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Delivering Quality Care: The Roles and Future of Midwives in Southern California

A Thesis Presented

by

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To the Keck Science Department

Of Claremont McKenna, Pitzer, and Scripps Colleges

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Professor Lara Deeb
Professor Gretchen Edwalds-Gilbert
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Abstract

The United States is ranked 27th in the world for maternal mortality, yet spends twice as much on maternity care services as countries with better maternal health indicators. Stuck in a technocratic and physician-dominated maternity care system, the U.S. depends on expensive technologies to control birth out of fear of pain and litigation, costing Americans billions of dollars and depriving women of the opportunity to have a transformative birth experience. Through an analysis of the medicalization of birth and the current biomedical model in birth, in conjunction with open-ended interviews with 5 hospital midwives and 3 homebirth midwives, the benefits and challenges of incorporating a midwifery model of care into our maternity services are explored. The midwifery model emphasizes that birth is not pathology and that psychosocial factors play a large role in birth outcomes. Basing their practice on collaboration, education, and support, midwives empower women, avoid unnecessary interventions, and offer a lower cost and higher quality care alternative. The current monopoly of women's health services by physicians is unsustainable. Incorporating midwives into the maternity care team could provide a sustainable alternative with the caliber of maternity care services that U.S. women and families deserve.

Definitions

American College of Nurse-Midwives: The professional organization that represents Certified Midwives and Certified Nurse-Midwives.

Certified Midwife (CM): Have a background in a health related field other than nursing and graduate from a midwifery education program accredited by Accreditation Commission for Midwifery Education (ACME).

Certified Nurse-Midwife (CNM): Registered nurses who have graduated from a nurse-midwifery education program accredited by the ACME and have passed a national certification examination to receive the professional designation of CNM.

Certified Professional Midwife (CPM): An independent midwifery practitioner that is certified by the North American Registry of Midwives (NARM). CPM requires that knowledge and experience in out-of-hospital settings.

Direct-Entry Midwife (DEM): Independent practitioner educated through self-study, apprenticeship, a midwifery school, or a college- or university-based program distinct from the discipline of nursing.

Lay Midwife: An unlicensed or uncertified midwife. All of the midwives in this investigation are certified or licensed.

Licensed Midwife (LM): A practitioner who is licensed in a particular state by that state's medical board.

Midwives Alliance of North America (MANA): Professional organization for all types of midwives. Recognizes diverse educational backgrounds and develops certification programs.

Medi-Cal: California's Medicaid program. Serves low-income families, seniors, persons with disabilities, children in foster care, and pregnant women. About 23% of California's population is enrolled.

Introduction

Support for and popularity of midwives has fluctuated throughout the ages. In Europe, midwives are now highly respected and widely used, though they suffered from various periods of persecution and witch-hunts claiming (Rooks 1997:13). Marsden Wagner, a perinatologist and perinatal epidemiologist also served as the director of Women's and Children's Health in the WHO for 15 years, identifies three main types of maternity care in the world. The first is the physician and technology dominated maternity care system in the United States, Ireland, Russia, the Czech Republic, and urban Brazil. A second model is the woman-centered approach with autonomous midwives and fewer interventions found in the Netherlands, New Zealand, and Scandinavian countries. A third hybrid model has been adopted in Britain, Canada, Japan, Germany, and Australia, which consists of a mix of these two models (2006:26).

Modern midwives in the United States fall under numerous categories: Certified Midwives (CM), Certified Professional Midwives (CPM), Direct-Entry Midwives (DEM), Lay Midwives, Licensed Midwives (LM), and Certified Nurse-Midwives (CNM). Each varies in accreditation and licensure, scope of practice, educational background, and third party reimbursement. All include in their scope of practice perinatal care, which encompasses prenatal, labor and delivery, and postpartum care for normal births. While all provide care during pregnancy, only Certified Midwives and Certified Nurse-Midwives are involved in promoting a woman's health through her lifespan, from adolescence through menopause, providing gynecologic care, family planning services, annual exams (PAP and breast), and management of sexually transmitted infections in male partners. Certified Nurse-Midwives are highly educated

health professionals, 82% have a master's degree and 4.8% have doctoral degrees (Fullerton et al. 2006, Fullerton J et al 2009).

Over 11,546 CNM/CMs are licensed to practice in the United States and account for over 93% of midwife attended-births, making up the majority of the midwife workforce ("Essential Facts about Midwives" 2011). Midwives attended 317,626 births in 2008, a record number, which represents 11.1% of all vaginal births and 7.5% of all births in the United States (Hamilton et al. 2010). According to the American Midwifery Certification Board, 96.1% of these were hospital births, 2.1% occurred in freestanding birth clinics, and 1.7% of these were homebirths ("Core Data Survey, 2010" 2011). In California there are 1,211 active Certified Nurse-Midwives and 219 Licensed Midwives, the majority of whom are Certified Professional Midwives ("Monthly Statistics" 2012). Women from a variety of ethnic backgrounds elect to use midwives. In 2008, 16.9% of midwife-attended births were Alaska Native/American Indian women, 8.1% were Hispanic, 7.0% non-Hispanic white women, 6.8% non-Hispanic Black women, and 5.9% Asian or Pacific Islander women (Martin et al. 2010).

Regardless of licensure or title all midwives share a similar philosophy of care. Care is typically woman-centric and based on the idea of partnership and collaboration. Acknowledging the importance of the woman's knowledge of her own body, midwives' attempt to provide quality care educating and empowering women to make their own, informed decisions about their bodies. They view pregnancy and birth as a profound and natural experience, and because of this they maintain a watchful eye over the natural processes, encourage women to trust their bodies, and use interventions only when necessary. Because of this philosophy, the World Health Organization believes midwives

are the best providers of care for normal pregnancies, which they estimate represent 60-80% of pregnancies (“Care in Normal Birth: a practical guide” 1996).

Research questions

1. How did the current technocratic model come to be? What are the current problems with this model?
2. What is the experience of midwives in this system in Southern California?
3. Can and how would increasing the prevalence and autonomy of midwives help create a more sustainable maternity care system?

Overview of Argument

In this thesis, I examine the current biomedical model of birth that dominates the American maternity system. By outlining the history of the medicalization of birth and the appropriation of birth by male physicians, I identify the key problems with the current American model. In Chapter 1, I outline how childbirth became medicalized as physicians became the primary birth attendants. Medicalization is the process by which nonmedical problems become defined and treated under medical supervision, usually in terms of illness or disorder. Anthropologist Brigitte Jordan coined the phrase authoritative knowledge, which identifies the information used to make decisions and take action (1997). Through the establishment of authoritative knowledge, the rhetoric of fear, and their ability to organize and create laws and standards of practice, early physicians displaced midwives. In fact, these techniques maintain physician dominance to this day. The modern Obstetrician/Gynecologists (OB/GYNs) wield technological interventions that appeal to our very basic desires: we like control, we like quick fixes, and we fear pain. These interventions will be explored in Chapter 2. The false sense of

control created by these interventions promotes the belief that a medicalized birth is a safe birth and a birth attended by a midwife or a birth outside the hospital is risky.

Because physicians have also internalized this message, they are quick to use interventions that may increase their sense of control and prevent a lawsuit, a practice called “defensive medicine” (Wagner 2006:23).

