings about the value of nurse-midwifery education.
>
> And those feelings were good. I mean nurse-midwifery education has proven to be a good educational process to become a midwife. Not the only one, but it's proved to be a good avenue to do it. We had to convince . . . I was chapter chair for four years. Prior to that, as being legislative chair, we had to convince nurse-midwives in both of our regions—Carol Bronte and Dorothea Lang downstate and myself upstate—that you could have the same educational process that is most valued in midwifery education without becoming a nurse first.

Like Dorothea, Elaine was spurred on by the international context:

> Robbie: So why is direct-entry so important that you were willing work for five extra years to achieve it?
>
> Elaine: Because it's honest. It's honest. It's dishonest to say that...nursing is a prerequisite, is the only way of producing a competent midwife. Look at the Netherlands. Look at their outcomes.

Midwifery was never eliminated in Europe as it was in the United States and Canada; rather, European midwives professionalized, creating national organizations in every European country and incorporating their education and practices into the formal health care systems. Midwives still attend the majority of European births, as they always have. In particular, the Netherlands is widely regarded as having one of the best midwifery systems in the world (DeVries et al. 2001; DeVries 2005). The Dutch midwifery educational system has never been involved with nursing; midwives attend a four-year vocational program in midwifery. Elaine had spent time in the Netherlands studying the Dutch system, its autonomous midwives, and its excellent outcomes, and had concluded that even without nursing, the courses necessary for midwives were "all there—microbiology, anatomy, physiology, social and health care sciences."

Elaine further explained her incentive for separating from nursing:

> Nurses have to take orders from midwives, not the other way around, and putting a midwife under nursing is a serious conflict of interest. I was outspoken about this when I entered the

> Medical University of South Carolina [MUSC] in '78 and told the faculty that midwifery was the goose laying the golden egg and nursing was robbing the hen house. I don't know why they didn't kick me out. The reality was at that time that nursing had no way of generating income, that legislators awarded money for midwifery that entered the coffers of the colleges of nursing and that a minuscule amount if any filtered into the departments of midwifery. Midwifery faculty at MUSC had to exist with old beat-up desks, cracked linoleum floors, and offices that looked like they belonged in third-world countries. . . . Guess what the nursing administration and faculty's floor and offices looked like?! Carpeted, decorated and well supplied with textbooks etc.
>
> Many of the faculty I had were originally missionary nuns or missionary midwives. All of them only saw the needs of women and babies. They saw infant and maternal mortality and morbidity that could be decreased . . . .[At MUSC] we had a high-risk, black teen patient population, with a high incidence of preeclampsia. Yet I came out of that program revering the beauty of holistic birth, an attitude that I already had but gained the confidence to pursue at all cost. One of the OB residents told me that the mortality rate was very high before the midwifery department was formed at MUSC. The midwives decreased those statistics significantly. They also supervised "granny" education.

Elaine's desire to separate American midwifery from nursing was tempered by reality. In order for the legislation to be passed, two major opponents had to be neutralized: the New York State Medical Association and the New York State Nurses Association (NYSNA). Both groups strongly opposed licensure of midwives without a nursing education. During last-minute negotiations, the Medical Association agreed to drop its opposition to this new direct-entry midwife in return for the requirement that all CNMs and CMs would be required to have a "written practice agreement" with an obstetrician, a family physician with obstetrical privileges, or a hospital obstetrical service, without which they could not practice legally. So in effect the CNMs traded the autonomy from physicians they had hoped to achieve for the right to incorporate direct-entry midwifery as a legal health profession in New York state. The New York State Nursing Association, while officially opposed to the new legislation, softened its opposition because the CNMs agreed to insert the wording that this new direct-entry midwife

would have to obtain "nursing equivalency" in her midwifery educational process. Members of NYSNA understood that few direct-entry midwives would meet the requirement for "nursing equivalency," and therefore nursing education would remain the entrée to midwifery for the vast majority of midwives in New York. These last minute negotiations occurred without the presence of direct-entry midwives and resulted in a redrafted bill in the House that was very different from the original draft legislation (personal communication, Sharon Wells, 2005). The determination of what constitutes "nursing equivalency" comes under the jurisdiction of the Office of Comparative Education within the New York State Education Department. Its function is to compare and evaluate curricula to determine which educational programs are equivalent to those of New York state. Additionally, the Office of Comparative Education evaluates the educational credentials of professional immigrants—doctors, nurses, engineers, etc. About this term, Dorothea said:

> We got "equivalent" in there. That was our goal. We knew we didn't want the future midwives to be any less than the nurse-midwives. We wanted her to possibly be more. . . .That's a step for midwifery. Because if you get people from all walks of life coming into one profession, you get a much broader base of professional colleagues. You get the people who write well, who sing well . . . the physical therapist knows the whole pelvic muscles far better than the nurse would ever know it. And they will then take over the leadership in midwifery. And the nurses will then sit back and say, "Hey, I never thought of that." And all of us, [five] thousand midwives all come from nursing. And we only are . . . all brainwashed only in one chain of thinking. And now this new thinking is coming in. This is a threat to the midwifery community. And I say, "It's a wonderful threat. Let's have it." Because I'm sick and tired of people stuck in the mud. We have to think futuristic!

Elaine explained further:

Robbie: Why does the law read "nursing education or the equivalent?"

Elaine: Well what happened was that we had the Medical Society and New York nursing absolutely opposed to this legislation. Big numbers. Big money. We could have passed the legislation years and years and years sooner had it just been nurse-midwifery. . . . There's no question

about it. We could have passed it without a written agreement in it. That was a last-minute compromise to keep [direct-entry].

And so in the final few days of the legislation, there was a major skirmish, and roundtable discussions, and hours of hammering out with the chairs of some of the committees, and with [our] key legislative proponents, [who] absolutely agreed that there could be a professional midwife. Because I had given the curriculum of the Netherlands to them years before and the United Kingdom's curriculum. They absolutely agreed that this was a professional midwife who had a sound academic and clinical program and all the components that were necessary. You didn't need geriatrics. You didn't need all the nursing courses to be a midwife. And it wasn't the practice of nursing anyway.

Elaine drove from Syracuse to Albany almost every week for ten years to work for this legislation. Like Elaine, all of the nurse-midwives responsible for creating and giving birth to this legislation were quite aware of the role they were playing in nurse-midwifery's struggle to redefine itself, and were certain that they were leading the way for the profession. "It is in New York where midwifery in the U.S. primarily evolved," said Dorothea Lang, "and the New York vision is leading the College right now. New midwives are receiving the benefits of all the efforts of the pioneering midwives in New York" (Chapter Minutes; ACNM Region II, Chapter 1; June 22, 1998).

RELATIONSHIPS BETWEEN NURSE- AND LAY-MIDWIVES IN NEW YORK: FAILED POTENTIALS

New York City: A Positive Beginning

The involvement of the New York lay/direct-entry midwives in the New York legislation must be understood in the context of the history of their relationships with New York nurse-midwives. We will chronicle both the positive and the negative sides of this "herstory," for the purposes of our analysis of both groups as subordinated and to indicate that this mutual subordination could have resulted in productive alliances, as indeed it has in other states. The first instance we know of their interactions was a mutually supportive relationship that developed in the late 1970s between Carol Nelson, an apprentice-trained midwife from the Farm in Tennessee, who later became a leader of the development of direct-entry midwifery in the United States, and Therese Dondero, the founder of the North Central Bronx Nurse-Midwifery Service and a leader in the development of nurse-midwifery in New York. As an RN, Carol Nelson had worked labor and delivery in Illinois in the late 1960s and early 1970s.

Her disillusionment with hospital maternity care was one factor that led her in 1973 to the Farm—a mecca for midwives involved in innovative birth practices (Gaskin 1978, 2003). During this era, hundreds of women traveled to the Farm from throughout the country in order to have an out-of-hospital birth. At the Farm, despite her years of labor and delivery experience, Carol assisted in over 100 births as an apprentice before she became a primary midwife attending births on her own.

Members of the Farm, which is variously known as a "hippie commune," a "social experiment," and an "intentional community," although poor themselves by American middle-class standards, in 1977 created an affiliated nonprofit health care collective, PLENTY, to carry out relief projects in Guatemala, South Africa, and the Caribbean. Their goodwill efforts also took them to the South Bronx in New York when they learned that this poverty-stricken area suffered from a lack of accessible ambulance service, which PLENTY realized it could provide.

Sharon Wells, who later became a major player in the political drama that unfolded around the midwifery legislation, was a member of PLENTY. Although not yet a midwife, she was an EMT and was involved in the efforts to establish the ambulance service. She also provided labor support for pregnant women and volunteered at North Central Bronx in the labor and delivery unit, the ER, and the NICU. Later, as the major lobbyist for the direct-entry midwives during the efforts to pass midwifery legislation, she was to encounter nurse-midwives from the North Central Bronx that she had once considered friends and colleagues.

At one of PLENTY's numerous meetings with the New York City Health Department and various hospital department heads, Therese Dondero was present to represent North Central Bronx midwives, although the North Central Bronx midwifery service did not exist separately from labor and delivery. According to Carol, Therese "honed right in, asking me 'are you doing homebirths?' And I said, 'I wouldn't consider doing births without an adequate backup system.' And she said, 'We're it!' She really encouraged me." And so the Farm in Tennessee began referring women in the Northeast who desired out-of-hospital birth to their PLENTY affiliate in the South Bronx.

While waiting for city permission to run the ambulance service, members of the PLENTY cadre in New York, including Carol, volunteered at emergency rooms in the South Bronx. Carol said, "A couple of us were CPR instructors and we started giving CPR classes, which at that time was a pretty new thing. A lot of the doctors and nurses didn't even have it at that point. I gave classes for the doctors and nurses at North Central Bronx Hospital, and for people at Montifiore Hospital, Lincoln Hospital, along with our volunteer work in the emergency

rooms." At Therese Dondero's invitation, Carol also began volunteering in labor and delivery at North Central Bronx, serving as what today we would call a doula. Carol and Therese met on a regular basis and Carol attended rounds occasionally, on invitation from Therese. What ensued was an open and supportive relationship between these two midwives who represented very different cultures and traditions, which turned into a "learning exchange" between Carol and the North Central Bronx midwives. Carol describes an example of this learning exchange:

> One night there was a lady . . . it wasn't her first baby but this baby was posterior so the labor was taking a while and it was real hard on the mother. Therese asked me, "What would you do in a situation like that?" So I told her that I would get the mother up and change positions and do some exercises, maybe pushing a bit on the baby with her hand to try to change the position, and then also some herbs to get the labor a little stronger. . . . This all seemed new to them because they didn't consider getting people out of bed once you were there and you were getting along in labor. . . . They might have her up walking the halls occasionally maybe early but changing positions so much was kind of a new concept. This was over time. . . . We did some labor coaching techniques. . . . I would do something and then the nurse-midwife would be right there doing it also, breathing with the woman.

So for a two-year period in the late 1970s, Carol Nelson attended homebirths in New York City with informal backup by the nurse-midwives at North Central Bronx and by Therese Dondero's future husband, North Central Bronx obstetrician Dr. Samuel ("Sandy") Oberlander. Carol notes that there also existed at that time a tiny network of direct-entry midwives in New York City who met together to study and discuss cases, whose meetings she attended. These homebirth midwives were "very underground." This situation ended abruptly when PLENTY was informed, off the record, that the City of New York Health Department was aware that Carol was delivering babies and that PLENTY would not receive its license to provide ambulance service as long as she continued to do so. So she left New York to continue midwifery practice on the Farm. The ambulance service became licensed to operate and did so very successfully until it was eventually absorbed by the city in 1984.

The open and mutually supportive relationship between Therese and Carol in part had to do with the 1970s, an era characterized by openness to new ideas. Physicians and nurse-midwives were not as

protocol-driven as they are today, and malpractice, shared liability, and insurance issues had not yet become barriers to innovation. Although the ACNM clearly differentiated itself from MANA, as a result of the growing grassroots homebirth movement and the midwives who developed from it, Therese Dondero recognized an opportunity for collaboration that would benefit women. Sadly, Therese died at the young age of forty in 1986. Carol said:

> Therese was such a powerful person, so strong in who she was and such a strong midwife and such a big influence on midwifery in New York that I think [the legislation] probably would have come down differently had she remained alive. I know that things changed at North Central Bronx when Therese was no longer alive. She made me feel welcome. . . . She gave me her home phone number. She said, "If you have to transport somebody, if you ever have any trouble, if the residents are giving you any trouble, you call me up and let me know." So it was a safe space. It was a sacred space. And she gave me the confidence that I knew I had a good backup system, which is such a vital issue, such a key issue with out-of-hospital birth and direct-entry midwives.

