

TYPES OF MIDWIFERY TRAINING: AN ANTHROPOLOGICAL OVERVIEW

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Potential midwives reading this book will want help in picking their educational path. Hoping to be of assistance, I offer the following brief overview. (More thorough and detailed overviews can be found in Frye 1995: 22-26 and Rooks 1997:164-178, 258-268). As I worked on this overview, I found it extremely difficult to make any kind of generalization that I could be sure was true. The differences between types of midwifery training are no longer easy to define: what I witnessed as I talked to midwives about this article was what anthropologists might call an *elision* between models of midwifery training (to elide in linguistics means "to slur over in pronunciation"). As you will see below, these models are increasingly blurring into each other.

The only hard and fast distinction I can make is the one between programs accredited by the ACNM's Division of Accreditation (DOA) and programs accredited by MANA's affiliate, the Midwifery Education and Accreditation Council (MEAC). In terms of experience and longevity, these two are not appropriately comparable: the DOA (under various names) has been in operation since 1957. During that time, it has accredited well over 50 nurse-midwifery programs and has pre-accredited two direct-entry programs.^{1*} MEAC has been in existence only since the early 1990s; it has accredited or pre-accredited 7 programs. If comparisons are to be made, it would be fairer to compare MEAC to the DOA as it was during its first decade. But this overview is not intended as an evaluation of either the DOA or MEAC, and I need a way of organizing the programs I will compare. Accordingly, I have organized this overview into two sections based on the distinction between DOA- and MEAC-accredited programs. Where I have enough information, I present the upside and the downside of each educational route.

Some of the information I present comes from the 60 interviews I have conducted over the past 4 years with both direct-entry and nurse-midwifery students or recent graduates. I make an effort to talk with them wherever I find them--I do not pretend that my sample here is representative. I include this kind of anecdotal information to help prospective students know in advance what to watch out for, so that they can work to obtain the best education possible through their chosen route.

The background knowledge necessary for a full understanding of this overview can be found in the preceding article on "The Ups and Downs of Nurse- and Direct-Entry Midwifery: An Anthropological Perspective." In what follows, the reader's familiarity with the information presented in that article is assumed. It is important to remember that first and foremost, the aspiring midwife should look clearly at her personal and career goals, her family and financial situation, and her learning style. Having taken stock, she should then explore all the options that offer what she needs.

ACNM DOA-ACCREDITED PROGRAMS

Fifty programs accredited by the ACNM's Division of Accreditation were in operation at the end of 1996. All of them are university-affiliated or university-based, and all qualify their students to practice at a safe, beginning level, caring for women during pregnancy, birth, and the postpartum period (and now across the life cycle), and equipping them to participate in health care institutions (hospitals, birth centers, and managed care organizations) and sometimes to manage private practices. The majority of faculty in these programs must be CNMs; faculty positions can also be held by experts in a given area, including MDs, PhDs, nurse-practitioners, etc. Clinical supervision is always the responsibility of CNMs or CMs. In-hospital training is the norm. The availability and depth

of both didactic teaching about and clinical experience in out-of-hospital birth can vary considerably from program to program. Out-of-hospital clinical experience is not required for certification or for program accreditation.

Every program includes specific criteria for entrance, structured learning objectives that work to ensure that every student masters the required body of knowledge, formalized didactic instruction, clinical experience with more than one clinical instructor, and involvement of several faculty members in judgment about the student's ability to provide safe, effective beginning level midwifery care. (An update on the status and number of DOA-accredited programs is published every year in the Journal of Nurse-Midwifery. For up-to-the-minute information, contact the ACNM national office and ask to speak to staff members from the DOA.) Nurse-midwifery educators have long been leaders in educational innovation, and they continue to develop and refine creative and interactive learning and teaching methodologies.*²

While most DOA-accredited programs are well-established and solidly funded, like all academic programs some are subject to sudden budget cuts, departmental reorganizations, and streamlining procedures. It is important to research the refund policies, educational and disciplinary policies, reputation, and success rate of a school thoroughly before enrolling. Talk to enrolled students and graduates. Are they receiving or did they get what they expected? Are they happy with their education? Were all policies, fees, and expectations disclosed to them?