Physicians maintain their dominance through emphasizing the idea of risk and that technology can fix the flawed female body and save the woman from pain and danger. In addition, physicians have a long history of organizing, starting with the original barber-surgeon guilds. The professionalization of physician and the creation of the American Medical Association and the American Congress of Obstetricians and Gynecologists (ACOG) have given physicians a platform to campaign against “alternative” models of health care.

In Chapter 3, I explore the role of one of these “alternative” health care providers, the midwife. By examining the experiences of different types of midwives in Southern California, I examine how a midwifery model fits in to our current biomedical system. Throughout this chapter I compare the care provider by midwives and physicians and the different practices of the midwives. I argue that a midwifery model of care is a more sustainable system of women’s health care for two reasons. First, a midwifery model provides high quality care for a lower cost. Midwives, regardless of licensure type, are less specialized than physicians and therefore cheaper to employ. Also, midwives use fewer costly interventions. Second, because midwives use fewer interventions and are more likely to collaborate with women, they help empower their clients as health care users, mothers, and women. Encouraging women to become more confident and capable

could have profound implications on gender disparities in the United States, for example, by elevating the value of motherhood.

Chapter 4 outlines the challenges facing the different types of midwives, all of which correspond to the original forces used by physicians to gain control of maternity care. Although midwives could potentially represent a sustainable and positive solution to our flawed maternity care system, these challenges need to be addressed. In my conclusion, I reflect further on the experiences of my participants to provide recommendations for creating a more sustainable, empowering and higher quality maternity care system in the United States.

Motivation

My interest in birth goes back to my 5th grade sexual education class. Like most 10 year-olds, my classmates and I were terrified by the stories our older siblings had told us about the film *The Miracle of Life*, a sex ed staple at the time. To this day I am unsure if my teacher purposefully or accidentally had forgotten to rewind the tape before hitting play because that day our class had the pleasure of watching the process of birth both forwards and backwards. While my classmates cringed, shrieked, snickered, and peeped through finger-covered eyes, I stared in awe. My teacher's description of a woman's body during labor resonated in my head. "The uterus is by far the strongest muscle in the entire human body. There is nothing as strong and powerful as a laboring woman."

My reverence for the human body shaped my academic career as I studied biology, but I also felt that just a scientific perspective did not provide me the deeper understanding that I desired. I recognized that the body is more than just a collection of cells maintained by physiologic functions and decided to investigate ideas of health and

how our cultural understanding affects the way we view, treat, and value our own bodies. I was fortunate enough to study systems of public health and health promotions in Ireland and Chile where I encountered different schools of thought and different types of health professionals, including midwives. I spent the summer before my senior year I spent working in a public health clinic in Northern Chile alongside two *matronas*, or midwives, who provide full scope midwifery. At the clinic, I saw the different type of care a midwife provides compared to an Obstetrician/Gynecologist. I saw how pregnancy is viewed and treated in Chile both culturally and medically, both the good and the bad aspects of each.

Coming home from my time abroad I felt inspired to investigate my own country's treatment of women's health. What does it look like? Do we have midwives? How does it compare to the Chilean system? As a scientist, a public health enthusiast, and a feminist I took the opportunity to explore these questions through my senior thesis. Understanding the medical treatment of the human body provides deep insight into our cultural norms, values, and is arguably one of the most powerful forces of social control (Conrad 1992:213). The value of exploring the cultural treatment of pregnant women is incredible as birth happens daily and it is the process by which new social members are added to a society (Davis-Floyd 1994:1125). I believe my investigation is extremely timely as the debates about women's reproductive health by a predominantly male Congress flood the news and President Barack Obama's universal health care system goes on trial with the Supreme Court.

Research Methods

In my investigation, I partnered an extensive historical and literature review and semi-structured interviews with five Certified Nurse Midwives (CNM) and three Licensed Midwives (LM). I recruited most of my participants through contact information found online in search engines such as the Yellow Pages and through the American College of Nurse Midwives (ACNM) and Midwives Alliance of North America (MANA) professional websites. Additionally, some participants were found via snowballing and personal contacts. The Scripps College Institutional Review Board approved my methods, which uphold the basic standards of research in addition to the protections granted by the Health Insurance Portability and Accountability Act of 1996. Prior to conducting interviews, participants signed a written consent form allowing me to record and transcribe the interview. To protect both the midwives' and their patients' identities all names have been changed and locations/places of practice have been omitted.

Prior to the interviews, I formulated a list of issues I hoped to discuss with each participant. All questions were open-ended to encourage more in-depth answers. Each of the eight interviews were semi-structured, which allowed me to modify my approved question list to encourage a more natural conversation and flesh out themes brought up by participants. Six of the interviews were conducted in-person at hospitals, homes, birthing centers, and a nursing school. Two interviews were done on the telephone. Ages of the participants ranged from mid-twenties to over 70 years-of-age. All of the participants were women, six have children, six were or are currently married, and all are licensed and practicing. The midwives were diverse in personality, religion, age, and ethnicity.

In addition, as a volunteer in the Labor and Delivery Unit at a local hospital, I am very familiar with the reality of a maternity wing in a Southern Californian hospital. This observation contributes to my argument as I have firsthand experiences witnessing the dominant biomedical model. I have seen all of the procedures described in Chapter 2 carried out on laboring women. These experiences contribute to my understanding of both the technical side of pregnancy and interventions, and to the general culture of the delivery room.

Chapter 1

Fixing the “Midwife Problem”: The Professionalization of Physicians and the Medicalization of Birth

*“Whenever a doctor cannot do good, he must be kept from doing harm.”
-Hippocrates*

Reproduction in the United States is a process that has become increasingly more and more medicalized. From artificial insemination to three-dimensional ultrasounds, each stage of pregnancy has been augmented by various technologies and procedures, including the act of birth itself. The modern field of obstetrics, like other fields in biomedicine, equates technology to progress and a higher quality of care (Wagner 2006:40). However, unlike most medical specialties, maternity care, pediatrics, and geriatrics are fields that theoretically monitor normal processes for potential problems. In this chapter, I outline how physicians replaced midwives as the primary attendants at births. I argue that the exclusive access to and authoritative knowledge of technology along with the ability of the primarily male practitioners to organize, standardize, and professionalize aided in the medicalization of birth in the United States.

The Professionalization of the Physician

Since the evolutionary shift towards bipedalism in hominids approximately five million years ago, it is speculated that women have had birth attendants. Physiological changes that allowed hominids to walk on two feet also made delivery of a baby a more treacherous endeavor, making it advantageous to have a knowledgeable attendant. (Trevathan 1997:82). References to birth attendants and midwives can be found in various ancient texts, including Hindu papyri and the Old and New Testaments of the Bible (Towler and Bramall 1986:9). In Exodus, the Pharaoh of Egypt asks two midwives

to kill all male babies born to Hebrew women. The midwives tell the Pharaoh that Hebrew women deliver their babies before the midwives can arrive, so that they do not have to carry out his orders (Exodus 1:18-19). Though the role existed long before, the word “midwife” arose from Middle English in the 14th Century and literally translates to with woman, *mid* meaning with and *wif* meaning woman (Mirriam-Webster).