The relationship between Therese and Carol had the potential to create a positive model for other relationships between nurse- and direct-entry homebirth midwives in New York state. As the following section shows, this potential was not realized in the relationships that developed between these two types of midwives during the 1980s and 1990s.

UPSTATE NEW YORK: DISPARATE IDEOLOGIES AND UNWORKABLE RELATIONSHIPS

Outside the greater New York City area, following the elimination of the traditional midwife, midwifery had little presence until the 1970s when the new homebirth midwives (some of whom were licensed in other states, and now call themselves direct-entry) began practicing. During the 1980s and early 1990s, while less than a handful of unlicensed midwives were practicing in New York City (Wolfe 1982), approximately fifty were attending births in upstate communities. Unlicensed midwives began providing homebirth services in Albany in the mid-1970s—a time when CNMs were not yet practicing there. They came from a variety of educational settings. Linda Schutt of Ithaca, having graduated from a formal, accredited school of midwifery in England, provided homebirth services without a license as her

education was not recognized as legitimate in New York state. Hilary Schlinger and Anne Frye had attended independent schools of midwifery in El Paso, Texas. After leaving New York City, Sharon Wells (who holds a master's in education) attended the North Florida School of Midwifery, a three-year program approved by the Florida Department of Education, and then practiced as a licensed midwife in the state of Florida. She returned to New York and was attending homebirths on Long Island when she became involved in the legislative efforts surrounding the proposed midwifery legislation. Others were apprenticeship-trained, studying in groups led by the more experienced midwives and working with a primary midwife in an apprenticeship relationship. These unlicensed midwives took their education seriously, delivering many babies under the supervision of a primary midwife before establishing their own independent homebirth practices. The ACNM standard in nurse-midwifery schools was twenty supervised deliveries as primary attendant prior to graduation. Most of the new unlicensed homebirth midwives had many more supervised deliveries than new CNMs. For example, Linda Schutt was required to attend fifty births as primary midwife in her British midwifery education. Hilary Schlinger, in obtaining her New Mexico licensure, also delivered approximately fifty babies as primary midwife. Their education did not match the "see one, do one" stereotype used as a pejorative characterization by some nurse-midwifery leaders. Over time these homebirth midwives came to be highly regarded and relied upon by the women in their communities.

In Syracuse throughout the 1970s, unlicensed homebirth midwives served an active alternative childbirth community outside the parameters of the medical establishment. These midwives practiced in an extremely cautious manner, with potential clients carefully screened about their commitment to having a homebirth by a group of supporters known as Advocates for Choices in Childbirth, a grassroots childbirth activist organization. This underground situation changed in the early 1980s when midwives who are now nationally known (Anne Frye, Dev Kirn Khalsa and later, Hilary Schlinger) moved to Syracuse and, although unlicensed in New York, began to openly practice homebirth midwifery. Their arrival roughly coincided with that of the first nurse-midwife in Syracuse, Elaine Mielcarski. In the beginning, the presence in Syracuse of one hospital-based nurse-midwife and three unlicensed homebirth midwives offered the hope of collaboration, and so on a few occasions these homebirth midwives brought women they were concerned about to Elaine for evaluation. Elaine's initial willingness to work with them stemmed from a shared participation in an incipient

national midwifery movement and a shared ethos of woman-centered care. But this potentially collaborative effort foundered. From the homebirth midwives' point of view, they were appropriately asking Elaine for advice on conditions about which another opinion would be helpful. They believed that they were referring in a responsible manner and that this reflected sound clinical judgment. But Elaine found herself "shocked" at what she perceived as their "lack of knowledge," and began to view them as "insufficiently educated" and "incompetent." Her opinions, once formed, remained frozen in time. Although the unlicensed homebirth midwives considered themselves to be experienced and well-educated, and continued to evolve as such, Elaine, no longer involved with them, did not experience this evolution. She did not believe that they should have a place in the nurse-midwifery legislation because she did not think their training was sufficient; rather, she hoped they would go on through further education to achieve the new kind of direct-entry certification she was trying to create.

By the late 1980s to early 1990s, approximately six direct-entry midwives attended homebirths in the area surrounding Syracuse and about the same number of CNMs attended hospital birth. As also happened in other upstate areas, CNMs newly employed by hospitals or physician practices encountered homebirth direct-entry midwives already in clinical practice. Differences in ideologies, styles of practice, and educational routes often generated conflict. The more pragmatic CNMs integrated themselves into the biomedical health care system and came to see homebirth midwives as uneducated, unsafe, and a threat to their public credibility. The more idealistic homebirth midwives were vocal in their criticism of nurse-midwives as being overly medical and not "real midwives." Among the homebirth midwives there also existed the feelings that come with marginalization by others—anger, bitterness, resentment. Communication and understanding between these two types of midwives, which ran smoothly in some states, became increasingly hard to achieve in New York.

Upstate New York has often been in the center of social movements of the day. The religious revivalism of the 1800s, the religious alternative community movements of which Oneida was but one example, the abolitionist movement, the women's suffrage movement, the labor movement, the antiwar movement, and the alternative childbirth movement—all have been a significant part of the history of upstate New York. (For example, the Cesarean Prevention Movement, now known as the International Cesarean Awareness Network, was founded and headquartered in Syracuse.) The unlicensed homebirth midwives in Syracuse were surrounded and protected by a strong social movement of women

who desired alternatives in childbirth—a factor that may have contributed to the divisions between homebirth midwives and the first CNMs in Syracuse.

Although some of the dialogue between midwives takes place in the public arena, more takes place outside of the power relations of the dominating class, in this case biomedicine. Such dialogues exemplify what Scott (1985, 1990) calls the "hidden transcripts" of subordinates. For example, the public critique of direct-entry midwifery by nurse-midwives focuses on issues of clinical competence and consumer safety. Privately, many nurse-midwives today recognize that direct-entry midwives are safe, competent practitioners. Their fundamental private critique has to do with image—the lack of a university-based credential, which has become a powerful symbol for competence in our health care system and accepted by nurse-midwives as necessary to establish credibility in a credentialed society. A representation of these hidden transcripts looks like this:

Nurse-Midwife: "You have copped out."
Direct-Entry Midwife: "No I haven't. I've opted out."

Direct-Entry Midwife: "You have sold out."
Nurse-Midwife: "No I haven't. I'm holding out."

Actual quotations from our interviewees flesh out these differing philosophies.

> Direct-entry midwife: [Nurse-midwives] don't understand the difference in the models of care. They think they are preserving midwifery. They cry in meetings because of the care they have to give, but they don't see that they could support us to keep giving the kind of care they wish they could give. They are oppressed by an oppressive system that puts them on report for the slightest thing, so they will be more cautious next time. They have been co-opted by the oppressor.

> Nurse-midwife: Lay midwives are selling themselves, women in general, and the profession of midwifery short by accepting an education that society regards as inferior. They make all of us look bad. No obstetrician would practice without degrees! Why should women accept anything less?

When asked, "But why can't both groups coexist?" one New York nurse-midwifery leader consistently responds, "In order to be strong

there must be one midwife—one type of midwife, one standard of care. Otherwise everyone is confused—the consumer, the insurance companies. The physicians knew this. That's why there is only one type of doctor." Of course she is referring to the historic contest between the *regular* physicians and the so-called *irregulars* at the turn of this century, in which the irregular physicians were regulated out of existence, interestingly enough roughly at the same time as the traditional midwife was being regulated out of existence. This historical parallel is very provocative because today there is not only one type of publicly recognized and accepted doctor, there are two—the Medical Doctor (MD) and the Doctor of Osteopathy (DO), whose historical evolutions and underlying philosophies for a while differed profoundly and are beginning to do so again, as DOs increasingly reclaim their original holistic orientation (Davis-Floyd and St. John 1998). (In addition, chiropractors and naturopaths claim the title "doctor." After decades of work, chiropractors succeeded in their legislative efforts in all fifty states, while naturopathic doctors [NDs] are legal and licensed in only seven states; their battle continues.) The DOs won acceptance and legitimacy by moving to university-based education equivalent to that of MDs, while many homebirth, direct-entry midwives held, and still hold, to their beliefs that university education entails a sellout to the medical model (as do thousands of naturopaths around the country who are also apprentice-trained). For the direct-entry midwife, opting out of hospital birth is a less pragmatic and more idealistic strategy to provide the freedom to define midwifery independently from medicine and to protect childbirth in the face of growing technocratic interference. In contrast, the pragmatic strategy of nurse-midwives for holding out a space within the medical system serves to reach greater numbers of women, particularly disadvantaged women, often in the face of intense opposition.

THE LEGISLATIVE EFFORTS OF THE DEMS AND THE CNMS' RESPONSE

In 1987 the unlicensed homebirth midwives of upstate New York became aware of the midwifery legislation in the New York legislature initiated by New York nurse-midwives. Hilary Schlinger, an unlicensed homebirth midwife in Syracuse at the time, remembers her reaction as "Why *haven't* we been included in the discussions and formulating of the bill?" Realizing that the midwifery legislation would inevitably impact them (their homebirth practices, while not legal, had been carried out without official interference), the unlicensed homebirth midwives of upstate New York decided to act.

Their first action was to contact several of the nurse-midwives leading the legislative effort to "ask for a seat at the table." After being "rebuffed," says Hilary Schlinger, "Alice Sammon and I quickly got ourselves—I would say pushed ourselves—into the discussion [by introducing our own bill.] We did so not because we thought that our bill had a chance of succeeding but because it was the only way we could see of stopping the momentum of the Gottfried bill, of getting a voice in the negotiations . . . and not be like flies that were swatted away. We were advised that the legislature would not act if there were two competing bills, and would press both parties to work out a compromise form."

Hilary holds a bachelor's degree from Cornell University, attended a direct-entry midwifery program in Texas, became a licensed midwife in New Mexico in 1982, and by her own account, "had a thriving homebirth practice in New York from 1982 to 1996." Alice Sammon, an RN and mother of five with two of her own children born at home, undertook a two-year apprenticeship and practiced as a homebirth midwife in Warwick from the early 1980s to the late 1990s. Their idea that the unlicensed direct-entry midwives should proceed with their own legislation in order to gain licensure and certification had not been a popular one with some unlicensed, homebirth midwives who remained suspicious of any kind of professionalization effort that might limit their autonomy, but Hilary and Alice were able to convince most DEMs in New York of the need for legislative action. So the unlicensed homebirth midwives (who had by this time formed an organization, the Midwives Alliance of New York [MANY]) introduced the Saunders Bill into the New York Legislature as an alternative to the Gottfried Act. With two competing bills before them, the New York Assembly Committee on Higher Education put aside both, requiring "the two groups get together and come back with one piece of legislation." MANY believed this accomplished what they had intended—the nurse-midwifery bill was stalled and they now had a place as stakeholders at the table. From the CNMs' point of view, the DEMs were unwelcome players and spoilers.

Rather than reintroduce their own legislation or work with nursing to kill the nurse-midwives' bill (which for a while appeared to be an option), the DEMs threw their legislative support behind the nurse-midwives' bill. Alice Sammon described her hopes and motivations in so doing:

> We were called to do what we do [homebirth] not for ourselves but out of necessity. Women wanted choices and options in birth and that included homebirth. That's what we were committed to—maintaining the option of homebirth that was safe

> and where we could also depend on a reliable and consistent means of transport to the hospital when needed. We wanted homebirth to be open; we wanted to be able to collaborate and be an integral part of the health care community. . . .
>
> [It was clear to us that] the nurse-midwives would own the title of midwife unless we did something. . . . We were fighting for our right to practice, to exist, for the right of diversity of educational opportunities within midwifery, to maintain apprenticeship education. We were looking for a mechanism where those of us who were already trained under an apprenticeship model and had years of experience could be granted licensure.

A shared ethos of serving the childbearing woman is reflected in both Alice's words and those we heard previously from nurse-midwives.

"It's not that we conceded" in supporting the Gottfried-Lombardi bill, Hilary states. "In reality, we were duped."