University-Based Programs

Upside: This kind of training is in alignment with the values, beliefs, and status consciousness of mainstream society; it is culturally thought of as the bottom line for white-collar professions. As a socially valued educational pathway, it carries concomitant benefits, including social recognition and prestige, easy access to government loans, and straightforward routes to advanced degrees, which bring prestige and salary raises and empower their recipients to teach, to start new programs, to effect changes in legislation, and to carry out research on client needs and various aspects of midwifery care. (In general, the higher the level of university training of a group of professionals, the higher the social prestige of the entire profession.) Being present on a university campus enables students to learn about and participate in a wide variety of learning experiences and gives them access to excellent libraries and other resources. University students have the opportunity to gain a liberal arts base in disciplines designed to expose the student to different points of view and ways of understanding the world, including the humanities, psychology, sociology, and the basic sciences, with the ultimate goal of making the student a “well-rounded” person.

While didactic learning is usually primary in universities, midwifery training, like training in other health care professions, always includes some form of preceptorship, in which students are exposed to one-on-one experiential learning with more than one preceptor. Because the clinical parts of university-based midwifery training are mostly carried out in hospitals (some university programs make an effort to provide their students with some—albeit limited—out-of-hospital experience), students also are exposed to and develop expertise in dealing with individuals of diverse sociocultural and economic backgrounds, a wide range of birth complications and unusual health conditions, and the latest and newest in medical technologies. Educators generally work with students to help them develop a critical sense of which technologies have efficacy, under which circumstances, and which ones do not. (The only currently operating DOA-accredited direct-entry program is university-based, at the SUNY-Brooklyn Health Science Center in New York City (aka SUNY downstate).)

I have interviewed students from university-based programs across the country, including New York University and Columbia University in New York, the University of Pennsylvania in Philadelphia, Case Western University in Ohio, and the University of California in San Francisco; for the most part, they rate their programs very highly, usually giving them an 8 on a 10-point scale.

Downside: The vast majority of university-based programs require that the student leave home for an extended period to attend, and almost all still require nursing training, including the fast-track programs at Yale, Columbia, and UCSF. The 30 students I have interviewed about their nurse-midwifery educational experiences were unanimous in agreeing about the downside of nursing training: it socializes them into an attitude of subordination in the medical hierarchy that they must work to overcome once they begin clinical study as midwives. It can also derail their lives and career goals: there is a strong ethic in nursing that (1) you are not really a nurse unless you

have practiced for at least 3 or 4 years, so students are expected by their nursing instructors to “put in their time” ; and that (2) you shouldn’t become a nurse-midwife without practicing as a labor and delivery nurse for several years first. The required nursing education can be completed in most programs within a year and a half, but some of the students I interviewed reported being heavily pressured to practice as nurses for an extended period before entering midwifery training. Some succumbed, some resisted, but all resented the pressure and the nursing belief that you are not well-qualified to be a midwife if you haven’t practiced as a nurse. Much less of this sort of pressure is experienced by students who enter the fast-track programs mentioned above, which are designed to make their students nurses solely so that they can become midwives; in such programs a briefer (one year) passage through nursing is the norm.

Tuitions in university-based programs range widely. Some university programs have tuitions of under \$20,000. Three students I interviewed graduated with debts in student loans of over \$100,000. More common were debts of around \$70,000. If money is a major issue, the prospective student would do well to shop around. Some students manage to go through their entire nurse-midwifery education without incurring debt. They may participate in work-study programs or work part-time, often as nurses, and apply for scholarships and grants (Cecilia Wachdorf, personal communication.)

A criticism often leveled at university training is that its standardization stifles individual creativity. I have not found this criticism to apply to the nurse-midwifery students I have interviewed. In our conversations, it was clear that they are accustomed to thinking “out of the box.” They reported that this kind of unbounded thinking is strongly encouraged by most of their teachers. Nevertheless, a very real downside to university-based nurse-midwifery education is that training offered in large cultural institutions such as universities will inevitably reflect hegemonic philosophies and practices. In the cultural realm of birth, the patriarchal medical model is hegemonic; midwifery training carried out in such institutions will inevitably incorporate many elements of a highly medicalized, patriarchal, and technocratic approach to birth. Thus, midwives will often be required to intervene in birth in ways contrary to the midwifery model in order to successfully graduate.