Prior to the 18th century men did not attend births in Europe or the United States because it was considered indecent. Instead, the sphere of birth almost exclusively belonged to female midwives (Brodsky 2008, Feldhusen 2000). In England, midwives attended the majority of births calling in the “barber surgeon” when delivering the baby was absolutely impossible. These male surgeons would remove the fetus in small pieces, via embryotomy, or by Cesarean section. As these men dealt exclusively with dead fetuses or mothers, they did not compete with midwives until the invention of forceps by Peter Chamberlain (or Chamberlen, in some texts) in 1560 and the release of forceps to the medical community in 1728 (Simonds et al. 2007:12, Northrup 1999:499). The invention of forceps proved problematic for both midwives and women. Since previously barber surgeons only were only summoned post-mortem, they were unfamiliar with normal birth processes. Yet, as the professional trained in the use of forceps, they began using them during normal labor (Northrup 1999:499, Cassidy 2006:131). The invention and proliferation of forceps in Europe during the 18th century may be the most important event in the rise of obstetrics and gynecology (Brodsky 2008). Due to rapid urbanization and the rise of rickets (skeletal deformation caused by malnutrition, which can have fatal implications in childbirth) the use of forceps became extremely common, aiding in the popularity of the barber surgeons (Simonds et al. 2007:12).

The 18th century also saw an increase in scientific knowledge regarding anatomy, physiology, and the processes of childbirth (Brodsky 2008). Additionally, the formalization of education and training for barber surgeons gave these male practitioners an advantage over the uneducated and disorganized female midwives. Barber surgeons gained influence because of the rhetoric of risk they perpetuated: that childbirth is dangerous and midwives are incompetent, rhetoric that remains dominant in today's society. By the end of the 1700s obstetrics had developed into an official medical specialty (Simonds et al. 2007:7).

Due to the sheer lack of male practitioners, midwives were able to maintain their role until industrialization in the 18th and 19th centuries, when their autonomy would be put into jeopardy (Brodsky 2008, Simonds et al. 2007). In the colonial United States, midwives were the primary caregivers for pregnant women (Rooks 1997:17). They frequently were the sole providers of health care and were highly revered in their communities and spread their knowledge via apprenticeships (Feldhusen 2000, Rooks 1997:18). The middle of the 18th century saw the development of a licensure law for physicians, the foundation of the first medical school, and the formation of two types of hospitals, voluntary hospitals (charities) and public hospitals, which were operated by the government (Feldhusen 2000). The ability of surgeons, apothecaries, and physicians to all come together under the title of "doctor" and form the American Medical Association (AMA) in 1847, allowed (and continues to allow) doctors to control and create licensure and standards of medical practice ("Timelines AMA History" 2012).

The widespread Puritan philosophy at the time prevented women from receiving an education, which allowed men to dominate the spheres of science and medicine,

creating the perception that midwives had no formal training and that physicians could provide better care than female practitioners (Feldhusen 2000). Fear continued to dominate women's thoughts about childbirth and upper-class women began to use physicians as their birth attendants (Simonds et al 2007). Attending births became essential to a successful medical practice as the physician that attended a woman's first baby frequently became the general practitioner for all of the family's health needs, which holds true today (Rooks 1997:19). In 2003, the primary reason for a woman to enter the hospital is to deliver her child (11% of all hospital stays), which may determine practitioner preference in the future (Merrill and Steiner 2006).

The industrial revolution of the mid-18th century caused a migration of people into cities and a need for hospitals to serve the increasing number of poor pregnant women who could not afford to hire an obstetrician to attend them in their own houses (Brodsky 2008). In response to this need, the newly founded hospitals established "lying-in" wards where poor women could deliver their babies (Rhodes 1995:52). These hospitals served as teaching centers for obstetricians, many of who had never seen a birth prior to training at the hospital (Rhodes 1995:53, Rooks 1997:15). Crowded, unsanitary conditions lead to high rates of puerperal fever in these lying-in wards, despite the fact that these women were being attended by "trained professionals" from one of the four all-male medical schools (Rooks 1997:19). In 1913, nearly half of all maternal deaths were related to puerperal fever, an infection of the uterus or other pelvic organs spread by the unwashed hands of physicians who came directly from doing autopsies to attend pregnant women (Rooks 1997:23-24).

By the 1900s, half of all births were attended by physicians and half were attended by midwives, primarily women, such as immigrants or black women, who could not afford a physician's fees (Rooks 1997:22). As the upper and middle classes continued to exclusively select physicians, midwives became stigmatized and their status continued to plummet (Simonds et al. 2007). At the turn of the century, the Progressive Era changed the understanding of expertise, especially in science, and allowed physicians to garner more authority as highly educated specialists (Borst 1995:1). As scientific knowledge is inherently male, they were able to claim supremacy over traditionally female values such as nurturing, intuition, and caring (Cahill 2000). I outline how scientific interventions have come to physically replace support and nurturing in Chapter 2.

The scientific knowledge possessed by the physicians assumed an inherent superiority over experience and was used to create the image of the "expert" ("Male appropriation of childbirth" 337). Important to note is the fact that "expertise" and "professional" are two different things. Ehrenreich and English define expertise as something that is worked for and shared, whereas professionalism is inherently elite, sexist, racist, and classist (1974). Armed with their professional authority and organizations, physicians continued to campaign against midwives to move birth into hospitals where physicians had full jurisdiction and the midwife was powerless, due to physicians' professional connections and ability to regulate licensure (Rooks 1997:22). The crusade against midwives is best understood as a business competition, not necessarily an ideological struggle (Simonds et al. 2007: 14).

With the goal of completely dominating maternity care, the AMA called for elimination of the "unnecessary evil" of midwifery (Ziegler 1913:33). *The Journal of the*

American Medical Association featured a summary of Dr. C.E. Ziegler's statement at the American Association for Study and Prevention of Infant Mortality in October 1912. Ziegler's statement effectively sums up the paternalistic view of the medical community on labor and delivery at that time, a view that continues today. He argues for the eradication of midwives, firstly, because they are unnecessary. Physicians can attend all pregnant women. Secondly, because he does not "believe it possible to train women of a type of even the best class of midwives to practice obstetrics satisfactorily. There is a great deal more in obstetrics than merely assisting the natural forces of Nature" (Ziegler 1913:36). He also objected to allowing midwives to attend any births because they "contribute nothing to [the] knowledge of the subject," and the cases they see should be allocated to training new physicians (Ziegler 1913:37). His statement summarizes the ideals behind the paternalistic field of medicine. First, monitoring nature is not enough; some sort of intervention is required. Second, the professional obstetrician provides the best care for women. Third, that science and scientific study is the most important form of knowledge. And fourth, women are second-class providers incapable of doing the same quality of work as a man.

In the first issue of *The American Journal of Obstetrics and Gynecology* in 1920, Dr. Joseph DeLee, author of the most popular obstetrics textbook at the time, sealed the intervention-riddled fate of pregnant women around the United States. He wrote that pregnancy was a pathological process that "damaged" women. He argued that active control of birth through the routine use of sedation during the onset of labor; ether during the second stage of labor, an episiotomy, and Pitocin to stimulate the removal of the

placenta would help prevent the evils of labor (1920:35). Of course, these interventions are only possible in the hospital under supervision of obstetricians.