> We were promised a seat at the table. I sat in on legislative meetings (most memorable to me being one in Tarky Lombardi's office) and negotiated wording on the bill. At that meeting, we were told (by his aide) that both the consumer seat on the board and the educator seat would go to direct-entry midwives [a term that the homebirth, unlicensed midwives at the time believed referred to themselves], so that we would have a voice in the board even if we couldn't hold midwifery seats on the first board incarnation. This never occurred.
>
> We were later told that our educations would be considered for equivalency. As you know, all were rejected outright. We even had a meeting with the Board of Regents College to discuss the feasibility of them being the agency, which would validate our "independent education," much as they do for LPNs becoming RNs. We also met with a representative from Empire State College looking for a similar way to validate our educations.

Sharon Wells was the major lobbyist for the New York direct-entry midwives' legislative process. While in Florida, she had worked on successful midwifery legislation there (see chapter 4). She moved to New York in 1990 and opened a homebirth practice on Shelter Island. Even before her arrival in New York, Sharon had become involved in the New York process through meeting Dorothea Lang at the 1989 MANA conference in New Orleans and hearing Dorothea describe her legislative

work in New York, which Sharon thought was a "great idea." Sharon said, "Dorothea told me that she wanted to combine midwifery under one law and to make nurse-midwifery and direct-entry midwifery equal. At that point I said, 'Well, that would work. I'll help you do that.' We had a long dialogue about this." In Sharon's words above, we again see the confusion generated by the disparate meanings given to the term *direct-entry* by nurse- and direct-entry midwives in New York. As we saw in the Introduction and chapter 1, this designation was commonly used in Europe to distinguish midwives professionally trained in government-approved programs designed for midwives who entered midwifery training without first having nursing education. To recap, this term was adopted and adapted from the European usage by the fifty or so unlicensed homebirth midwives of New York, most of whom by the early 1990s had at least ten years or more of practice under their belts and had developed considerable professional expertise. Thus they rejected the term *lay* in favor of direct-entry, a more professional title, which they believed best reflected their point of demarcation from nurse-midwifery and their beliefs that neither university education nor nursing training should be a prerequisite for training as a midwife. Direct-entry, as the formerly lay midwives adapted it, means entry directly into diverse educational settings, including apprenticeship, and does not necessarily require a college degree; direct-entry, as the nurse-midwives were using it, means entry into a formal university-based program that does not require nursing as a prerequisite.

Schlinger emphasizes now that the stance of the unlicensed homebirth midwives was not at the time "anti-university."

> Again, the issue is not place, or that we reject higher education, but who controls the content. We saw such programs as "nurse-midwifery minus the nursing" and with no seat at the table for those of us who had long been practicing direct-entry midwifery and even designing direct-entry programs. What a different outcome could have occurred had we been given an equal voice in the process! Imagine educators from both the nurse-midwifery and direct-entry realms sitting down as equals together to design educational programs drawing from the best of both worlds! Instead, we were pushed out again and again.
>
> We did not reject university training in and of itself but as the only route into the profession. As evidenced by meetings with such institutions as Regents College and Empire State College, we were looking for ways to validate experiential learning. We were also working nationally to form NARM and MEAC (both Alice and

> I were on the MANA board), with the national Department of Education, with such entities as the National College of Midwifery and the Seattle Midwifery School, etc. to find ways to validate direct-entry education. Furthermore, we believed that apprenticeship should be retained as a vital part of training, and should not be abandoned in favor of only a classroom-based model. Our call was for multiple routes of entry, not anti-university.

In contrast, the New York CNMs were determined that the new direct-entry midwife they were seeking to create would emerge from midwifery programs within credentialed institutions of higher education recognized by the New York State Education Department. While some New York midwives, both direct-entry and nurse-midwives, thought the new legislation would lead the way toward legalization of the already established direct-entry homebirth midwives (as happened in Ontario in 1993), the key nurse-midwifery players behind the legislation were clear from the beginning that it would not do so unless the homebirth DEMs undertook higher education or were able to establish "equivalent" education. The ACNM legislative leaders hoped and expected that the university-based direct-entry programs they wished to establish would provide an accelerated route to this higher education—an open door through which the formerly lay midwives could pass. Elaine Mielcarski, in particular, had pinpointed funding opportunities she hoped to use to create direct-entry programs around the state, and Dorothea Lang provided written proposals that demonstrated specific plans for creating streamlined pathways for practicing midwives to enter such programs. But like Hilary, Alice Sammon regrets that "we [direct-entry midwives] were never consulted or included in the development of the equivalency process. We had practicing midwives, educated but educated differently, and the CNM leadership felt that they could decide what we needed to do. We should have been included in the developmental process. Our input would have been valuable" (personal communication 2005).

While Elaine's early contacts with direct-entry midwives had been largely negative from her perspective, Dorothea had attended MANA conferences for many years, despairing that the ACNM would ever develop and accredit direct-entry midwifery educational programs. Once it became clear that she could achieve her dream of direct-entry professional midwifery education through ACNM after all, Dorothea used her knowledge about the educational processes of direct-entry midwives to develop specific charts and tables for making ANCM-style direct-entry education as simple and straightforward as possible for them to achieve.

By the mid-1980s, all New York state–approved nurse-midwifery programs were affiliated with a university; admission prerequisites included being an RN with upper level credit in the health and social sciences toward a baccalaureate degree. Between 1984 and 1992, advice from legislators and discussions with the Health and Education Department made it crystal clear to Dorothea and the other CNM legislative leaders that "the potential for developing a new licensure mechanism for professional midwives would be viable *only* if the new law continued to require similar or higher academic degree preparations, knowledge, and skills." Dorothea explains:

> The upstate and downstate leaders of the NYS [New York state] chapter of the ACNM strategized ways to achieve this kind of higher education for non-nurse-midwives. . . . These could culminate in the required university-affiliated midwifery education core curriculum and clinical practice requirements. Sets of these documents and graphic charts were circulated to legislators, their education and health committees, the Education and Health Departments, the Board of Regents, other key decision-making leaders in New York state, as well as to SUNY and Empire College, which specializes in adult education. (Dorothea Lang, personal communication, 2005)

The New York DEMs we interviewed report that over ten years of lobbying effort, they had spent approximately $20,000 to pay their own lobbyist and had acquired support from various legislators, but in the end they were faced with two alternatives: to support the nurse-midwives' bill, or to work with nursing to kill it. The latter option existed because they had been approached by representatives of NYSNA proposing a bargain: help NYSNA kill the Gottfreid-Lombardi Bill, thereby keeping nurse-midwifery under the jurisdiction of the Board of Nursing, and NYSNA in turn would help the DEMs pass a bill of their own. Having grown out of the alternative birth movement of the 1960s and 1970s, these homebirth midwives held a jaundiced and distrustful view of the nursing profession. They saw entering into a political "you scratch my back, I'll scratch yours" agreement with NYSNA as an ethical sellout that went against their idealism and desire for a united midwifery profession (see chapter 1). A third alternative—to withdraw from the process altogether—did not seem possible because they knew that inevitably they would be affected by any midwifery bill. Alice said, "If they got a bill passed that said 'midwifery,' and we were not identified and included in it, we would be excluded, which is exactly what happened."

So despite their status as unwelcome participants, the New York DEMs continued to support and attempted to influence the wording of the nurse-midwives' bill. As far as they understood at the time, the bill did not contain statements about "nursing equivalency" or "physician supervision" or "written practice agreements" and gave more leeway to educational diversity. During their negotiations with the CNMs, they came to believe that they would come away with a seat on the new Board of Midwifery and would have input into the creation of direct-entry educational programs. In addition, they expected that their participation in the process would result in a law providing them with a means towards licensure and recognition. They participated in what Alice called "this tremendous lobbying wheel that had been created that we were a part of. We had our whole network across the state in place lobbying for this bill for a full year [1991–1992]. Letters, phone calls, the whole thing."

Sharon Wells said,

> I practically lived in Albany that year. . . . Visiting senators. Visiting all the legislators. Taking in packets. Being available to comment on the floor. It's a never-ending process to lobby because as soon as you get through all of them, you need to go back and start over with new information. . . . If you look at the bill jacket, it had twenty sponsors from each house on it. That's all my work. All the sponsors that I went out and gathered for it. Without my help they couldn't have gotten this bill through.
>
> We fought for every word. We wrote a section that actually was intended for me, a board position, of a midwifery educator. I was led to believe from the beginning that this was a position they were writing for me, so that direct-entry midwives could be included. It was the only way to get direct-entry midwives included. So we put that into the bill as one of the board positions—the only board position that was available to us at that point.
>
> I think we had one meeting [with the nurse-midwifery leaders, and we had some major disagreements] and after that they would never sit down with us. People would not return my phone calls. They wouldn't dialogue with us.
>
> And then lobbying . . . Hilary, Alice, and I would run into them in Albany. We were working on the same bill, really, and they would have to deal with us at times, and they always said it included us. But they were rude and not nice.

Subculture and personality clashes intensified this difficulty in communication. CNM legislative leaders saw the DEM legislative leaders as "contentious, tactless, and unprofessionally dressed." DEM leaders saw the CNMs as "sneaky, closed-mouthed, and conspiratorial." The DEMs insist that their defensiveness and contentiousness arose from their growing conviction that the CNM leaders really did not want to work with them. Later they realized that their desire to reach unity of legislative intent with the nurse-midwives set them off on a kind of parallel lobbying path that left them out of any real decision making between the legislators and the nurse-midwives.

Alice Sammon's perceptions of these events are very different from those of the nurse-midwives directly involved.

Alice: ACOG [American College of Obstetrics and Gynecology] had been invited into the process for a full year and had refused to sit at a negotiating table with the direct-entry midwives and the nurse-midwives. In the meantime we met but we never agreed. There were always arguments. Always [they would tell us] we had to let X happen and "don't worry, you would be gotten in."

So two weeks before the bill went to the floor of the Senate and the assembly . . . in a closed-door meeting that we did not find out about until after . . . it was ACOG and the certified nurse-midwives and different representatives from the state legislature and state education department. We to this day do not know exactly what went down at that meeting. But deals were made. And we were cut out. Totally cut out.

Robbie: But [a state official] told me that the Midwifery Practice Act never had anything to do with you. That he had no idea why you thought it ever had anything to do with you. That he had spent years telling you guys that it had nothing to do with you. And he wondered, "Where on earth did you get the illusion that it had something to do with you?"

Alice: Well, in his mind it never had, even though for years we were trying to get the bill written so it would clearly deal with us. Even though we had been lobbying for years, even though we . . . would be placated. We were always hearing about meetings just before they happened . . . always pushing our way in . . . always trying to have our voice represented. But never seen as key players, as anything that needed to be listened to. Because of the bill's implications, we felt we needed to have input into it. That input was never accepted. . . . And in fact the bill *does* clearly deal with us—it clearly makes us illegal and does not provide a mechanism for us to be legal. . . . So we need to be now chastised for not complying with the law. We realize *now* that from the beginning the bill was never going to be about us.

From a factual point of view, parts of the stories of the DEMs and the CNMs are irreconcilable. The DEMs involved in the legislative efforts bitterly insist to this day that "we were promised a voice in the bill," while CNMs say they were not. Hilary Schlinger sums up the DEMs' beliefs: "At every turn there was deception. [They would say] 'Of course we're working with you' when in fact they were working against us." Sharon Wells told us that she realized only after all was over that the bottom line for the New York midwives was separation from nursing and that they would, in Sharon's words, "compromise anything to accomplish that." She didn't understand at the time that her conception of direct-entry and that of the New York CNMs were so fundamentally different:

> The bill was so horrendous. It was like night and day. It went from being an autonomous practice act to being under the control of the doctors. And as far as I could see, the nurse-midwives were in no better shape. In fact, they had given up freedom to have this bill . . . their main focus was to get out from under nursing. It was an obsession. That's all they cared about. They sold us out to get out from under nursing.
>
> Donald Ross, our lobbyist, and I tried to salvage anything we possibly could in the proposed law. We went through it word by word and tried to make it so it wasn't as bad by taking a word out here, or putting a word in there. Just altering it so that it didn't come out that the doctor had complete control. That it didn't come out that it had to be signed protocols. It doesn't say signed protocols. It says written protocols.
>
> There were certain little things that I could do—the education. I thought I had preserved the education. We thought we had one board position, like I said. Then when it all got played out and the law . . . became a law . . . and we started actually going for interviews as people who wanted to be on the board, I was turned down.
>
> We had lost everything. I knew we had lost everything. We lost autonomous practice. That was number one. The nurse-midwives lost any ground that they had.
>
> After they passed the law, it was such a bad law, I was so devastated that I came to the Farm. I went to Ina May's house. It took me a week before I could even hardly talk. That's how bad a shape I was in. So Ina May put me down at the computer and had me start writing "The New York Sell Out" (Wells 1992).