For example, some SNMs (student nurse-midwives) have discussed with me in interviews their distress over the unnecessary interventions they are often asked to perform. They report that they are usually able to resist cutting unnecessary episiotomies (four of my most recent interviewees had only cut one during their entire training), but that there is no way to get out of applying the other interventions that are standard in most hospitals, such as routine monitoring, labor induction and augmentation, IV administration, analgesia, etc. The early exposure to birth complications that many student midwives experience often makes them afraid of birth—a fear that can translate into overdependence on medical technologies and a lack of the confidence needed to become guardians and guides of the natural process of birth. It is important to know that the level of medicalization of nurse-midwifery education varies from program to program. Some university-based programs are highly humanistic and woman-centered in their approach; others are far more oriented toward technomedicine.

The graduates of university-based programs with whom I have spoken generally appreciate their training and value their technical skills. Some also express a fear of all the things that can go wrong at birth, note their dependence on support from other hospital personnel, and wonder how that fear and that dependence will affect their development as midwives.

Some students complained that they were ill-prepared for the private practices they tried to open because they were not taught business skills or how to deal with insurance forms and companies. Several recent grads have told me that they had tried to attend home births, but soon realized that they were totally unprepared for out-of-hospital practice. Indeed, lack of home birth training opportunities was a major complaint voiced by all of my student interviewees.

The second most serious complaint, also voiced by all my interviewees, was that during their training, their potential role as primary health care providers was heavily stressed, but upon graduation, none of them felt qualified to provide primary health care. (Some of their Instructors have told me that they shouldn’t worry: having obtained the theory and the knowledge in school, they will gain the necessary experience after graduation.) Two complained that they did not get enough practice in neonatal resuscitation and infant examinations, because those were taken care of by neonatal nurses in the hospitals where they were trained. And four complained about an

abusive instructor or preceptor. (Since faculty in such programs are continuously evaluated, it is unlikely that such situations are allowed to continue.)

Another major source of stress was reported by SNMs who enter programs in which clinical and didactic components are separated in time. About half of my interviewees were in programs in which they studied didactically for a year before gaining any clinical experience. They found this both frustrating--a further delay in their desire to practice midwifery--and "disconnected." They struggled to learn the didactics in isolation, often finding that the information made no sense in the absence of hands-on experience. Then later when they gained the hands-on experience, they had to link it back to a piece of information they had intellectually acquired over a year earlier. In group discussions between my interviewees, there was unanimous agreement that those who had been in programs in which clinical and didactic work happen in tandem from Day One had received a much more viable and rewarding training experience.

University-Affiliated Distance Learning Programs^{3*}

Upside: These programs creatively combine formalized, modular education with community-based and at-home learning. They allow the midwife to learn in evaluable components, interacting via computer (and occasionally in person) with other students and with various faculty members, and to be preceptored one-on-one by a nurse-midwife in her community. Unlike the situation in university-based training programs where each student has a variety of preceptors, the student-preceptor relationship in distance programs may be a much closer one, more like the intimate, trusting relationships developed in apprenticeship training. Such a relationship can be an extremely productive context within which to develop both midwifery skills and self-confidence. And it is often supplemented by exposure to other preceptors when the student is trained in multiple sites. Distance programs also combine some of the advantages of university-based education (social prestige and status, access to advanced degrees), with the advantages, especially for women with children or other family demands, of becoming a nurse-midwife without having to leave home for more than brief periods every year. And they are more likely to include training for out-of-hospital birth than most university-based programs.

The largest DOA-accredited distance learning program is the Community-based Nurse-midwifery Educational Program, better known as CNEP. It was specifically designed "in response to the need to prepare more nurse-midwives, to prepare nurse-midwives for practice in birth centers, and to make it easier for women living in small towns and rural areas to become CNMs" (Rooks 1997: 167). This program has been extremely successful. From its inception it tapped into a large pool of obstetrical nurses who wanted to become nurse-midwives but were not free to leave home for the necessary two years of study. For the same reasons, it has also attracted many direct-entry midwives who wanted to become CNMs. By reputation, the CNMs produced by the CNEP program acquire the same level of technical expertise as other CNMs, yet are also among the most holistically oriented and least medicalized of nurse-midwives, and tend to be very community-oriented. (For a detailed description of the CNEP program, see Rooks 1997:167-170.) I have interviewed 5 recent CNEP graduates; all were in general very happy with their learning experience (the downside exceptions are described below).