It is argued that women found hospital births more appealing because the pain of childbirth could be avoided through such interventions as “twilight sleep,” one of the first anesthetics (Feldhusen 2000). Invented in Germany, “twilight sleep” promised to provide a pain-free birth and a healthy baby, which appealed to both society women and feminists who wanted to end the “scourge and suffering in childbirth” (Mitford 1992:53). Dr. DeLee is quoted to have said, “Naturally, the profession eagerly grasped this opportunity to relieve women of the pain of childbirth, and these drugs soon were extensively employed here and abroad” (DeLee 1920:36). Unfortunately for women, “Twilight Sleep,” a mix of morphine and scopolamine, a powerful hallucinogen, does not actually relieve pain, but rather, erases away the woman’s memory and self-control (“Definition of twilight sleep” 1999). In response to the availability of pain relief and campaigns by physicians, the number of hospital births increased from 30-50% in 1921, 70% of urban women in 1939, 88% of all births in 1950, and 97% in 1960 (Feldhusen 2000).

Moving birth into the hospital had two main effects. First it enabled obstetricians to have sole control over birth, as midwives were not licensed to practice in the hospital (Brodsky 2008). Second, it cemented the notion that pregnancy is pathology, which although harmful, is not surprising considering the culture of medicine and the patriarchy in which it arose. Physicians benefited (and still benefit) from portraying pregnancy as a disease because they are the experts in disease (Simonds et al. 2007:31). Since the body is viewed as a machine, with the male body being normal and constant, “Pregnancy, then, is a stress and disease-like state caused by the presence of the fetal parasite” where the

pregnant woman is different from other women only because of the fetus growing inside her (Simonds et al. 2007, Martin 1987).

By nearly eliminating midwives during the 1900s, physicians garnered exclusive control of difficult and abnormal birth, enabling the medicalization of birth processes and subsequently controlling even normal birth, now redefined under the idea of birth as pathology (Simonds et al. 2007). The near elimination of midwifery in the 1900s is the result of various economic and social factors including: less self-sufficient families, scientific discoveries, the public acceptance of allopathic medicine, increases in the number of hospitals, the invention of the automobile, the introduction of anesthesia, and economic prosperity that led to a larger middle class (Rooks 1997:23). These aided the physicians in maintaining their hegemony over childbirth, but the most important influence was the professionalization of obstetrics.

Through their success in organizing and reinforcing their own authority through labor groups such as the AMA, and their elite connections to lawmakers, which combined allowed physicians full control of licensure and status, physicians successfully expanded their influence to encompass a sphere of knowledge that traditionally had belong to women (Borst 1995:4). The male appropriation of childbirth in the 20th century marked the first time in history that men became the predominant birth attendants¹.

Implications of Medicalization

Childbirth is an excellent example of medicalization, the “process by which non-medical problems become defined and treated as medical problems,” or where everyday

¹ Although it is important to note that currently female OB/GYNs are beginning to outnumber male OB/GYNs, as women account for 75% of the OB/GYN program graduates (“Trend: Number of female OB/GYNs rising” 2007). I do not believe that the gender of provider significantly effects the type of care provided as medical school is extremely competitive, values traditionally masculine characteristics, and indoctrinates physicians’ to be in a way of being. For more on this see Chapter 2.

life comes under medical dominion, influence and supervision (Conrad 1992:209-210). Sociologist Peter Conrad writes, “This is a sociocultural process that may or may not involve the medical profession, lead to medical social control or medical treatment, or be the result of intentional expansion by the medical profession” (1992:211). As outlined above, the medicalization of childbirth is the result of intentional expansion first by barber surgeons, the preliminary OB/GYNs. The medicalization of childbirth is reflected in many features of our society such as “the diminution of religion; an abiding faith in science, rationality, and progress; the increased prestige and power of the medical profession; the American penchant for individual and technological solutions to problems; and a general humanitarian trend in western societies” (Conrad 1992:213). Although it may be easy to blame a medical monopoly for the lack of quality care and the current maternity care expenditure, it is important to recognize the role patients play in maintaining and forming such a system (Wertz and Wertz 1989). However, it is clear by the sheer number of women’s issues that have been medicalized (spousal abuse, contraception, menopause, PMS) some members of society play a greater role in establishing these relationships than others (Conrad 1992:222).

A key feature of medicalization is the monopolization by physicians of anything that can be related to “health” or “illness,” which allows them to maintain “medical surveillance” over all related processes (Foucault as discussed by Conrad 1992:216). The professionalization of physicians played a huge role in the medicalization of birth, and now, in the current business model of health care, birth has been transformed into a business, which reinforces the pressure on physicians to maintain their hegemony. Because the medical system evolved the way it did, OB/GYNs are forced to use the same

strategies originally used to displace midwives to maintain their control of maternity care. Their already established status as professionals and authorities in the realms of pregnancy and birth, along with the organization and systematic support they have in the form of lawmakers and insurance companies, allows them to effectively eliminate any real threat to their livelihood.

However, these same forces limit their ability to practice and provide quality care. During medical school, they are indoctrinated into a mindset based on the authority of technology, which allows them to provide quick, impersonal care to overcome the internalized fear of birth and of litigation. There are three main criticisms of the medicalization of childbirth. First, by intervening with a natural process, physicians attempt to “manage” birth, which decreases the control of the laboring woman. Second, the emotional and physical wellbeing of the woman and her family is risked to incorporate expensive technologies. And third, women are robbed of a potentially transformative and empowering experience (Fox and Worts 1999:327-8).

Wagner argues that a more humanized model of birth is necessary for the United States. During technological development, at first only the positive characteristics may be apparent, until the technology becomes widespread, then the negative consequences are finally recognized (Wagner 2006:28). This is true in the current medical model described in Chapter 2. The potentially lifesaving technologies such as Cesarean section (C-section) and Pitocin, have disseminated and are now almost universally available and frequently used during labor and delivery, and have both financial and health costs to women. In the next chapter, I analyze four common interventions (epidurals, Pitocin,

electronic fetal monitoring, and the C-section) to identify the major flaws in our current maternity care system and how they potentially affect women's birth experiences.

Chapter 2

Machines that Go Ping: Modern Obstetrics in the United States

*“And that’s the most expensive machine in the whole hospital...Aren’t you lucky?”
-Monty Python’s *The Meaning of Life**

As outlined in Chapter 1, OB/GYNs have long fought for the exclusive ability to provide maternity services. The current medical model holds true to its paternalistic roots: the physician is all knowing, the body is pitted against the mind, and technology reigns supreme. Davis-Floyd and Sargent describe this system as “technomedicine” that “objectifies the patient, mechanizes the body, and exalts practitioner over patient in a status hierarchy that attributes authoritative knowledge only to those who know how to manipulate technology and decode the information it provides” (1997:8). In the modern American maternity system, the authoritative knowledge that fuels decisions comes from complicated technology and the elite few that can interpret and wield these interventions (the interventions described below serve as examples of this). The most important feature of authoritative knowledge is not that the information is true, but that it counts (Jordan 1997:58). This is not surprising, as gynecologists and obstetricians, in the United States, became the primary managers of births in the United States through the exclusive knowledge of and dependence on these tools (forceps and then anesthesia).