> That was when I wrote that, when it was right fresh from coming from that.
>
> To me it looks like they went from the frying pan into the fire. I still believe that.

Few of the nurse-midwifery leaders we interviewed respond directly to the accusations of the direct-entry midwives in this story, repeating, "It wasn't about them. It was never about them." In other words, the motivation behind the legislation had nothing to do with homebirth or the direct-entry midwives providing homebirth services. From their viewpoint, it was first and foremost about autonomy from nursing. Secondly, they perceived the legislation as a means of guaranteeing the competence and safety of midwives without nursing education. "It's not about homebirth, it's about education," stated a prominent New York City nurse-midwife. (Hilary Schlinger disagrees: "No, it's about ownership of the word midwife!")

The educational issue was key. Elaine Mielcarski (personal communication, 2004) stated:

> Right from the start, I gave articles to the governmental and legislative people showing the Netherlands statistics and the Netherlands curriculum full of basic sciences, health sciences, etc. Remember that the midwives graduating from the Netherlands program who chose to go on could be accepted right into the Ph.D. program of the University of Amsterdam. Their undergraduate education, which entailed many more academic weeks per year, times four years, probably was the equivalent of our master degree programs. Unfortunately for them, the lay midwives also spoke of the Netherlands outcomes and homebirth, then submitted a bill fashioned after ours but requiring only apprentice education. They were able to get a sponsor in only one house with no other signatures on that bill. Their effort failed on its own merits. It blew me away. I never conceived that they would not be willing to expand their education. To be fair, some were.

The firm belief of the nurse-midwives was that any legislation that did not include nursing equivalency for direct-entry education would be doomed to fail. Dorothea said, "To get out of nursing, this [nursing equivalency] was absolutely necessary or else only nursing education would be allowed as a prerequisite into midwifery. Some lay midwives

still do not understand all of the intricate New York state educational, licensure, and practice requirements. The Saunders Bill, or any bill, if passed would have needed similar New York state requirements in order to become legally enacted" (personal communication 2005).

Although the CNMs insist that there was no sellout, negotiations did take place prior to the passage of the legislation around what nursing equivalency would entail. According to Dorothea, these negotiations took place with the following concepts in mind:

1. If the basic academic core prerequisites and the health and social sciences for entrance into nurse-midwifery education (traditionally acquired during the academic years for a bachelors degree nursing credential) could also be acquired in a similar/equivalent academic baccalaureate-level science pathway, then the equivalent prerequisites for entering a midwifery education program could be met.
2. Once admitted into a NYS-approved university-affiliated midwifery education program, both applicant groups (the post-nurse applicant and the post-health science applicant) would be required to master the identical academic, clinical, and practical components of the midwifery education program.
3. Upon successful completion and graduation, all must pass the New York State Board of Midwifery–approved midwifery examination.
4. Any midwife who meets all prerequisites and who successfully passes this examination and pays the fee is eligible for New York state licensure to fully practice professional midwifery (CNMs and CMs).
5. As was required prior to the new legislation, all private and public midwifery education programs have to seek approval via the NYS Education Department to educate midwives for practice in New York state.

To this day, the original New York DEMs continue to wonder what would have happened if they had entered into a political alliance with the NYSNA nurses to prevent the CNMs from creating their new type of direct-entry midwife and to get a law of their own. They refused such an alliance because of their commitment to midwifery and reluctance to associate with nursing, and because they did not want to impede the CNMs' legislation; they just wanted to be included in it. At the same time, the CNMs are certain that no matter what the home-birth direct-entry midwives had tried, they would not have succeeded without incorporating university education into their training because

of New York's strong and long-standing emphasis on higher education for all professions. Dorothea continues to emphasize the importance of university-based credentials—her vision included "multiple pathways giving university credit for a variety of prior education and would include extra courses in pharmacology, well-woman care—whatever would help the DEMs meet CM or CNM requirements." But Hilary Schlinger, who went on to become a CNM, stated, "What we needed was not *more* education, but a way to validate our education. From my perspective now, having become a CNM, my education at the time was more adequate than that of many CNMs I have met." She continues:

> University-based education is not the issue. The issue is who gets to define what this education looks like. A university education based on Anne Frye's *Holistic Midwifery* looks very different from one based on *Varney's Midwifery.* To us it was about direct-entry midwives being able to define midwifery education. What we saw was a model of (medicalized) direct-entry midwifery education being offered up that looked like (medicalized) nurse-midwifery minus the nursing. Again, it was a fundamental issue of who got to define the word "midwife," starting with who got to define the parameters of midwifery education. It [the proposed direct-entry education] didn't incorporate the midwifery *I* know. (Personal communication, 2005)

Anthropologically speaking, Hilary is correct: education and identity are intimately linked. The way a midwife is educated and thus socialized into midwifery does indeed have a profound effect on the kind of midwife she is likely to become (see Benoit et al. 2001). Fundamental disagreements about identity will lead to fundamental fights about education, as happened among the midwives of New York.

THE CREATION OF THE CERTIFIED MIDWIFE

The New York State Professional Midwifery Practice Act was passed in 1992, and in 1994 the New York State Education Department established a Board of Midwifery to provide regulatory governance over the profession of midwifery separate from nursing and medicine—a situation unique in the United States for nurse-midwives.[5] Thus the New York CNMs were the first to create a new classification of hospital-based midwife for whom licensure as a Registered Nurse (RN) would no longer be a requirement.

At first there was a great deal of resistance to the idea of direct-entry on the part of ACNM members who were deeply committed to both their nursing and midwifery identities and wanted to keep an unbreakable link between the two, but ultimately most New York CNMs came to support the legislation. This large-scale membership support was in many ways a direct result of strategic efforts by a strong, informal, national coalition of midwifery leaders who had been meeting and strategizing how to convince ACNM members that direct-entry midwifery should be embraced by the ACNM. The members of this informal national coalition included Dorothea Lang, Elaine Mielcarski, Helen Varney Burst (then Director of the Nurse-Midwifery Program at Yale and of the ACNM's Division of Accreditation [DOA]), Joyce Roberts (then President of ACNM), Katherine Camacho Carr (then Vice President of ACNM, elected President in 2005), Richard Jennings (then Director of Midwifery at Pennsylvania Hospital and Chapter Chair for the ACNM in Pennsylvania), and nationally known researcher and midwifery proponent Doris Haire. The articles they wrote and their informational and lobbying efforts within ACNM generated agreement among most of the membership that the time had come to open the ACNM to direct-entry education. Many CNMs began referring to the opponents of direct-entry as "the old guard" who were "stuck" in their commitment to nursing.

One of the agendas of this informal coalition of ACNM leaders was to stave off the crisis that would result if New York midwives established their own credentialing exam. If necessary, the New York CNMs were prepared to "go it alone," meaning that the New York Department of Education would create its own testing for licensure. But from the standpoint of New York's CNMs, it made much more sense for the ACNM Certification Council (ACC) to be the testing agency for all New York midwives—both nurse-midwives and the new direct-entry midwife. This would allow for the immediate licensure of nurse-midwives under the new Board of Midwifery. New York CNMs also believed that using the ACC exam would provide increased legitimacy for this new direct-entry midwife.

In the end, the ACNM, ACC, and DOA leaders endorsed the concept rather than have New York create its own licensing mechanism.[6] Joyce Roberts, then President of ACNM, worked with the DOA to carry out a Delphi Study to identify "the nursing knowledge, skills, and competencies that are essential for midwifery." The DOA reached "consensus" on these items and then developed "a mechanism for accrediting non-nurse midwifery education programs" based on

criteria "developed for accreditation of basic midwifery educational programs" (Roberts 1996:1–2). The ACC subsequently adapted its national certifying exam to test both nurse- and direct-entry midwives for ACC certification, which would then qualify them for state licensure in New York as a Certified Midwife (CM). This series of events made it possible for the nurse-midwifery program at the SUNY Health Science Center at Brooklyn (informally referred to as SUNY Downstate) to expand its program to encompass direct-entry students and develop a means of teaching this identified set of skills to direct-entry students (those without a nursing degree). Over 100 potential students and others attended SUNY Downstate's first presentation of the new direct-entry program to the public. Six students were accepted into the first class, which began in 1996. Originally desiring to make the process so streamlined that the educational program would take only one year, the downstate educators, with feedback from students, realized that the learning curve was too steep, and so in 1999 expanded the program to two years and offered a Masters of Science in Midwifery degree at completion. A student with a baccalaureate degree in any field can take any of the thirteen basic science prerequisites she has not already had (which for liberal arts students may take one year), and enter the SUNY Downstate program and graduate as a midwife two years later.[7]

For years, CNM leaders debated the question of what to name this new kind of midwife. In articles calling for her creation, Helen Varney Burst had tentatively titled her a Certified Professional Midwife (CPM). Some ACNM members favored this term, while others felt that to call her a professional might imply that nurses were not professionals. The issue became moot when MANA members met in October 1994 to choose the name of their own new kind of certified direct-entry midwife. In an ironic twist of history, their meeting took place a few months before the meeting in which the ACNM was to pick its name for its own new kind of certified direct-entry midwife. Because they felt a strong need to identify themselves as professionals in order to rid themselves of the "lay" appellation, the members of MANA's Certification Task Force chose Certified Professional Midwife, CPM (see chapter 3), as the title for their new certification, leaving the ACNM with little choice but Certified Midwife (CM). At first some ACNM leaders felt deep resentment about this "preemption" of their designation, but later came to embrace the term, as "Certified Midwife" satisfied their deep desire to be midwives.[8]

EFFECTS OF THE NEW YORK MIDWIFERY PRACTICE ACT ON DIRECT-ENTRY HOMEBIRTH MIDWIVES IN NEW YORK

The new law has resulted in both winners and losers in New York state. The winners, whose dream turned into reality, have been nurse-midwives, the new certified midwives (CMs), and consumers seeking a hospital birth assisted by a recognized professional midwife. The losers, whose experience turned into a nightmare, have been homebirth consumers, especially in upstate New York, and the unlicensed homebirth midwives who served them. While not legal under the previous statutes, these midwives had nevertheless practiced openly, providing homebirth services mostly in upstate communities. The new law resulted in redefinition: practicing midwifery without a license, formerly a misdemeanor, became a felony. Dorothea Lang (personal communication, 2005) reemphasizes the point that "*any* professional midwifery act would have had the same result."

The effects of this redefinition were not immediate. It took until 1994 for New York state to form the New York Board of Midwifery. The first elected chairman was Elaine Mielcarski. Licenses to practice midwifery were issued to approximately 450 nurse-midwives who had held permits to practice under the old law. Some months later, New York's practicing direct-entry midwives were invited by the Board of Midwifery to apply for licensure; approximately thirteen did so. This invitation appeared sincere: some board members hoped that at least some of the practicing DEMs would meet the criteria for state licensure, which would entail evaluation of their education and passing the ACC exam. Following ten months without a response, all applicants received a letter of denial from the board, dated December 8, 1995, with the recommendation that they "attend a registered midwifery program, to work towards a certificate of midwifery" (Linda Schutt, personal communication, 2004). The fact that the educations of Linda's direct-entry homebirth colleagues were not deemed by the New York State Office of Comparative Education to meet the standards for nursing equivalency became the basis for the state's rejection of their license applications.

Again, from the perspective of nurse-midwives, this was not intentional on the part of board members. As described above, they had hoped to create many "open doors" to the requisite higher education for the practicing homebirth midwives. But the funding they hoped to put behind this effort never came through, and to date (2005), thirteen years after passage of the New York law, the SUNY Downstate program is still (effectively) the only one of its kind in the nation—an

ACNM/DOA-accredited midwifery educational program in which students can become an ACC-credentialed midwife without also obtaining a nursing degree.