A number of other DOA-accredited programs also offer distance tracks for nurse-midwifery students; check with ACNM for up-to-date information. I have not studied these programs, and thus cannot speak to their individual pros and cons. Should DOA-accredited distance programs for direct-entry students be developed, I'm sure they will be very successful; there are many women who want to be midwives but cannot leave home to study and do not want to become nurses. (SUNY downstate has recently hired a new faculty member to develop a distance direct-entry program.)

Downside: A student's ability to enter a distance program will depend on whether she can find a CNM who practices within driving distance willing to serve as her preceptor. Should this one-on-one relationship not prove to be a compatible one, the student may have difficulties completing her training. I have been told of two incidences in which this preceptor-student relationship was extremely trying for the student; such problems seem rare.

Perhaps the major problem with distance programs is the sense of isolation students often experience--the feeling that "I am all alone with my computer." Distance students often try to organize study groups with other students within driving distance, which sometimes works and sometimes doesn't. "Nobody walks you through it,"

said one student. “Nobody spoon-feeds you the information. You’ve got to be highly motivated to do the work on your own.” (This is also true in modular university-based programs in which the students must creatively problem-solve. “Spoon-feeding” is most common in programs based around the didactic lecture format.) For those who are highly motivated, such programs can be ideal. One of my CNEP interviewees, who had no family and “really got into it,” reported that she “whizzed through” the program. But the other four reported major difficulties in staying on track. They noted that those who are not so self-disciplined, or who try to work full- or part-time as nurses, have a family life, and still complete the CNEP program, often have bouts of succumbing to panic and despair. A common reaction is to avoid the computer for days or weeks at a time. Failing to log in regularly, my interviewees reported that they fell more and more behind, then were afraid to log in and find out how far everyone else had progressed. Each one of the four thought that she was the only one who had let this happen; all were surprised to find how much company they had had without knowing it! In the end, they all “got their act together” and got through; their advice to others is to “stay in touch with total regularity” and to report and ask for help with any problems. The help is there, they said, but you have to ask for it.⁴

All five CNEP graduates reported that, as in some university-based programs discussed above, their didactic and clinical work was completely separate. The first year of study is spent on computer; none of them were allowed to begin clinical work with their preceptors until the second year. Those who were working as labor and delivery nurses didn’t mind this disjuncture so much, but those with little nursing experience, or who had not worked as nurses for some time, did find the same problems with this disjuncture that I describe above. On the other hand, there is value in working full time with a preceptor, which enables the student to offer and to learn about the importance of continuity of care, as opposed to participating in more structured university-based programs, where student’s busy schedules often do not allow them to stay the course with a given client.

Another downside of distance programs as of this writing is that all current DOA-accredited distance programs still require nursing training as a prerequisite (this will soon change). I do not have information about other potential downsides to distance programs; I have only interviewed a few CNEP graduates, who were all very happy with their education. I suggest that any students seeking to enter a particular distance program talk to a number of its graduates.

MEAC-ACCREDITED PROGRAMS

All MEAC-accredited programs qualify their students to practice at a safe, beginning level, caring for women during pregnancy, birth, and the postpartum period, and equipping them to run independent midwifery practices. Most faculty in these programs are direct-entry midwives; some are CNMs. These programs prepare direct-entry midwives primarily for out-of-hospital practice. Hospital training is available in only a few such programs; such training is generally not required for certification or for program accreditation. All comply with MEAC standards relating to midwifery philosophy, curriculum, faculty, students, facilities and resources, credit hours, student services and resources, admissions and enrollment policies, financial management, and student success in relation to mission (Mary Ann Baul, personal communication). These programs have undergone comprehensive study and peer examination, which have ascertained that the program directors have set structured learning objectives, provided services that enable students to meet those objectives, and can, in fact, show that graduates have benefited from the learning experiences provided.