The unique maternity care system in the United States is testimony to Foucault’s argument that our medical system could only have evolved under a sex and class divided society such as our own (Foucault 1995). Due to its formation through an elite process of professionalization, our medical system developed as a business, a model that distorts the

care it provides (Perkins 2004). The implications of the business model of medicine are three-fold. First, unlike other businesses, in health care consumers feel more vulnerable and are less likely to question their providers. People become more alienated from their bodies, they depend on the health “experts” to help them, making them unlikely to question expert authority (Perkins 2004). Second, by reframing maternity care in a hospital setting and subsequently as pathology, the medical system has limited a woman’s access to social support and increased her dependence on interventions based on notions of authoritative knowledge. Third, the business model views bodies as machines (Martin 1987), and babies as commodities (Katz-Rothman 1996).

Anthropologist Emily Martin discusses how the body has come to be viewed as a machine, where the masculine body is standard. Under capitalism, women’s bodies are viewed as flawed machines, women as unskilled workers, and doctors as expert managers. By reframing women’s bodies in this light, they are able to play off the lack of social support provided by the hospital setting and promote the use of interventions, which allows them to feel in control, avoid litigation, and maintain a level of dominance. These interventions are also more likely to be geared toward successfully delivering the baby than the mother’s wellbeing (Pitocin, EFM, C-section). By enforcing the idea that women’s bodies are flawed, especially during a potentially transformative time, the maternity care system in the US continues the societal trend of alienating women from their bodies.

Today, gynecologists include in their scope of practice women’s health care throughout the lifespan. The focus of OB/GYNs is on disease, which can be seen in their scope of practice. They are responsible for a deep “understanding of reproductive

physiology, including the physiologic, social, cultural, environmental and genetic factors that *influence disease in women*” (“The Scope of Practice of Obstetrics and Gynecology” 2005). Obstetricians are gynecologists that have additional training in maternal-fetal medicine and beyond the primary care responsibilities they are also surgeons able to operate on the female reproductive system. OB/GYNs have one of the widest scopes of practice of all medical doctors and because of this I narrowed my investigation to just one slice of their expertise: labor and delivery.

Modern interventions, though not as horrific as “twilight sleep” or embryotomies, continue to put pregnant women and their babies at risk through systematic disempowerment of women as consumers, denial of quality care, and maintenance of a flawed maternity care system in which doctors are forced to practice defensive medicine. Feminist writers have long believed that the treatment of women’s bodies by health care reflects their position in society (Cahill 2001:334). By analyzing the following interventions we can see that women’s bodies are considered abnormal and need to be controlled (Cahill 2001:334).

The rhetoric of risk plays a large role in maintaining the status quo in maternity care. The selection of risk is a social process, and issues that are considered “risky,” may actually pose very little danger (Arney 1982). For example, birth in the developed world has never been safer. However, the United States maternity system was based on rhetoric of risk, and maintains that rhetoric today in order to justify physician and technological dominance. In modern obstetrics the following interventions are not considered risks to women because “risk is conceptualized as emanating from women’s bodies gone wrong or awry, rather than from acts done to women’s bodies” (Simonds et al. 2007:222). Most,

if not all, of these interventions were originally created in response to a small number of complicated births, but began to be applied more broadly and then routinized (Rooks 1997:59).

Natural Labor or Birth without Intervention

Before outlining the most common technological interventions in labor, I will first outline what labor looks like without interventions. One of the most important features of childbirth is that, while each woman and each pregnancy are completely unique, there are general trends. Childbirth is divided to stages. During the first stage the uterus begins to contract and the cervix begins to efface and dilate. Gradually contractions increase in length, usually to no more than a minute, and come more frequently, around every 5 minutes. When the cervix is 4 centimeters dilated, progress begins to accelerate and there is an increase in a vaginal discharge called the “bloody show.” The second section is called active labor and is the period in which contractions become more frequent and more intense, and the cervix dilates to the full 10 centimeters. When contractions consistently come every 3 minutes, or 5 minutes for some women, and last a minute or more, it is time to call the birth attendant. For first-time mothers, active labor lasts between 4-8 hours although it is not uncommon for it to last longer or as little as one hour. This portion of labor can be shortened with the use of Pitocin and may last longer if an epidural is administered.

Transition is the final portion of active labor, the shift from the first stage to the second, and can take anywhere from a few minutes to a few hours. During transition the cervix fully dilates, the baby begins to descend into the pelvis, and contractions are the most intense coming every 2-3 minutes and lasting longer than a minute. Once transition

is over, there can be a large amount of bloody discharge. In the second stage, women begin to push and contractions become more spaced out to allow for recovery for the woman and the fetus. The urge to push is associated with the location of the baby in the pelvis; when the baby is lower, the woman will feel a stronger urge to push. Each contraction of the uterus pushes the baby down the birth canal until the baby begins to crown. At this point, sometimes called the ring of fire because of the associated burning sensations, the tissue in the perineum begins to stretch to allow for the head to pass through. This stage, on average, lasts an hour for a first-time mom and 20 minutes if the woman has previously had a vaginal delivery. Epidurals have been shown to lengthen this stage.

During the third stage of labor the uterus contracts to deliver the placenta and lasts between 5-10 minutes, on average. The uterus continues to contract after delivery to collapse the blood vessels where the placenta attached to the uterus. This is extremely important to prevent hemorrhaging. Breastfeeding the baby immediately after delivery encourages the production of oxytocin, the hormone that stimulates uterine contractions, and can help prevent excessive bleeding.

Lithotomy Position and Epidurals

The lithotomy position has been used since Hippocrates' time for various surgeries and vaginal examinations and consists of a position in which patients lie on their backs with their knees and hips flexed and thighs apart. It is commonly used in hospital labor and delivery for a variety of reasons including the inability of a woman to move due to interventions such as an epidural, Pitocin, or Electronic Fetal Monitoring. It is obvious that lying on your back may not be the most practical delivery position, as it

does not use the force of gravity. In the lithotomy position, the baby must curve up around the pelvic bone, making the woman's body work even harder (Simonds et al. 2007:20). Because the lithotomy position has been standard for many years, even before the invention of the above interventions, it is more likely to have gained popularity out of convenience for the physician. By confining women to their beds and making it easy to quickly examine their progress, the lithotomy position allows for minimal patient attention (Simonds et al. 2007:20). However, this lack of movement can cause labor to slow (Mitford 1992:110), which may increase the risk of having a labor augmented by Pitocin. Researchers have shown that squatting during the second stage of labor helps prevent the unnecessary use of Pitocin (Golay et al. 1993:73-78).

Movement during labor is important for two reasons. First, it allows women to listen to their body and actively engage with their labor. Second, movement helps minimize pain. When women are kept in the lithotomy position they are more likely to require an epidural (Davis-Floyd 1992:122). If they are not allowed to move their labor is likely to slow, and Pitocin will be administered to induce contractions, which will be more painful, and they are likely to request an epidural (Wagner 2006:13).

An epidural refers to epidural anesthesia, which is a regional anesthesia, that blocks pain below the waist. Epidurals act by physically blocking the nerve impulses in the spine from transmitting pain messages to the brain ("Epidural Anesthesia" 2007). Anesthesiologists are required to administer an epidural, which can consist of a variety of drug combinations. The American Pregnancy Association lists several advantages and disadvantages of using an epidural. The advantages include: allowing women in prolonged labor to rest, reducing pain, which may improve a woman's experience, and an

epidural “will allow you to remain alert and be an active participant in your birth” (“Epidural Anesthesia” 2007). The disadvantages include a drop in blood pressure, a need for continuous fetal monitoring, shivering, backache, and nausea. Epidurals require maintaining one position, which may cause labor to slow down or stop, and women are warned that, “You might find that your epidural makes pushing more difficult and additional interventions such as Pitocin, forceps, vacuum extraction or Cesarean might become necessary” (“Epidural Anesthesia” 2007). Thus epidurals start a cascade of interventions, and supposedly allow a woman to be more present at her birth, while less able to feel her body at the same time.