Hilary Schlinger expresses a common feeling among New York's DEMs: "I believe, but have no proof, that the information given in our original applications was then used in prosecuting us—perhaps passed on to investigators within the department. I do know that cease-and-desist orders quickly followed." On December 13, 1995, five days after receiving her letter of rejection from the Board of Midwifery, DEM Roberta Devers-Scott of Syracuse was arrested in her home, taken away in handcuffs, and charged with the felony of practicing midwifery without a license. Within days, ten or so homebirth midwives received cease-and-desist orders from the state of New York. (Hilary received her cease-and-desist order in January 1996.) Three were arrested and/or prosecuted, and some homebirth clients were investigated and harassed. These actions were carried out by the Office of Professional Discipline, the enforcement office within the Office of the Professions of the State Education Department. Members of the Board of Midwifery denied that they had anything to do with these events, and nurse-midwives central to the statutory process insisted that the inclusion of a felony count was not initially part of the wording of the bill. It was placed into the bill at the end by legislative staff because in New York, it is a felony to practice *any* profession without a license. (It is important to remember that nurse-midwifery in New York was not a licensed profession until the passage of this bill. Nurse-midwives were licensed only as nurses. As midwives, they received a "permit" to practice under the 1907 Sanitation Code.) Several nurse-midwifery leaders stated, "We didn't know that was going to happen. We just didn't know." Pat Burkhart, director of the nurse-midwifery educational program at New York University, who became a member of the New York Midwifery Board, expressed their feelings:

> We nurse-midwives in New York state who were working desperately to obtain passage of the bill were focused on fighting off the state medical and nursing societies and did not stop to consider the ultimate consequences of legalizing ACNM-certified direct-entry midwives. Once the law passed and was being implemented, most of us were shocked to realize that the practice of unlicensed midwifery had been transformed into a felony. When the members of the new Board of Midwifery became aware that the state attorney's office had begun prosecuting unlicensed midwives, we were appalled and we did not understand

> why they were doing so. We were told that complaints from consumers were what led to the prosecutions, but our further investigations did not completely verify that statement. We talked with the state attorney's office, asking them to back off and insisting that unless there was clear indication of a need to investigate a particular midwife, there was no reason to enforce a law just to enforce a law.

Nevertheless, the history of negative political interactions with nurse-midwives ensured that the New York DEMs would be quick to assume that the criminalization of their practices was intentional on the part of the CNMs who had promoted the bill. They met the denials of intent with skepticism, and accusations were made that a "witch hunt" was underway. Their sense of injustice, and that of their consumer supporters, were expressed in various public demonstrations in favor of the homebirth midwives who had been harassed.

Justified or not, the feelings of betrayal, anger, and grief on the part of New York direct-entry midwives have been and remain profound. Sharon Wells went for an interview to try to achieve a place on the board but was turned down. She received a cease-and-desist order from the state telling her to stop practicing, but after an expensive legal battle was never actually charged. Disillusioned and emotionally wounded, Sharon moved back to the Farm in Tennessee, where she continued to work with the North American Registry of Midwives to develop its own national certification for direct-entry midwives, the CPM (see chapter 3). Roberta Devers-Scott eventually plea-bargained her case and moved to Vermont, where she became licensed and opened a homebirth practice. Defeated and newly terrified of arrest and prosecution, most homebirth direct-entry midwives also left the state, moving to New Hampshire or Vermont, where they can practice legally. Alice Sammon moved to Maine, where she continues to work as a homebirth midwife and as adjunct faculty at Birthwise Midwifery School in Maine (a MEAC-accredited program). Hilary Schlinger moved to Albuquerque, set up a homebirth practice, and proceeded to work toward meeting the legislative requirements for New York licensure. She did finally gain licensure as a CNM after receiving an RN degree through New York state's distance learning program, the Regents College. Moving back to New York to open a homebirth practice, she was unable to obtain the requisite written physician agreement and has recently returned to Albuquerque. The few unlicensed direct-entry homebirth midwives who remain have to practice as invisibly as possible. The end result has

been to make access to homebirth very difficult in upstate communities where few CNMs or CMs provide homebirths.

The small number of CNMs and CMs licensed under the new law in New York who offer homebirth services find themselves traveling longer distances to serve consumer demand for homebirth and/or suffering from a lack of physician backup. These legal homebirth midwives also find themselves overcome by illegitimate complaints from hospitals, doctors, and labor and delivery room nurses who do not understand homebirth. The Disciplinary Committee within the Department of Health takes up these complaints and has been particularly aggressive in pursing complaints against homebirth midwives, legal and illegal, creating financial as well as emotional distress for these few legal homebirth midwives. As a result, there has been a further marginalization of, and lack of access to, homebirth in communities previously served by unlicensed direct-entry midwives.

Alice Sammon's and Sharon Well's New York "nightmare" did not diminish their commitment to homebirth midwifery. Asked how she felt about devoting ten years of hard work to the New York legislative process, Alice responded with a resigned smile, "some good had come out of it after all." She and Sharon both noted that had they been included in any way in the New York legislation, they would have thrown all of their prodigious energy into working together with the CNMs for the future of midwifery in New York. Rejected and excluded, they turned their attention to the national level and were instrumental in realizing the wider dream of generating a national certification designed to support and preserve the apprenticeship training and the midwifery model of care they value so highly (see chapter 3). In 1995, both Alice and Sharon became CPMs. Their critical involvement in this national process—a direct result of being "shut out" in New York—is yet another example of how formative the events in New York have been for American midwifery as a whole.

Like the massive ripples created by dropping a large boulder into a small pond, what happened in New York has affected legislative efforts in other states and has had a hugely negative impact nationwide on relationships between CNMs and homebirth direct-entry midwives.[9] Local nurse-midwifery leaders in a few states have attempted to introduce legislation similar to New York that would establish the Certified Midwife as the only legal direct-entry midwifery credential, and have attempted to block legislative efforts to legalize CPMs. Perhaps most sadly, because of the suspicion engendered by events in New York, even when local ACNM leadership proffers no opposition to direct-entry licensure, DEMs in various states have assumed that such opposition

exists. Their distrust has led them to reject real opportunities to work with nurse-midwives on various types of legislation, engendering the same lack of trust on the other side. For the most part, this lack of trust comes from DEMs' felt sense that even if they collaborate with CNMs on legislation, the CNMs could "sell them out" at the last minute by making agreements with physicians that the legislation will not include them after all. DEMs think this is what happened in New York—that the nurse-midwives sold them out to the doctors at the end. In contrast, the nurse-midwives think they did no such thing; they insist that their last-minute agreement with the doctors to accept written practice agreements had nothing to do with the unlicensed homebirth midwives of New York: "It was never about them." But perception is powerful, and the perception among DEMs around the country of a "New York sellout" has been a major impediment to establishing trust between these groups.

After both the positive and negative effects of the passage of the New York Midwifery Practice Act of 1992 became clear, many New York CNMs came to deeply regret its results for the practicing DEMs, and to wish for means for them to achieve licensure in New York. Linda Schutt, the British-trained midwife who practiced (illegally) for years as an independent, unlicensed, homebirth midwife in upstate New York, was one of the original thirteen unlicensed homebirth midwives to apply for licensure (her application was initially denied). Her direct-entry training in England met the New York educational standard for midwifery education, but she had to meet the nursing equivalency requirement by taking courses at SUNY's Regents College. Eventually allowed to sit for the ACC exam, which she passed, she became the first midwife to obtain CM certification in New York state (and thus in the nation). Her example made it clear that the New York midwifery legislation can work for foreign-trained midwives, who previously would have had to complete an American nurse-midwifery program in order to be licensed. Linda Schutt is now (2005) the chair of the New York Board of Midwifery—a fact that New York nurse-midwives point to with pride and view as proof that the legislation is ultimately leading to the end result they intended.

Julia Lange-Kessler, a longtime homebirth midwife practicing in Orange County, New York, who became a CPM in 1995, did walk through ACNM's open door. Receiving twenty-two hours of credit for her CPM certification from SUNY Downstate and taking basic science courses, she entered SUNY Downstate's direct-entry program, graduated, and is now both a CPM and a licensed CM providing hospital birth services in her community.

When we asked other New York direct-entry homebirth midwives why they did not, like Julia, choose to walk through ACNM's open door by becoming CMs, they were passionate in their responses, emphasizing the "offensiveness" of the compromises that would be entailed. For example, Alice Sammon, already an RN with a college degree who probably would have had easy ingress into the new direct-entry (CM) program, exclaimed:

> It's because direct-entry midwives were not included in the creation of that program. That is a *nurse*-midwifery program that they are *saying* is a direct-entry midwifery program. You want to be a midwife, and you don't want to be a nurse, and you start out with these high ideals, and then you comply and compromise in your educational program, saying, "Oh, I'll just go through these hoops because then, when I get out, I can work the way I want to and I can make it change. Then because you have to pay back loans, or you need a steady salary, you take a job. Now you're dependent on that job. Your vision of working for women and changing the system fades as you do what you have to do to keep your job.
>
> The job situation for CNMs in New York has been very challenging. I have listened to them over and over again complain about how they cannot do midwifery care. They are required to provide a medical model of prenatal and birthing services. The more you are criticized or your position is jeopardized, the more you attempt to conform, do it right, achieve higher educational standards, because now we will be accepted and now we will be able to give midwifery care. Well, acceptance has come at the price of compromising the model of care. Increasingly CNM services and birth centers have been closed. The compromises are not providing a diversity of services.
>
> I think that we hold truths that keep a balance. There needs to be a mechanism for me, and women like me, to be legal. Creating a program based on ACNM standards, and telling me I have to go through that, is not providing a mechanism for me to be licensed, acknowledging who I am and the skills I hold, and the whole system that we have created that is equally as valid. I could see them for political reasons deciding they have to survive but to ignore the truth makes them part of the same thing that they think they're fighting against.

Another original direct-entry homebirth midwife still questions the right of the CNM legislative proponents to define direct-entry midwifery, noting that women are taken care of in the neighboring states of New Hampshire and Vermont by state-licensed homebirth DEMs who are competent practitioners but whose training is not recognized in New York. And Hilary Schlinger noted sadly that

> whereas once central New York was a hotbed of birth activism, the place where the Cesarean Prevention Movement arose, where there were vital consumer organizations like Syracuse's Advocates for Choices in Childbirth, where we had an ongoing midwifery study group for more than a decade, where midwives from diverse communities (I mean diverse—Mennonite, Native American, Lesbian, Fundamentalist Christian, among others) unitd to work on a common cause, there is now a void—no consumer groups, no homebirth midwives, seemingly little demand for homebirth. If the intent of the nurse-midwives, in laying claim to the title of "midwife," had been to destroy any vestige of the fact that other midwives had ever existed, then they succeeded. (Personal communication, 2005)

ANALYSIS: PLACE OF BIRTH AS A STRUCTURAL FACTOR

While education and identity are core issues in this New York midwifery struggle, place of birth is the underlying determinant of the differences in approach to these issues. Nationwide, ninety-seven percent of CNMs attend births only in hospitals, while ninety-seven percent of DEMs attend only births at home. The ACNM states that standards of care are the same regardless of place of birth. But the place of birth inevitably affects the nature of the birth experience for both mother and midwife. In hospitals the childbirth milieu reflects the competing care models of midwifery and obstetrics, and everyday decision-making by nurse-midwives involves negotiation and compromise between these models. Homebirth midwives do not wish to make such compromises: they tend to see their integrity as midwives as part and parcel of their autonomous homebirth practice under a holistic model of birth that honors the woman's individual rhythms, not hospital protocols and routines. (Freestanding birth centers, in which both CNMs and CPMs attend births, account for fewer births than at home. Many are forced to close because of malpractice costs and reimbursement problems.)

The educational traditions of each group reflect this division in place of birth. The intimate and complex nature of apprenticeship

training is particularly fitting for a focused, specialized training in homebirths, which are intimate, complex, and unique. University training, combined with clinical experience in a hospital and community-based public health setting, is more appropriate to the exigencies of hospital practice and to the full-scope primary care for women of all ages that CNMs now provide.