Every MEAC-accredited program offers a combination of formalized didactic instruction and one-on-one clinical experience, usually with more than one clinical instructor, and involvement of several faculty members in judgment about the student’s ability to provide safe, effective midwifery care from the prenatal through the postpartum period in out-of-hospital settings. MEAC accreditation indicates that the school adheres to established criteria, policies and standards, thereby providing an assurance of quality for employers, educators, government officials, and the public (Mary Ann Baul, personal communication). (For more detailed and up-to-date information about MEAC-accredited programs, contact MEAC, 220 W. Birch, Flagstaff, AZ 86001, or electronically at amabaul@aol.com and/or see listings published annually in the MANA News.) MEAC educators are developing flexible, creative, and innovative models for on-site and distance learning that creatively combine didactic instruction and self-paced learning with apprenticeship.

One of the factors prospective students should evaluate is the financial stability and resources of the program. All accredited programs must have refund policies, and policies to finish training their enrolled students

even if the school must close. It is important to research the policies, reputation, and success rate of a program thoroughly before enrolling. Talk to enrolled students and graduates. Are they receiving or did they get what they expected? Were all policies, fees, and expectations disclosed to them? Are they happy with their education?

College- or university-based direct-entry programs:

Confounding my attempts to use “university-based” to distinguish DOA- from MEAC-accredited programs is the Miami-Dade Community College in Miami, Florida, which offers a three-year program (opened in 1996) leading to an associate in science degree in midwifery. In addition to didactic training in the basic sciences and humanities, the program includes a strong apprenticeship component. Additionally, students have access to high-tech equipment and a variety of clinical experiences in hospitals, public health facilities, birth centers, and home birth practices in Florida and at a high-volume hospital in Jamaica. Since ACNM will soon require the baccalaureate, this community college model, which combines the advantages of a college education with a deeply held commitment to independent midwifery, seems especially appropriate for replication elsewhere.

Further blurring the boundaries between DOA-accredited and other programs, Bastyr University in Seattle, Washington offers midwifery training for naturopathic physicians in a program that blends these two complementary professions. I mention it only for its uniqueness; it does not properly belong in this discussion as it has not sought MEAC accreditation, but rather is accredited by the naturopathic accrediting body.

Private midwifery schools, some of which are degree-granting:

Upside: Private schools can create and teach any model of midwifery they please, free of the hegemonic influence of technomedicine that is pervasive in university-based training. They can offer highly tailored, focused, and formalized combinations of apprenticeship and didactic training that can meet established standards and be easily and continually evaluated, while at the same time keeping their philosophy and practice holistic and woman-centered. They usually offer courses not only in clinical training but also in midwifery philosophy and the practical side of how to run a midwifery business. And, unlike one-on-one apprenticeships, students in these schools have exposure to several primary faculty members who are in teaching positions because of their demonstrated expertise, and can interact with and learn from each other. Some schools offer extensive additional training in herbs, homeopathy, and/or other forms of alternative medicine. Most educators in these schools seek to imbue their students not only with technical knowledge but also with a philosophy that stresses the importance of honoring and respecting the sacredness of women’s bodies and the ever-present spiritual dimensions of pregnancy and birth.

Two of the private schools that are MEAC-accredited or in the process of becoming so offer advanced degrees recognized by the states in which they operate: the Utah School of Midwifery in Springville, Utah, which offers the Bachelor’s and Master’s degrees; and the National College of Midwifery in Taos, New Mexico, which offers degrees all the way up to the PhD. Both of these programs have strong apprenticeship components and are extremely affordable.

Downside: Some private midwifery schools are expensive and thus out of the reach of many potential students, while others are quite affordable: the tuitions of the MEAC-accredited private schools range from \$8000 to \$22,000 (for the whole program). The expense of these private programs can be quite a lot higher than the expense incurred in an apprenticeship. Universities may be equally or more expensive, but federal loans and grants are often available to help with university tuition; such aid is generally not available to students in private programs. (It will become available if MEAC is successful in gaining Department of Education recognition [see the preceding article, endnote 35].)