Like the lithotomy position that both increases the likelihood of epidural use and is required by epidurals due to below the waist numbing, an epidural makes a woman physically less active in her labor, while remaining mentally active. This reflects the Cartesian dualism of our culture where mind is held over matter. Staying in control mentally and avoiding pain are more important than being able to actively participate via conscious pushing in the birth process. Fox and Worts argue that in American hospitals women are denied positive social support, which encourages them to accept medical intervention (1999:343). In the United States, it is estimated that 66% of women labor with an epidural (Lieberman 1999). Unfortunately, the epidural can be the first in the cascade of interventions that may lead to a Cesarean section. In response to the slower contractions caused by an epidural or the lithotomy position, physicians may administer Pitocin, which is discussed in the next section.

Pitocin

During labor the woman's body naturally produces oxytocin, a hormone synthesized in the pituitary gland (Bowen 2010). Oxytocin has incredibly important functions such as stimulation of milk production and lactation, stimulation of uterine contractions to initiate labor, and also plays a major role in maternal attachment (Bowen 2010). Pitocin, a synthetic version of oxytocin, can be administered during labor and delivery for three reasons: to induce labor, to augment labor, or to actively manage the third stage, the delivery of the placenta.

The WHO recommends that, when trained professionals are available, the third stage of the delivery be actively managed to prevent postpartum hemorrhaging, a leading cause of maternal deaths in developing countries (Mathai et al. 2007:323). During the third stage of labor, the uterus continues to contract and begins to shrink, causing the placenta to separate from the inner membrane of the uterus and be expelled (Smith 2012). There is an increase in clotting factors in the mother's blood to prevent bleeding to death in case the placenta fails to separate from the endometrium (Smith 2012). As mentioned above, oxytocin not only causes the uterus to contract but also stimulates milk production, so putting a new baby straight to the mother's breast is the traditional technique to produce more endogenous oxytocin and expel the placenta (Gaskin 2010). Active management of this third stage, as WHO recommends, can include the routine use of Pitocin. However, they also warn "inappropriate use of uterotonic drugs, especially before childbirth, can be associated with significant maternal and perinatal morbidity and even death" (Mathai et al 2007:323). In the United States, physicians and midwives alike can administer Pitocin during this stage to prevent hemorrhaging.

In 1954, Dr. Emanuel Friedman profoundly changed the role of such uterotonic drugs for labor augmentation in obstetrics. Dr. Friedman gathered data on the relationship between cervical dilation, fetal positioning, and use of anesthesia and applied this information to create a mathematical formula to predict the normal progression of birth (Cassidy 2006:157). His findings became known as the Friedman Curve, which allows doctors to compare their patients' progress to the average length of each stage of labor depending on how many children they have had (Joy 2011). The Friedman Curve has become essential in the formation of hospital protocol, to the discomfort of Dr. Friedman himself who is distressed by the misappropriation of his findings (Cassidy 2006:157). The statistical analysis done by Dr. Friedman is too frequently applied to all women, despite the ability for a woman's progress in labor to be longer than average but still considered well within normal (Simonds et al. 2007:63).

The Friedman Curve exemplifies how obstetric practices view the body as a machine, instead of taking into consideration the health and state of the mother or baby, a scientific formula is used (Sakala 1993:1239). She is diagnosed with "failure to progress," "uterine inertia," or "dysfunctional labor" (Brodsky 2008:139). All of these terms imply something inherently wrong with the female reproductive system requiring some sort of intervention to make it functional, and that something may be Pitocin. This diagnosis also makes a woman doubt her own capabilities (Sakala 1993:1242). The notion that birth is a constant progression towards delivery and that women's bodies are all the same reflects our paternalistic medical system, and many health professionals and women will testify to the constant starting and stopping of labor depending on a multitude of factors (Gaskin 2010).

When uterine contractions are not strong enough to deliver the fetus or placenta or if labor has stalled according to the Friedman Curve, physicians administer Pitocin via IV (“Pitocin: Risks and Reasons for Induction and Scheduled Births” 2010). Pitocin augmentation can be “the difference between having a natural vaginal delivery and having a Caesarean section” because “rather than waiting for a labor to completely stall, the use of Pitocin can help to jump start a labor that is going slowly” (“Pitocin Pros and Cons” 2012). However, “Pitocin creates a birth that needs a great deal of intervention.” Because Pitocin strengthens and lengthens uterine contractions, Electronic Fetal Monitoring (which will be explained on 37) becomes necessary to monitor the wellbeing of the fetus (“Pitocin Pros and Cons” 2012). Uterine contractions, natural or stimulated, reduce the oxygen supply to the fetus momentarily; natural contractions are spaced to allow an adequate recovery period between contractions. The rapid and strong contractions caused by Pitocin augmentation can deprive the fetus of oxygen, and can cause brain damage (Mendelsohn 1982:174, Rooks 1997:319). EFM usage is intended to alert the doctor if the baby goes into distress due to a lack of oxygen.

Although Pitocin shares some functions with endogenous oxytocin, it fails to produce all of the benefits as oxytocin. First, synthetic oxytocin does not as effectively dilate the cervix, which increases the likelihood a drug such as Cytotec (See EFM section) will be used for dilation (“Oxytocin-injectable Pitocin” 2012). Second, the amount and rate of production of oxytocin also differs. Endogenous oxytocin is pulsed in small amounts to synchronize contractions while Pitocin is administered continuously via IV, which eliminates the natural “breaks” between contractions (Brodsky 2008:143). Third, natural oxytocin also helps to minimize the pain of contractions through the

production of endorphins, a morphine-like substance that blocks pain receptors (Rooks 1997:129). Because Pitocin is administered intravenously and EFM is required, it not only overrides the ability of the body to produce natural pain reducers (endorphins), but it also immobilizes women. As outlined above, movement helps minimize the pain of contractions, which because of the Pitocin are now stronger and more painful (Rooks 1997:129). Other important inhibitors of endorphin production are fear or stress, both of which may arise from the diagnosis of “failure to progress” and the beeping of the EFM (Wagner 2006). Fourth, at the end of a non-augmented labor, oxytocin levels peak to stimulate fetal ejection, bonding, and lactation (Bowen 2010). Augmented labor lacks this spike and Pitocin does not encourage maternal bonding, but rather prevents it as synthetic oxytocin interferes with endogenous oxytocin production, disturbing the natural release of the “love hormone,” which can interfere with breastfeeding and bonding (Lothian 2005:43).