Throughout the process of working for the Midwifery Practice Act, the call by New York nurse-midwives for "one type of midwife, one standard of care" became a mantra encoding the political and philosophical rationale for the development of direct-entry midwifery by nurse-midwives. Many CNMs see the knowledge base of nurse-midwifery and hospital care as more complex and superior to that of homebirth midwifery, insisting that if a midwife is experienced as a hospital midwife, she is capable of doing homebirths, and that midwives must first become proficient at attending births in hospital. (The reality is that New York midwifery students in ACNM/DOA-accredited university programs who desire exposure to homebirth are rarely able to achieve it because these programs are not allowed by malpractice carriers to incorporate homebirth.) In contrast, DEMs see homebirth as primary:

> The direct-entry view of midwifery education holds that we first learn birth from women, from observing un-interfered-with normal birth that can best be seen at home. All other knowledge builds from this base. It holds that the physical realm emphasized by institutionalized, medical-model practice and education leaves out the many other dimensions of the birthing process. It holds that midwives cannot truly understand birth by learning in a system that provides fragmented care. It holds that the emphasis on classroom learning often occurs at the expense of actual experience, that it is experience with birth that dissipates fear of birth. It holds that fear of birth motivates interference, while knowledge of, and respect for, the process make such high rates of intervention unconscionable. (Hilary Schlinger, personal communication, 2005)

Alice Sammon expands upon Hilary's point, again illustrating the primacy of place of birth:

> Rather than the emphasis on learning care of the women as a totality and as a whole unit, the education is fragmented. You're taught to give fragmented care, and you're not taught to see the

person as a whole system. They're seen in pieces. And your education supports that because you're taught in pieces. A true apprenticeship program . . . you learn as the situation comes up to you. So if you, in a clinical setting, are confronted with postpartum hemorrhage, or shoulder dystocia, or whatever, then you build your didactic learning for that week or month . . . on what you've just seen.

The approach is backwards in an institutionalized educational system. It's Thursday, so on Thursday we are studying pre-eclampsia. Well it doesn't matter that yesterday you just saw a postpartum hemorrhage. This is Thursday and you're studying pre-eclampsia. Or this semester we're doing microbiology . . . you know . . . or whatever else.

Rather than expanding, this kind of education funnels midwives' thought processes. It creates a mentality that's dependent on a system to provide you answers rather than building inherent knowledge and an intuition base so that the midwife learns to trust that whatever she needs at that time is available to her. You're taught to depend on only what you can see in books . . . only what you can call down to the doctor for . . . I'm a firm believer that there needs to be very strong didactic education. But this other component is missing in institutionalized education. And I think that is the heart and soul of midwifery.

The lack of concern regarding the impact of the New York legislation on access to homebirth service and independent practice throughout the state has been justified by the idea, stated by several nurse-midwifery leaders, that "first we must be strong in the hospital, then we can push outwards to include homebirth"—a strategy often heard from those same midwives who call for "one type of midwife, one standard of care." Implicit in this strategy is the notion that the homebirth DEM is less than the nurse-midwife, more on a par with the traditional birth attendant—someone who needs to be "brought up" to the level of the ACC-certified midwife.

New York's original DEMs argue that this viewpoint belies the reality of diversity within American midwifery in both place of birth and educational tradition, and reflects a hierarchical philosophy of knowledge. Many DEMs around the country believe that homebirth constitutes a fundamentally different kind of midwifery with a distinct if overlapping knowledge base. Homebirth may appear simple to the uninitiated because of its standard of avoiding unnecessary intervention. Yet the pieces that make up a successful homebirth are as complex

as those comprising a hospital birth. The homebirth midwife dances a fine tango with the birthing mother and family. The ability to refrain from inserting oneself into the birthing situation while at the same time keeping the ability to observe, draw conclusions, and carry out a safe birth are skills not easily honed in the hospital. Also, the hospital-based midwife easily becomes accustomed to the support of nursing staff, on-call physicians, etc. Homebirth midwives become used to independence and the reality that the buck stops with them. They must be able to manage the entire range of prenatal care, labor and delivery, postpartum care, observation of the neonate, education on breastfeeding, and support for the family in the home during the first few days and weeks after birth. Additionally, as they are almost always self-employed practitioners, they develop an entrepreneurial spirit and the skills necessary for managing a small health-care practice.

In spite of these differences, a growing trend within the grassroots of midwifery recognizes that home and hospital midwifery, nurse- and direct-entry midwifery, share a knowledge base and skills even as each holds unique characteristics. This trend is reflected in the growing respect among many nurse-midwives for the knowledge base of the CPM as evaluated and validated by NARM. One result is that in New York, some CNM leaders are now working to create streamlined routes for CPMs who hold baccalaureates and graduate from MEAC-accredited programs to become CMs in New York, despite their lack of hospital experience (Mary Ann Shah, personal communication, 2004). Already, several midwives who graduated from MEAC-accredited direct-entry midwifery programs in other states (including the Seattle Midwifery School and the National College of Midwifery) have had their education deemed to meet nurse-midwifery equivalency, have taken and passed the ACC exam, and have been licensed in New York.[10]

In December 2003, NARM presented its certification process and exam to the New York Board of Midwifery and the New York State Education department, which had long stated that it would consider the NARM exam as a possible route to licensure for midwives in New York state. The committee that reviewed the exam found it "to have matured and improved significantly over the years," but "still lacking in well-woman and primary care as well as pharmacology, all necessary for the NYS scope of practice" (Linda Schutt, personal communication, 2005). Having committed itself to the ACC (ACNM) exam, New York state is loath to incorporate a second exam into its licensure process.

Sharon Wells describes an irony in this story that cannot be lost. The numbers of CPMs nationwide have far outpaced the numbers of CMs over the past ten years.

> The CM and the CPM were created basically at the same time. Now there are about fifty CMs and over 1,000 CPMs. As of September 2005, the CPM process is used as part of the regulatory process in twenty-one states. The number of CMs is quite small compared to this growing number of CPMs. In fact, I do not see how an institution of higher education can continue to support a degree that produces so few graduates. On the other hand, the CPM is steadily increasing and now with the recently published Johnson-Daviss [2005] journal article documenting homebirth outcomes, out-of-hospital birth with a CPM has been shown to be a safe option. (Sharon Wells, personal communication, 2005)

THE SITUATION IN NEW YORK TODAY

The health care system in New York City continues to hold national significance. In the 2002–2003 academic year, 14.8 percent of our nation's medical residents and 14.3 percent of the obstetrical residents nationwide were trained in New York state, the majority within the New York City hospital system, even though New York state represents only six percent of the population nationwide. This large concentration of medical residents is a major source of health-care dollars from the federal government, which helps keep the New York City hospital system afloat (Physician Workforce Studies Unit, Center for Health Workforce Studies, SUNY Albany, personal communication, 2004).

New York City in particular depends on medical residents to provide care to the underserved. There is a financial incentive for the hospitals to have as many residents as possible; for example, in downstate New York, hospitals are given a $150,000 premium for each obstetrical resident. This situation is complicated by recent changes in state regulations limiting the number of hours a resident may work. The midwifery services within the city's hospital system, some at large teaching hospitals, have been players in health-care politics and compete toe to toe with obstetrical residents for space, money, and clients, as well as with nursing for funding. "Where once there were no residents, now residents compete with midwives for the deliveries. Throughout the system in New York City midwives are asked to work longer hours, for less pay and with less support," stated a nurse-midwife who works at a long-established midwifery service.

Over 1,000 CNMs/CMs (in 2005) hold a New York state midwifery license. Foreign-trained and other midwives can apply for licensure and furnish their academic credentials to the New York State Education Department Office of Comparable Education to be screened for equivalency.

Despite a growing trend among nurse-midwives toward employment with physician groups, in 1997, thirty-two percent of New York state licensed midwives (all of whom are CNMs or CMs) were employed by hospitals. Nineteen percent reported working in a midwifery group practice, and three percent in a freestanding birth center (New York State Department of Health and the New York State Education Department 1997).[11] Throughout the state, the number of births attended by midwives has grown at a steady pace, from seven percent in 1998 to 10.66 percent in 2002 (National Center of Health Statistics 1999). But in New York City, midwifery births have declined. In 1997 nurse-midwives accounted for 12.2 percent of Big Apple births, falling to 9.7 percent in 2002 (Perez-Pena 2004). Causes for this decline include: the closing of long-standing midwifery services, reimbursement issues, changes in birth certificate information (e.g., physician signing birth certificates for midwife deliveries), hospital reorganizations, a growing liability insurance crisis involving all childbirth professionals, the competition between midwives and OB residents over normal deliveries, and high transfer rates out of midwifery services due to restrictive protocols. These collectively constitute a threat to midwives' share of normal deliveries. Recent economic pressures on city-owned hospitals and the Health and Hospital Corporation of New York (previously the Department of Hospitals) have placed some midwifery services at risk.

The Elizabeth Seton Childbearing Center, a freestanding birthing center associated with St. Vincent Catholic Medical Center (previously known as the Maternity Center Association Childbearing Center) has shut down. This leaves only two freestanding birth centers operating in New York City—Morris Heights Childbearing Center in the Bronx and the Brooklyn Birth Center. In nearby New Jersey, the only three independent birthing centers run by midwives have also closed. In all cases, drastic rises in malpractice insurance have been cited as the reason for the closings. The popular September Hill Birth Center near Ithaca, New York, also closed, leaving upstate New York without a freestanding birth center. Midwife Lonnie Morris, who attended more than 7,000 births in twenty years, shut Englewood New Jersey Birth Center after her malpractice rates jumped from $30,000 to $300,000 a year. She simply stated, "I couldn't pay my bills" (personal communication, 2004). The Columbia/Presbyterian Midwifery team at the Allen Pavilion Hospital, considered a mainstay of New York City midwifery services along with North Central Bronx, has become greatly restricted in its labor and delivery service, presently doing very few births. This development has been a sore point for New York City midwives, as the midwifery service at Columbia/Presbyterian Hospital in New York City

was the first New York hospital to permit a nurse-midwifery delivery (in 1955 on an experimental basis).

As elsewhere, rising professional liability insurance rates, low payment rates, and the difficulty of being included in managed care panels have become major obstacles in carrying out the dream of an independent midwifery in New York state. When Medical Liability Mutual Insurance Company (MLMIC), the primary insurance carrier for obstetricians and nurse-midwives in New York, was denied a sixty-one percent policy rate increase and was offered only a ten percent increase for Licensed Midwives by the New York Insurance Department, MLMIC informed New York Licensed Midwives that new applications for coverage would be denied and that existing policies would not be renewed. MLMIC will continue to provide policies to hospitals that employ midwives, but not to private physicians who employ midwives (personal communication from New York Friends of Midwives 2004). TIG Insurance Company, underwriter for ACNM's malpractice insurance, announced that it would no longer accept new applications and would not renew policies after June 30, 2003 (letter from Kathleen McMahon CNM to Gregory Serio, New York State Insurance Department). The new malpractice carrier for ACNM, Contemporary Insurance Services, is placing high prices on individual midwives, with yearly policies starting at $16,000 and annually rising incrementally to $25,000 in the fourth year.

In New York state the trend toward group practice and shared liability is particularly strong. The parameters of clinical decision-making and practice guidelines have become the purview of the physician group, as opposed to the individual clinician. As a result, the rise in group practice has made the tradition-bound profession of medicine all the more conservative. Solo practitioners, particularly those with untraditional, innovative practices (the very practitioners most likely to support homebirth) are increasingly the targets of state investigations in New York.

The statutory requirement of a written practice agreement with a physician (the compromise made by nurse-midwives with the New York Medical Association in order to achieve the right to create licensed direct-entry midwifery in New York) presents a powerful barrier to independent practice, including homebirth, by licensed midwives in New York, as well as in other states. (Unlicensed direct-entry homebirth midwives practiced without formal practice agreements in New York, although most had informal arrangements with physicians.) Few physicians are willing to enter into formal practice agreements involving homebirths or independent midwifery practice, and even those few

who are privately supportive find themselves hindered by the realities of professional politics and economics, including ACOG's anti-home-birth stance, which makes professional marginalization a likely end for any physician who enters into a practice agreement with a midwife who practices independently and/or delivers in the home—legal or illegal. Family practice physicians who practice obstetrics risk losing referral arrangements with obstetricians if they enter into such arrangements. Thus, although many New York CNMs have expressed to us that they would prefer to practice independently and attend births at home, by 2005 only about twenty licensed midwives (out of 1000+) have been able to obtain the requisite agreements with physicians.