Like university programs, private schools require moving from one’s home to the location of the school (unless they have a distance education element). They are often organized around the strong personalities of one or a few experienced midwives and will inevitably reflect their individual values and styles. Many private midwifery schools have an “overseas” component, which is an added expense. Like some nurse-midwifery programs, midwifery schools are continually challenged to find enough births, especially out-of-hospital births, to meet the experiential needs of students. Students may be “placed” with a midwife for an apprenticeship for a period of time. Usually this works well, because mentors are allowed to choose the students they wish to work with. I have heard

of three instances of problems between the mentor and the student involving personality conflicts or the imposition of unusual and extreme duties. Such occurrences are rare: in accredited schools all mentors and faculty are evaluated and students have opportunity for feedback and grievance procedures, so that abusive or extremely demanding relationships are not allowed to continue.

Another problem faced by private schools is the fact that taking the middle ground of combining formalized education with MANA's holistic midwifery model can subject them to criticism from both sides: (1) many in ACNM denigrate them as "trade schools" that do not guarantee the broad education that university training does; and (2) some proponents of apprenticeship training occasionally criticize them for offering a didactic approach that over-emphasizes what can go wrong and, like university-based CNM programs, can sometimes produce midwives who fear birth.

While the caveats are many, the rewards can also be great: the 7 graduates of private midwifery schools whom I have interviewed generally seem thrilled with the individualized education they have received and the holistic, woman-centered philosophy that permeates their education.

Distance learning programs (see endnote 3), which now include apprenticeship.

Distance direct-entry programs like the National College of Midwifery in Taos (which has applied for MEAC accreditation) and the two MEAC-accredited distance programs offered by the Utah School of Midwifery and the Midwifery Institute of California will no doubt form a major part of the wave of the future in direct-entry education. Whether under the aegis of MANA or the ACNM, the benefits of programs that allow student midwives to remain in their own communities are clear.

Apprenticeship

Upside: Midwifery educator Sharon Wells provides the following apt description of apprenticeship:

This student is in an experientially-based educational setting that is client-centered. This student's education is self-paced, self-motivated and community-oriented. The learning occurs within the setting of the midwifery practice and not at a separate clinical site. Most learning is experiential and/or problem solving in nature. The didactic occurs by self-study, guided study courses, or workshops. The educational focus is upon normal pregnancy, labor, delivery, postpartum and the newborn. This midwifery student learns continuity of care, counseling skills, and to trust her own intuition in addition to her midwifery skills. The length of this educational process depends upon the apprentice and the midwife, but usually lasts from two to four years. The mentor may suggest using core competencies and a skills check list if they are available. "Graduation" occurs when the senior midwife and the apprentice think the apprentice is ready to function as a midwife safely on her own. Most births occur at home.^{5*}

Apprenticeship learning involves the whole human being--body, emotions, mind, spirit-- and therefore is the most powerful form of learning there is. We all learn to be full members of our cultures through this kind of experiential learning. Pure apprenticeship learning is connection-based, as opposed to didactic learning which can seem to take place in a vacuum, with no apparent connection to anything. If the apprentice attends a birth with her mentor, for example, during which the woman hemorrhages, the apprentice will spend the next day studying every book she can find on postpartum hemorrhage and quizzing her mentor about its management. She knows, in an immediate and visceral sense, why this knowledge matters.^{6*}

Because birth turns out well most of the time, apprentices attending home and birth center births usually are not exposed early on to pathology, and have the time to build up a profound trust in process of birth and in women's ability to give birth. Their training gives them a much broader experience of the wide range "normal" birth can take when it is not technologically controlled. (See preceding article, endnote 8.) The establishment of this kind of trust can have a great deal to do with the relationship between the apprentice and her mentor. I have interviewed a number of apprentices and mentors around the country, and am always impressed by the special quality of their relationship. Most mentors care deeply about the apprentices they take on, get to know them intimately, become committed to making sure they obtain the best education possible, and work to bolster the student's trust both in birth and in herself as she learns.

To fear birth is to generate complications that result from the fear. Midwives who trust birth profoundly tend to help women give birth more effectively: to trust a woman to give birth is to help her trust herself--this is part of the magic and the great strength of apprenticeship training. Another part of that magic and strength is continuity of care. In high-volume programs, continuity of care can be very hard to achieve. But it constitutes part of the essence of apprenticeship training, where the student accompanies her mentor not only to the birth of a given client but also to every prenatal and postpartum visit. It is apprenticeship training that establishes the midwifery ideal for continuity of care, an ideal that other training programs do the best they can to emulate.