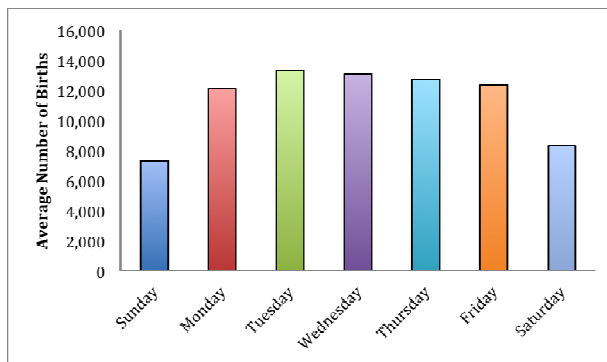
Because Pitocin increases contraction strength and duration without producing the same physiological pain reduction, women report augmented births as being more painful and more pain medications are administered (Lothian 2005:42). As previously mentioned, these also carry risks.

The strong and frequent contractions caused by Pitocin can have other devastating consequences for mother and baby. One such danger is amniotic fluid embolism (AFE), in which amniotic fluid, fetal cells, hair, or other debris enter the mother’s blood stream and cause an allergic reaction (Wagner 2006:155-158). Other risks of augmented labor include incorrect positioning of the fetus, making labor more difficult putting the fetus at risk for brain damage especially if the membranes have already ruptured (Mendelsohn

1982:174). Without the amniotic sac, the fetus no longer has a protective cushion surrounding and holding it in place and can be pushed against the pelvic bone during contractions. This is especially devastating if the physician has misestimated the due date and the fetus is underdeveloped (Mendelsohn 1982:174).

An alarming trend with Pitocin use is the correlation between the increased rate of augmentation in the past 20 years and the trend towards “Workday” births, during daylight hours Monday-Friday (Figure 1, Martin et al. 2010). It is hard to believe that women are almost twice as likely to deliver their baby on a Tuesday as opposed to a Sunday naturally, which gives strength to safe childbirth advocates’ argument that

Figure 1: Average Number of Births by Day in 2008 physicians are augmenting labor out of (Martin et al. 2010:



convenience and not in the best interests of the woman (Wagner 2006:78). In his book, *Male Practice*, Dr. Robert Mendelsohn, self-proclaimed medical heretic, argues that

doctors blame women for increased rates of Pitocin use, as opposed to admitting the importance of convenience (1982:175). They argue that Pitocin is administered because women are too weak, in too much pain, or because it is more convenient for the woman (1982:175).

The risks associated with labor augmentation are compounded when Pitocin is used to induce labor (Cassidy 2006:178). Inducing labor when not medically necessary is dangerous as it “forces a very complex system into action before it is really ready to begin” (Rooks 1997:313). It is estimated that 3% of births may require induction

(Mendelsohn 1982:172). In 200, a study conducted by Childbirth Connection, surveyed 1,447 nulliparous (first-time) mothers, 24 hours after giving birth. They reported that 54% of births were induced by artificial membrane puncture, 44% were induced by artificial oxytocin, and 53% had Pitocin administered to strengthen or augment contractions (Declercq et al. 2006:3, 23). 18% of mothers cited a non-medical reason for induction (Declercq et al. 2006:3). These statistics vary significantly from the National Vital Statistics Report in 2011 (Table 1), although both show a significantly higher level than the 3% suggestion.

Table 1: % Labors that were induced or augmented in 2011 by ethnicity (Martin et al. 2010)

Ethnicity	% Induced	% Augmented
White	27.64	20.97
Black	20.88	20.15
Hispanic	17	18.26
All	22.76	19.9

Underestimating the due date is common, which is why the FDA and ACOG advise against inducing labor unless in a medical emergency, for example a post term pregnancy lasting 42 weeks or more (“FAQ154: Labor, Delivery, and Postpartum Care”). To induce labor the physician manually ruptures the sac with an amnihook (similar to a crochet hook) or with drugs like Pitocin (Simonds et al. 2007). Despite the warning against inductions, 55% of women reported artificial membrane rupture during their labor (Declercq et al 2006). Infection of the amniotic sac becomes a concern after rupture as does prolapse of the cord, in which the umbilical cord descends through the cervix and requires immediate delivery by Cesarean (“Umbilical Cord Prolapse” 2008).

Induction of labor is risky regardless of whether or not a woman attempts a vaginal birth after Cesarean (VBAC) or not, but the risks are magnified in a VBAC labor

(Cassidy 2006:178). VBAC women have a scar on their uterus from their previous Cesarean delivery making them at a higher risk for uterine rupture. If the muscular walls of the uterus rupture due to over stimulation, the fetus has a 30% chance of neurological injury or death, and the mother has a 1-2% chance of dying (Wagner 2006:83). The risk of a normal, unscarred uterus rupturing is 1/33,000 births. Women who have previously had C-sections and are attempt a VBAC have a 1/200 risk of uterine rupture without augmentation, 1/100 risk with Pitocin augmentation, and 1/43 risk with a Pitocin induction (Wagner 2006:83).

Electronic Fetal Monitoring (EFM)

During labor, the fetal heartbeat is continually checked through EFM or auscultation, periodically listening to the heartbeat through a special stethoscope. EFM can be done externally and internally. External EFM consists of two flat sensors on a belt placed around the mother's belly to measure the strength of contractions and the heartbeat of the fetus ("Maternal-Fetal Intervention and Fetal Care Centers" 2012). Internal EFM is done once the cervix has dilated 2 centimeters and the amniotic sack has ruptured. Then the nurse is able to insert an electrode through the vagina and cervix into the uterus, where a sensor is attached to the fetal head ("Maternal-Fetal Intervention and Fetal Care Centers" 2012). ACOG states that EFM is used to help detect potential changes in fetal heart rate and allows medical professionals to treat the underlying problem while simultaneously preventing the use of unnecessary procedures ("Maternal-Fetal Intervention and Fetal Care Centers" 2012). The EFM provides reassurance for both providers and patients that it is safe to continue labor. The only drawback to EFM, according to the ACOG, is that once connected to the machine patients are unable to walk

around, but “may find a comfortable position on the bed” (Maternal-Fetal Intervention and Fetal Care Centers” 2012).

The near universal use of EFM in hospitals and the endorsement by ACOG reflect the flaws in our maternity care system, one of which is incorporation of technology into clinical practice without evidence for its benefits. Originally EFM was used only for “high-risk” pregnancies, but as is evident throughout the history of maternity care, the technology quickly disseminated to be used on all pregnant women (Katz-Rothman 1996). Since 1975, EFM has been used in most hospital births (about 80% in 1984) despite multiple literature reviews stating that it has no benefit and is no more effective than listening with a fetoscope (Thacker 2004). Although ACOG claims that EFM helps to prevent the use of unnecessary intervention, studies have found a strong correlation between EFM usage and unnecessary C-sections and vacuum/forceps usage (Thacker 2004). The use of EFM alone increases the likelihood of operative vaginal delivery by 30% and C-section 160% (Thacker 2004).

A recent article from *The Journal of Obstetric, Gynecologic, & Neonatal Nursing* criticizes these studies as focusing too much on past EFM use. The authors argue:

Fetal Heart Rate monitoring was not appropriately tested prior to being implemented into clinical practice. With the clarity of hindsight, we can identify many reasons why FHR monitoring increased the Cesarean rate without improving perinatal mortality in the first few decades of use. But focusing on why FHR monitoring has not worked in the past and calling for discontinuation of this technique is not the solution (King and Parer 2011:670).

The first sentence demonstrates a practice all too common in maternity care: the clinical use of an intervention prior to a complete understanding of its implications. Examples of seriously harmful interventions from our recent past include radiation imaging of fetuses

in mothers and prescription of Thalidomide, a drug used to treat morning sickness but later found to cause serious birth defects.