Just as New York midwives find it difficult to attend homebirths, so women who wish to birth at home find it difficult to find a midwife since passage of the midwifery legislation. Carolyn Keefe, a childbirth activist representing New York Friends of Midwives (NYFOM), reports that "consumers and midwives who move into most of New York state are pretty stunned at how hard it can be to find homebirth services and at the ways the law impedes access to those services" (personal communication, 2004). Keefe goes on to state:

> Midwifery in New York state remains at the mercy of the medical profession. In most cases, it is the doctor who decides the midwife's scope of practice. Midwives are dependent on the individual doctor's recognition of midwifery's value—whether medical, philosophical, or economic. . . . As long as the written practice agreement is in place that will continue to be the case. It makes midwives reluctant to challenge the obstetrical community and organization.
>
> It's also important to note that a concentrated effort by medical and obstetric organizations to eliminate midwifery in New York state would be frighteningly easy. By putting pressure on physicians and hospitals, most, if not all, of the written practice agreements could easily be pulled and access to midwifery in New York state all but eliminated. This state regulated midwives nearly out of existence once and could do so all too easily again, this time using liability insurance as an excuse. That's one of my fears as a consumer advocate, and I fear that the lack of consciousness about this risk allows midwives to remain divided.

Nurse-midwives nationwide share the barriers to practice described above. However, in New York it is significant that the unique legislation granting the profession its own board and its own professional oversight

has not served to insulate nurse-midwives from these barriers. The legislation has not provided any special protection or power, nor has it improved the ability of New York licensed midwives to establish independent practices. Additionally, the large midwifery services within the New York City hospital system, long a source of great pride for New York midwives, have become particularly vulnerable to the systemic shake-up occurring at this time within the American health care system. New York licensed midwives have organized a statewide association to begin to take on these barriers to practice and to initiate reform initiatives—the New York State Association of Licensed Midwives (NYSALM) (www.nysalm.org).

CONCLUSION: "WE'RE ALL *MIDWIVES* NOW"

Nurse-midwifery as we know it today, particularly in New York state, has its roots in the intersection of significant historical trends that culminated in the shift from home to hospital birth and the elimination of the traditional midwife. As we have seen, the profession grounded its beginning in the rise of the modern health care system and has developed a professional culture characterized by pragmatism, flexibility, and resilience, all of which have allowed it to survive within a medical model of care often at odds with the midwifery model. Our analysis of this culture has been informed by James Scott's (1985, 1990) analysis of "everyday acts of resistance" by subordinated classes against powerful dominating forces. It is both too easy and inaccurate to view the seeming acquiescence and daily conformity of the CNM to obstetrical domination of childbirth as representing "false consciousness" (identification with one's dominator). The goal of the profession nationwide is to practice midwifery to the greatest extent possible under obstetrical and nursing regulatory authority. Symbolic conformity to some obstetrical norms, what Scott (1985) would call a "mask of compliance," often shapes a strategy for resistance. Core values of the profession—avoidance of open confrontation, patience, flexibility, and negotiation—characterize this mask of compliance with its everyday acts of resistance. Although the New York CNMs did not gain everything they had hoped for with the passage of their legislation, it can be understood from their standpoint as a pragmatic series of giant steps toward survival and a still-hoped-for clinical independence from obstetrics.

The legislative success of New York state CNMs in achieving their goals through pragmatism, strategy, and negotiation, along with the failure of the homebirth direct-entry midwives to be included in the

law, is the essence of the story we have told in this chapter. In temporal terms, this discussion is moot: ACNM-certified midwives (CNMs and CMs) are solidly established in New York state and other kinds of midwives are not. The licensed midwives practicing in New York are now regulated by their own Board of Midwifery and they have created a new kind of culture around their inclusion of the CM, dropping the term nurse-midwife in most circumstances and insisting that in New York, "we're all *midwives* now." The gains that have been made, the uniqueness of the midwifery services within the city's hospital system, and the numerous women in many walks of life that are served by the city's midwives, constitute a source of deep pride among nurse-midwives.

New York's direct-entry homebirth midwives, proud of their entrepreneurial spirit and independence from the obstetrical profession, turned their defeat in New York and their idealism, now tempered by a hard-learned pragmatism, into a new national certification. The giant steps they have recently taken toward achieving legitimacy while remaining autonomous are described in chapter 3.

TIMELINE OF EVENTS IN NEW YORK MIDWIFERY

1906 New York City midwives are studied by the Public Health Commission of the Association of Neighborhood Workers. Its report paints a negative picture of New York City's traditional midwives.

1907 New York state changes the state Sanitation Code to establish regulations for midwives under the State Health Department. New York City midwives are regulated and given permits to practice by the City's Health Department.

1912 The concept of nurse-midwifery is publicly articulated for the first time by Clara Noyes, a New York nurse educator, at the International Congress of Hygiene and Demography.

1914 Dr. Fred Taussig, at the annual meeting of the National Organization of Public Health Nurses, endorses the concept of establishing schools of midwifery limited to "graduate nurses."

1917 The Women's City Club of New York City establishes the Maternity Center Project, providing prenatal care to 2,400 women in its first year of operation.

1918 The Maternity Center Association is established, its goal to set up neighborhood clinics bringing "every pregnant mother . . . under medical and nursing supervision." In 1921, the Maternity Center Project is turned over to the MCA.

1931 A nurse-midwifery educational program, the Lobenstine Clinic and School of Midwifery (affiliated with MCA) opens its doors.

1941 New York City's Midwifery Board eliminates itself, citing a lack of granny midwives to regulate. In 1934, granny midwives held 1,997 permits. Within five years, they held only 270 permits and their numbers continued to dwindle. The number of nurse-midwives did not make up for the losses. For decades, professional recognition and clinical positions remain almost nonexistent. In 1962, only twenty-one nurse-midwives hold a permit to practice in New York City.

1958 MCA's School of Nurse-Midwifery moves to Kings County Hospital in Brooklyn (precursor to SUNY Downstate) becoming the first hospital-based nurse-midwifery educational program.

1959 New York City's Health Code is amended, making both RN licensure and nurse-midwifery certification requirements for obtaining a midwife permit.

1970 The Maternal and Infant Care Project of New York City (part of the federal public health campaign aimed at improving infant mortality rates, arising out of Social Security Act of 1963) establishes the first hospital-based nurse-midwifery service in New York at Delafield Hospital's Obstetrics and Family Practice Center with permission to attend births at Columbia/Presbyterian Hospital.

1975 The first urban freestanding birth center is opened in New York City by the Maternity Center Association (MCA).

1982 Legislative campaign begins to pass what ultimately becomes the Midwifery Practice Act.

1992 The Professional Midwifery Practice Act passes the New York House and Senate and becomes law.

1994 The New York Board of Midwifery is formed. Licenses to practice midwifery issued to 450 CNMs who held permits under the old law. Nurse-midwifery-attended births are at eight percent in New York state, having increased from four percent in 1981. Twelve DEMs apply for state licensure and are denied ten months later.

1995 ACC/ACNM choose Certified Midwife as the title for the new ACC-certified direct-entry midwife. Thirteen DEMs apply for state licensure and are denied. Cease-and-desist orders sent to approximately ten unlicensed homebirth DEMs.

1996 SUNY Downstate's direct-entry educational program initiated. Linda Schutt CPM becomes the first CM.
1997 ACNM gives full voting privileges to CMs.
2000 The New York State Association of Licensed Midwives (NYSALM) is formed. (www.nysalm.org)
2003 NARM process and exam evaluated by New York State Education Department, but not accepted for New York.
2005 Over 1,000 CNMs and around fifty CMs hold New York state midwifery licenses.

ACKNOWLEDGMENTS

First and foremost, we thank our New York interviewees for the time they spent with us, patiently answering our questions and forthrightly explaining their actions and points of view. We also express deep appreciation for their comments and helpful edits on this chapter to Anne Frye, Kathy Carr, Carolyn Keefe, Dorothea Lang, Ronnie Lichtman, Elaine Mielcarski, Carol Nelson, Judith Rooks, Barbara Katz Rothman, Hilary Schlinger, Linda Schutt, Nancy Villa, Richard Waldman, Deanne Williams, and Raymond DeVries.

Maureen's personal acknowledgment: I dedicate this work to my two men (my husband and son). They put up with me these seven years while I, together with Robbie, gave birth to this postdates baby—the New York chapter.

ENDNOTES

1. When we speak of hospital-based midwifery services, we are referring to midwifery services that are distinct from traditional labor and delivery services, administered by a Midwifery Service Director and where nurse-midwives are salaried by the hospital or by the Ob/gyn department faculty practice, to work in its midwifery service. In New York state these midwifery services are mainly found in New York City. Outside of New York City there are only several such services in New York state. Most New York-licensed midwives are employed by an Ob/gyn physician group and attend hospital births in this capacity.
2. Lilian Wald, an RN, public health nurse and personal friend to some of the earliest nurse-midwives, was one of the movers and shakers in the settlement house movement, establishing the Henry St. Settlement House in New York City.
3. During the 1930s and 1940s, several other nurse-midwifery schools and services were established in other states. In 1939, the Frontier Nursing Service established the Frontier Graduate School of Nurse-Midwifery in Hyden, Kentucky. In 1941, the Alabama Department of Health established a nurse-midwifery educational program at Tuskegee College as well as a homebirth service demonstration project. The Tuskegee project closed after only five years, but its demonstration of the ability of trained midwives to significantly decrease maternal infant mortality rates in rural Alabama within

a short period of time made its mark on the history of nurse-midwifery. In 1943, the Medical Mission Sisters established a nurse-midwifery service in Santa Fe, New Mexico, and in 1944 a nurse-midwifery educational program, the Catholic Maternity Institute, began at this service. Through its affiliation with the Catholic University of America, the Catholic Maternity Institute in Santa Fe became the first nurse-midwifery school to grant a university degree (Corbin 1959).

4. By statute, nurse-practitioners in New York state are licensed as nurses and also receive an additional license to practice their advanced nursing specialty (i.e., Adult Nurse Practitioner, Pediatric Nurse Practitioner, Family Health Nurse-Practitioners, Women's Health Nurse-Practitioner, Ob-Gyn Nurse Practitioner, etc.). The Board of Nursing within the New York State Education Department governs them.
5. Other models for regulatory governance of nurse-midwifery are as follows: Utah has a Board of Nurse-Midwifery but has no means for incorporating direct-entry midwifery under its jurisdiction. New Jersey has incorporated the ACC-credentialed Certified Midwife under its Board of Nursing but has not granted the CM prescriptive authority. CNMs in Rhode Island, New Mexico, Connecticut, and American Samoa are licensed under their Boards of Health. Illinois has an Advanced Practice Nursing Board with jurisdiction over all advanced practice nursing, including nurse-midwifery. CNMs in the remaining states practice within the purview of a combination of models—Boards of Nursing, Boards of Medicine, Joint Boards of Medicine and Nursing, Boards of Public Health. In a direct effort to avoid the turf battles in New York, midwives in Massachusetts are proposing legislation that would also establish a Board of Midwifery, this time including CNMs, CMs, and CPMs (see chapter 9).
6. It is not difficult to understand why the possibility of a separate licensing process in New York state would present a threat to the ACNM. Nationwide credentialing has provided a stabilizing effect on the profession and aided its growth. Another example lies in nursing. Nationwide reciprocity for RNs has existed only since 1978 with establishment of the NCSBN (National Council of State Boards of Nursing), which then instituted a national nursing exam, the National Council Licensure Examination (NCLEX), and became recognized as the national testing agency for the nursing profession. In the 1980s, a move by the California Board of Registered Nursing to establish its own licensing exam was taken seriously as a threat to the entire nursing profession and was prevented.
7. Graduations of direct-entry students from SUNY Downstate by year are as follows: 1997, four; 1998, four; 2000, four; 2001, four; 2002, two; 2003, five; 2004, six; 2005, four. Total: thirty-three graduates (an average of four per year), all of whom have been certified as CMs. (Ronnie Lichtman, personal communication, 2005)
8. Nurse-midwifery in New Hampshire, as in most states, comes under the jurisdiction of the Board of Nursing. The apprenticeship-trained midwives practiced without legal recognition until the early 1980s, when New Hampshire passed legislation providing voluntary certification for direct-entry, homebirth midwives. The statute established requirements for certification and a process for certification through a state exam. The statute gave the title of Certified Midwife to those midwives who became certified by the state through this process. In 1990, two years prior to the 1992 New York midwifery legislation, the New Hampshire Midwives Association (NHMA) registered (state trademarked) the title of Certified Midwife with New Hampshire's Secretary of State as "owned by the New Hampshire Midwives Association (NHMA)."