As Wells indicates above, pure apprenticeship training, which includes few didactic elements, is increasingly rare. Today's apprentices are developing experiential trust in birth and learning continuity of care in the context of semi-structured curricula that their mentors design to make sure the training meets the standards set by NARM. These curricula include a tremendous amount of reading and often involve weekly classes taught by midwives in their communities, which may be supplemented with college courses in the basic sciences and other relevant areas. Many apprentices complete their training by working in high-volume clinics in the U.S. or the Third World where they can be exposed to multiple complications of birth and can learn to deal with them effectively.

An additional benefit is that apprenticeship is both financially and geographically accessible. Women who do not have the money or the mobility to attend a private school or university-based program can still learn how to be competent practitioners and build an economically viable business to support their families while serving their communities.

Downside: Apprenticeship learning, because it is so fluid, can be hard to evaluate for efficacy. The success of the process can depend on the skills of the mentor; having just one person involved can offer opportunities for subjectivity that are reduced when several faculty have had experience with a student. Pure apprenticeship is only as excellent as the teacher and the student make it. If the learner is not motivated, the greatest teachers cannot help her. If the teacher is not a good teacher, the learner will be challenged to obtain the needed education. There is the additional risk that the learner may not be able to judge whether she is getting a quality, thorough preparation. If the student has only one mentor, and if that mentor is deficient either in knowledge, clinical judgment, skills, or the ability to interact with clients, the student can be at risk, and therefore the future clients she may serve. If the apprentice does not learn sufficient skills for entry-level practice, then moves to a different community, there may be no one to judge her competence. These are in fact some of the reasons why many direct-entry educators are working to combine apprenticeships with more didactic models.

Apprenticeships can span the spectrum from inspiring, loving mentorships to abusive, traumatic relationships. (Of course, so can clinical preceptorships within universities, much like what residents/interns go through in the last years of medical school.) Abusive student-mentor relationships should under no circumstances be allowed to continue. In a school or university setting the student will be helped to end such a relationship and will be encouraged to give feedback so that other students will not have to endure the same. Ending one-on-one apprenticeships without such institutional support can be more difficult for the student. (On the positive side, I have interviewed over 20 apprentices and many of their mentors across the country, and in general find this to be a very special and mutually nurturant relationship in which the mentor is almost always deeply committed to responsibly working with and caring for her student.) Most experienced direct-entry midwives take very seriously their obligation to mentor the students seeking to follow in their footsteps. But at present there are relatively few experienced direct-entry midwives available to serve as mentors. As their numbers increase, more student options will obviously become available. Students should know that many apprentices work with more than one mentor, sometimes traveling to live with their second mentor for extended periods, in order to ensure that they have exposure to more than one style of practice.^{7*}

Until recently, apprenticeship training in midwifery carried no certification and had no standards---in part, CPM certification was developed to address this lack. Apprenticeship training alone is in general not recognized in the technocracy as a valid educational route in most professions, although because of its unique combination of intimacy and efficacy, there is a growing trend in adult education toward re-valuing apprenticeship (aka mentorship) as a viable educational style for the 21st century.^{*8}

And as I hope all the above has made clear, there is also a growing convergence between experiential apprenticeship models and more formalized didactic midwifery education. Good luck, and don't forget to honor your sisters and their educational choices!

Endnotes

1. The two direct-entry programs I know of that have been pre-accredited by the DOA are at SUNY-Brooklyn and at Education Program Associates (EPA) in San Jose, California. Due to financial difficulties, the entire EPA program, including both its nursing and direct-entry tracks, has been closed.

2. Johnson, Peter G. and Judith T. Fullerton. "Midwifery Education Models: A Contemporary Review." Journal of Nurse-Midwifery 43 (4); Sept/Oct 1998, in press.

3. Mary Ann Baul, the Executive Secretary of MEAC, provided the following useful overview of distance learning (personal communication 1998):

Distance learning, in order to be effective, should offer a complete program, in as much depth and with the opportunity for student support as in an onsite program. It should be collaborative (that is--there should be interaction between faculty and students, and even better, interaction among different students in the program, whether real-time or time-delayed.) It should have specific learning outcomes for each course, and a way to evaluate those outcomes based on standards. Its faculty should be well-qualified as both instructors and also have training in distance learning and education technologies. There should be a strong commitment by the program to provide support for both faculty and student services. The program should have very clear expectations and guidelines, with appropriate access to needed resources. It should be evaluated as to its efficacy regularly, by students, administrators and instructors. Of course, there is no way to learn midwifery solely by distance education. There must be a very strong, highly supported and guided preceptor or mentor in the student's community in order to teach her the clinical skills required to complement the didactic learning at a distance. There are five types of distance learning, with upsides and downsides to each type. They appeal to and are successful for different types of learners. I will list them and briefly go over benefits and disadvantages.