   Following the passage of the New York midwifery legislation and the change of ACNM bylaws recognizing the ACC-certified CM as eligible for membership in the ACNM, the ACNM federally trademarked the title Certified Midwife. Mary Ann

Shah, then President of ACNM, sent a cease-and-desist letter to the New Hampshire Midwives Association warning them to stop using the title or face legal action. New Hampshire's Attorney General ruled that the federal trademark of the CM title held no legal validity in New Hampshire. In order to differentiate themselves, the New Hampshire direct-entry midwives began calling themselves New Hampshire Certified Midwives (NHCM). In 1999 a second midwifery statute passed the New Hampshire legislature further regulating direct-entry midwifery. This second statute mandated CM licensure for direct-entry, homebirth midwives. It established a Board of Midwifery, which would oversee the practice of state-licensed Certified Midwives. Further, the statue makes the NARM exam the certification exam for New Hampshire Certified Midwives. Despite the threats of the ACNM, the statute did not change the title of Certified Midwife. One midwifery leader in New Hampshire stated, "We could have chosen to change the title from Certified Midwife to Certified Professional Midwife at that time . . . but we had been practicing under the title Certified Midwife since 1980 and we didn't want to give it up. We wanted the historical continuity that the title gives us here in New Hampshire. It's what we have been called, and called ourselves, for so many years."

In an extreme irony, an ACC-certified CM from New York applied for licensure in New Hampshire. New Hampshire's Attorney General has ruled that any ACC credentialed CM, in order to obtain a license to practice midwifery in New Hampshire, must first take the CPM exam and then apply to the Board of Midwifery as a CPM for CM state licensure.

9. As an example, in Texas a law beneficial to DEMs was defeated by CNMs because of failed communications between the two groups resulting directly from the mistrust engendered by the New York situation. In Ohio, a bill revising nurse-midwifery regulation, which would have made direct-entry midwifery illegal, was changed only through the efforts of direct-entry midwives. In Utah and Tennessee, legislative efforts by DEMs to become legal were fought by local CNMs. Nevertheless, DEM legislation was successfully passed in both states.
10. As of February 2005, there were forty-eight CMs: twenty-nine graduates of SUNY Downstate, two graduates of other DOA-accredited programs, and twenty graduates of programs not accredited by the ACNM (some of these are foreign-trained and some are graduates of MEAC-accredited schools). The breakdown of the CMs who did not graduate from SUNY Downstate is as follows. One CM, who had previously practiced as an unlicensed direct-entry midwife and a PA, graduated from a DOA-accredited direct-entry track created especially for her by the nurse-midwifery program at the Baystate Medical Center in Springfield, Massachusetts. She remains the only direct-entry graduate of this program, although other PAs could apply. Another CM graduated from the now-defunct EPA program in California. Of the twenty CMs who graduated from midwifery schools not accredited by the ACNM, two were educated in the United Kingdom, and one each in the Netherlands, Peru, Chile, and Iran. At least five graduated from MEAC-accredited programs: one from Seattle Midwifery School; three from the National College of Midwifery; and one from the naturopathic midwifery program at Bastyr University. One is a PA in Washington state. On the other seven, we could find no information. (Our thanks to Ronnie Lichtman, Director of the SUNY Downstate program, for much of this information.)
11. These figures represent midwives throughout the state and are not broken down by regions. Because there are few hospital-based midwifery services outside of New York City, the percentage of New York City midwives who work within one of the city's midwifery services is most likely greater than shown by these numbers.

REFERENCES

American College of Nurse-Midwives. 1987. *What Is A Nurse-Midwife?* (Brochure). Washington, D.C.: American College of Nurse-Midwives.

American College of Nurse-Midwives. Chapter Minutes; ACNM Region II, Chapter 1 (June 22, 1998):22.

Benoit, Cecilia, Robbie Davis-Floyd, Edwin van Teijlingen, Sirpa Wrede, Jane Sandall, and Janneli Miller. 2001. "Designing Midwives: A Transnational Comparison of Educational Models." In *Birth by Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe*, ed. Raymond DeVries, Edwin van Teijlingen, Sirpa Wrede, and Cecilia Benoit, 139–165. New York: Routledge.

Burst, Helen V. 1978. "Our Three-Ring Circus." *Journal of Nurse-Midwifery* XXIII(fall):11–14.

Corbin, Hazel. 1959. "Historical Development of Nurse-Midwifery in this Country and Present Trends." *Bulletin of the American College of Nurse-Midwifery* 4(1):13–26.

Cuddihy, Nancy R. 1984. "On Nurse-Midwifery Legislation." *Journal of Nurse-Midwifery 29*(2): 55–56.

Davis-Floyd, Robbie. 1998. "The Ups, Downs and Interlinkages of Nurse- and Direct-Entry Midwifery: Status, Practice and Education." In *Paths to Becoming a Midwife: Getting an Education*, ed. Jan Tritten and Joel Southern. Eugene, OR: Midwifery Today, Inc.

Davis-Floyd, Robbie, and Gloria St. John. 1998. *From Doctor to Healer: The Transformative Journey.* New Brunswick, NJ: Rutgers University Press.

DeVries, Raymond. 2005. "A Pleasing Birth." In *Dutch Maternity Care and the Cultured Science of Obstetrics.* Philadelphia, PA: Temple University Press.

DeVries, Raymond, Edwin van Teijlingen, Sirpa Wrede, and Cecilia Benoit, eds. 2001. *Birth by Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe.* New York: Routledge Press.

Dye, Nancy Schrom. 1987. "Modern Obstetrics and Working-Class Women: The New York Midwife Dispensary, 1890–1920." *Journal of Social History,* 20 (spring 1987):549–564.

Fiedler, Dolores E. 1971. "Cut the Cord." *Journal of Nurse-Midwifery* 18(3):3.

Harris, David, Edwin F. Daily, and Dorothea M. Lang. 1971. "Nurse-Midwifery in New York City." *American Journal of Public Health* 61(1): 64–77.

Hellman, Louis H. 1967. "Nurse-Midwifery in the United States." *Obstetrics and Gynecology* 30(6):883–888.

———. 1971. "Nurse-Midwifery: Fifteen Years." *Bulletin of the American College of Nurse-Midwives* XXI(3):71–79.

———. 1972. "Challenges for Nurse-Midwifery in the Seventies." In *New Horizons in Midwifery.* Proceedings of the Sixteenth Triennial Congress of the International Confederation of Midwives, October 28–November 3, 1972, Washington, D.C., ed. Alice M. Forman, Susan H. Fischman, and Lucille Woodville. London: The International Confederation of Midwives.

Hemschemeyer, Hattie. 1962. "Our 30th Anniversary—A Tribute." *Bulletin of the American College of Nurse-Midwifery* VII(1):5–14.

Howard, Esme J. 1994. *Navigating the Stormy Sea: The Maternity Center Association and the Development of Prenatal Care 1900–1930.* Master's thesis, Yale University School of Nursing.

Gaskin, Ina May. 1978. *Spiritual Midwifery.* Summertown, TN: The Book Publishing Company.

———. 2003. *Ina May's Guide to Childbirth.* New York: Bantam.

Johnson, Kenneth C. and Betty Anne Daviss. 2005."Outcomes of Planned Home Births with Certified Professional Midwives: Large Prospective Study in North America.." *British Medical Journal* 330(7505): 1416, June. www.bmj.com.

Kobrin, Frances E. 1966. "The American Midwife Controversy: A Crisis of Professionalization." *The Bulletin of the History of Medicine* 40(4):350–363.

Lang, Dorothea. 1977. "The American College of Nurse-Midwives; What Is the future for Certified Nurse-Midwives in Hospitals? Childbearing Centers? Homebirths?" In *21st Century Obstetrics Now.* Vol. 1. published by the National Association of Parents and Professionals for Safe Alternatives in Childbirth.

Lesser, Arthur J. 1972. "Issues in Planning for Better Maternity Services in the United States." In *New Horizons in Midwifery.* Proceedings of the Sixteenth Triennial Congress of the International Confederation of Midwives October 28–November 3, 1972, Washington, D.C., ed. Alice M. Forman, Susan H. Fischman, and Lucille Woodville. London: The International Confederation of Midwives.

Litoff, Judy Barrett. 1978. *American Midwives. 1860 to the Present.* Westport, CT: Greenwood Press.

May, Maureen. 1999. "Midwifery in New York State: Identity, Power and Politics." Paper presented at the Annual Meetings of the American Anthropological Association, Chicago, Illinois, in the session "Daughters of Time: The Shifting Identities of Postmodern Midwives," organized by Robbie Davis-Floyd and Sheila Cosminsky.

National Center for Health Statistics. 1999. *National Vital Statistics Reports.* Volume 47, Number 27 (December 2).

New York State Department of Health and the New York State Education Department. 1997. *Professional Midwifery Preparation and Practice in New York State* (July).

Perez-Pena, Richard. 2004. "Use of Midwives, a Childbirth Phenomenon, Fades in City." *New York Times.* March 15, 2004.

Pew Health Professions Commission. 1995. *Pew Commission Report on Reform of the Health Professions.* San Francisco: UCSF Center for the Health Professions.

———. 1999. *Charting a Course for the 21st Century. The Future of Midwifery.* San Francisco: UCSF Center for the Health Professions.

Reagan, Leslie J. 1995. "Linking Midwives and Abortion in the Progressive Era." *The Bulletin of the History of Medicine* 69:569–598.

Redman, Annie. 1997. "Professional Midwifery Practice Act of New York, 1992: A Case Study of Nurse-Midwifery Politics." Master's thesis, Yale University School of Nursing.

Roberts, Joyce Roberts. 1996. "The Certification of Non-nurse-midwives by the American College of Nurse-Midwives." *Journal of Nurse-Midwifery* 41(1):1–2.

Rooks, Judith. 1997. *Midwifery and Childbirth in America.* Philadelphia, PA: Temple University Press.

Rosenthal, Elisabeth. 1997. "To Pay New York Hospitals Not to Train Doctors, Easing Glut." *New York Times.* February 1, 1997.

Scoggin, Janet C. 1996. "How Nurse-Midwives Define Themselves in Relation to Nursing, Medicine, and Midwifery." *Journal of Nurse-Midwifery* 41(1): 36–42.

Scott, James C. 1985. *Weapons of the Weak. Everyday Forms of Peasant Resistance.* New Haven, CT: Yale University Press.

———. 1990. *Domination and the Arts of Resistance: Hidden Transcripts.* New Haven, CT: Yale University Press.

Shoemaker, M. Theophane, Sr. 1947. *History of Nurse-Midwifery in the United States.* Washington, D.C.: Catholic University Press.

Stevens, Anne A. 1918. "An Experiment in Maternity Protection: Report of the Work of the Maternity Center of the Women's City Club of New York City." Unpublished paper Presented at the Biannual Meeting of the National Nurses Association. Cleveland, Ohio, May 1918. WCCNY microfilm, reel 20, frames 205–207.

———. 1918. "The Work of the Maternity Center Association." Transactions, 10th Annual Meeting, American Child Hygiene Association, November 11–13, 1919, Asheville, NC (WCCNY microfilm reel 20, frames 209–231).

Weisl, Bernard A.G. 1964. "The Nurse-Midwife and the New York City Health Code." *Bulletin of the American College of Nurse-Midwifery* IX(1):8–14.

Wells, Sharon. 1992. "The New York Legislative Sellout." *Birth Gazette* 8(4):32–33.

Wolfe, Leanna. 1982. *Giving Birth in New York City. A Guide to Childbirth Options*. New York: New York Public Interest Research Group, Inc. (NYPIRG).

Women's City Club of New York. 1917. Bulletin published by the Women's City Club of New York, vol. 1, no. 6 (October).

———. 1919. *Summary of the First Year's Work. Preliminary report to Club Members on the Maternity Center. From its opening September 15, 1917 to October 1, 1918.* New York: Women's City Club of New York, February.

———. 1920. *Our Hopes Justified.* New York: Women's City Club of New York.

Fig. 2.1 Maternity Center Association's National Office and home of the MCA Childbearing Center from 1952 to 1996. Photo from the MCA archives.

Fig. 2.2 Dorothea Lang and Elaine Mielcarski, 1997. Photographer: Robbie Davis-Floyd

Fig. 2.2 Dorothea Lang and Elaine Mielcarski, 1997. Photographer: Robbie Davis-Floyd

Fig. 2.3 Linda Schutt, the first CM, flanked left to right by ACNM Chief Executive Officer Deanne Williams and President Joyce Roberts, 1997. Photographer: Robbie Davis-Floyd