1. Correspondence courses. These are paper-based, so they don't require a lot of technology, but students taking them rarely talk to faculty or other students. Such courses may not have deadlines, so student must be very motivated with lots of self-discipline to finish the program.
2. Mentored or directed study. Can also be paper based, or partly on computer, but student has communication with a faculty member. Usually there are fewer deadlines or scheduled interactions than in on-site programs, so again, students must be very self-directed and motivated.
3. Online education. Here, students use a variety of interactive technologies, such as logging on to a chat room, to discuss ideas and work on projects with other students, as well as doing outside reading and assignments. There are regularly scheduled times for work together and with instructors, which are very good for interaction with other students and faculty. However, this can be very time-consuming, and the technology can be challenging and complex. The student will have great need for technological support to get the work done, unless she has excellent computer skills.
4. Internet-based education. This is where the instructor speaks to the student over the Internet (like television), but then is also able to interact with the student and expect assignments within limited time periods. (SUNY-Stonybrook's entire distance program is available via the Internet.) The instructor guides the student to research on the Internet. The technology can also be intimidating to the student here.
5. Video correspondence. An instructor is taped on site giving a class. The video is sent to the distance student, along with reading and work assignments. The upside is that the student gets to see hands-on demonstrations and note how other students are reacting to the instructor. The downside is that her particular questions may not be answered.

The two distance learning types most commonly used in direct-entry midwifery education are correspondence, and directed study; online education is sure to follow. Nurse-midwifery programs like CNEP make extensive use of online education, Internet chat groups and bulletin boards, etc. Students should know that completion or success rates are higher for students who have scheduled class periods, clear assignments, and deadlines, as well as interactions with other students and teachers for support during the learning process. If distance learning encompasses these components, the student has a better chance of succeeding.

4. Researchers Carr, Fullerton, Severino, and McHugh (1996) found that the degree of dedication to the program of study, the amount of time students set aside to study, and whether or not the students had a study partner were all significant predictors of whether individuals would drop out or would complete the distance program in which they were enrolled. (Katherine C. Carr, Judith Fullerton, R. Severino, and M. Kate McHugh. 1996. Barriers to Completion of a Nurse-Midwifery Distance Education Program." Journal of Distance Education 9:111-131.)

5. Sharon Wells, "Caught in the Middle of the Maternity Care Crisis and a Political-Educational Debate," Birth Gazette, Spring 1993 9 (2):16-19.

6. Nurse-midwifery educators point out that this kind of connected learning is not unique to apprenticeship, but is a common feature of nurse-midwifery education as well. I find that it is a question of emphasis—nurse-midwifery programs stress didactic learning according to a pre-set study schedule; aside from that, the student is also free, if she has time, to study whatever she likes on her own and to discuss whatever comes up with her preceptor. Apprenticeship programs stress experiential learning according to the rhythms of individual women and individual births; didactic learning takes place away from the client and thus tends to be less immediately connected to the situation at hand. But some university-based programs utilize a case study approach, which combines experiential learning with synthesis of new information and critical thinking and analysis

7. An example of the eclectic form many contemporary apprenticeships take is provided by well-known childbirth educator and author Nancy Wainer Cohen, who underwent two years of apprenticeship training with a midwife in Boston where she lives, interspersed with periodic trips to Michigan for weeks at a time to apprentice with Valerie El Halta. Toward the end of this process, she spent 8 weeks in El Paso at Casa de Nacimiento and two weeks with Shari Daniels in Jamaica; in both places, she attended many births in short order and learned to deal with a wide range of complications.

8. An example comes from the high-tech computer industry, in which many young people without college degrees are receiving on-the-job training from mentors within a given company in specialized computer skills not taught in universities (Kate Bowland, personal communication).

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