Currently, the drug misoprostol, like EFM, demonstrates the failure of maternity services to put the health and safety of women over convenience and dependence on birth augmenting interventions. The FDA approved misoprostol, otherwise known as Cytotec, to reduce the risk of anti-inflammatory drug induced gastric ulcers in high-risk patients (“Misoprostol Information” 2009). The FDA specifically warns against the consumption of Cytotec by pregnant women at the top of its drug report in capital letters: “Cytotec administration to women who are pregnant can cause abortion, premature birth, or birth defects. Uterine rupture has been reported when Cytotec was administered in pregnant women to induce labor” (“Misoprostol Information” 2009). Cytotec is now used to provide women with abortion services.

The standardized use of a procedure that is ineffective or even harmful begs the question: why do physicians continue to incorporate a practice that is futile?² In their meta-analysis of articles on EFM, Banta and Thacker include potential reasons why an ineffective technology would maintain such popularity, a second main flaw in the American maternity system, a movement towards unquestioning acceptance of technology (1981). They argue that since a generation of physicians trained to monitor labor via EFM they simply do not know another way to do it, there exists an “inappropriate faith in electronic and machine-based technology,” (Banta and Thacker 1981:1527). Hewlett-Packard inventor, Konrad Hammacher, believes that EFM technology is not sufficient to order a Cesarean and should not be the focus of care (Cassidy 2006:121). A sales leader, Hewlett-Packard monitors have been used in over

² This problem is not unique to maternity care.

forty-five million births within the first twenty-five years (Cassidy 2006:121). According to doctors, EFM provides assurance that everything is going according to plan and that if something changes they have done everything possible to control the birth (Cassidy 2006:121). Jessica Mitford argues that insurance companies played a key role in the standardization of EFM because insurance providers like Blue Cross and Medicaid accepted EFM without testing its efficacy before determining their reimbursement rates for the procedure (1992:160). Because insurance companies cover EFM, doctors are quick to strap women down in the case of a lawsuit.

In 1988, the chairman of the Department of Obstetrics, Gynecology and Reproductive Biology at Harvard Medical School described EFM as a “failed technology” but predicted that it would be difficult for obstetricians to stop using it in the absence of a substitute, in part because of the fear of being sued. Doctors, especially in the United States, are quick to endorse EFM because of the feared malpractice suits (Thacker 2004). The EFM provides a large amount of data with minimal work. As Cassidy writes, “Mothers, and hospitals fearing malpractice litigation, remain lulled by the sense of safety the beeping devices offer” (2006:121). Because nature is considered dangerous and needs to constantly be monitored, these women are subjected to constant surveillance (Simonds et al. 2007). Scholars interpret this phenomenon through Michel Foucault’s theory of surveillance and power (Arney 1982). In his panopticon theory, one can always be seen without seeing, which encourages the internalization of institutional norms (Foucault 1995). In the hospital patients are watched from the nurses’ station and are reduced to lines on a computer.

By confining women to their beds to monitor their babies, physicians and hospitals attempt to protect themselves against litigation while simultaneously making their own jobs easier (Cassidy 2006:121). Monitoring women via machine eliminates the constant need to check-in on the patient because the EFM is constantly connected to the nurses' station, where one nurse has the responsibility to sit and continually check the monitor, providing hospitals the financial incentive to continue EFM. The ability to keep constant watch of laboring women via EFM creates a distance between the provider and the mother by minimizing physical interaction between a nurse and the patient (Katz-Rothman 1996). Instead of touching the patient, putting skin to skin, information about her body is received by a machine and then forwarded to the nurses.

One of the most important aspects of EFM is that it enables physicians to treat mother and baby as separate patients whose needs are no longer in sync. By having a reading on the state of the fetus, doctors are able to interpret faulty readings or “non-reassuring” EFM outputs and go straight to the intervention that provides them the most control and the most protection from litigation, the C-section.

Cesarean Section (C-section)

The C-section could be considered the ultimate intervention, the culmination of the medicalization of birth. A Cesarean section is an abdominal surgery consisting of an incision in the mother's belly and uterus to deliver a baby (“Cesarean Section” 2010). In 2011, 32.8% of babies were delivered via Cesarean in the United States (Menacker and Hamilton 2010). While C-section rates have increased at an alarming rate in the United States, up from 4.5% in 1965, 5.5% in 1970, and 24.1% in 1986, the procedure itself has

existed for thousands of years (Joy 2011). The WHO states that no more than 10-20% of babies need to be delivered via C-section (Sachs et al. 2000).

Critics of modern obstetrics argue that obstetricians are highly trained surgeons responsible for overseeing a natural process (Wagner 2006). The current medical model, beginning in medical school, trains them to see labor and delivery as dangerous; at any moment things will go wrong. As surgeons, they use their expertise, surgery, to prevent and respond to twists, such as performing an episiotomy or a C-section. Despite the frequency of Cesarean deliveries, they are still considered a major abdominal surgery and increase serious risks for mothers (“Cesarean Section” 2010). According to the American Pregnancy Association, Cesarean deliveries are typically the result of:

- Placental separation from the uterine wall or previa, when the placenta covers the cervix
- Uterine rupture
- Breech position of the baby, when the baby is not facing head down in the uterus
- Cord prolapse, when the umbilical cord is delivered before the baby
- Fetal distress
- Failure to progress
- Repeat Cesarean
- Cephalopelvic Disproportion, baby’s head is too large or a mother’s pelvis is too small for the baby to pass
- Active genital herpes
- Diabetes
- High blood pressure of the baby or mother after membrane rupture
- Multiple births (“Reasons for a Cesarean Section” 2006)

For mothers, the potential risks include: infection, injury to organs (bladder, bowels), hemorrhage, adhesions (scar tissue that causes pelvic pain and may cause future pregnancy problems such as those listed above), extended hospital stay, extended recovery time, which may be detrimental for mother-baby bonding, reactions to medications, risk of additional surgeries, death, and emotional issues such as feeling negatively about their birth (“Cesarean Section” 2010). There also exists a list of

potential complications for baby such as, breathing problems, low APGAR³ scores (babies delivered via C-section are 50% more likely to have lower APGAR scores than vaginally delivered babies), fetal injury, and premature birth.

Cesarean deliveries are one of the most common surgeries performed in the United States (Minkoff et al. 2004). The rise in the number of Cesarean sections has been attributed to various influences including technological, cultural, professional, and legal factors (Minkoff et al. 2004). Technologically, two factors that may increase the rate of C-sections are the rise of fertility therapies, which increase the number of complicated births, and the “cascade of interventions.” The “cascade of interventions” starts with the lithotomy position, which leads to an epidural for pain management or Pitocin to start stalled labor (these two interventions also lead to each other, as outlined above). Pitocin augmentation requires the use of EFM, which increases the likelihood of a C-section (Sakala 1993:1240). Sakala identifies four factors that lead to C-section: feeling unsafe and unsupported, spending too much time in the hospital (Friedman Curve), lithotomy position, and other interventions (1993:1242).

From a legal perspective, the fear of litigation drives these interventions, such as EFM and Pitocin, to make sure they are doing everything possible to control the birth and prevent litigation. “Doctors get sued for the Cesareans they don’t perform or don’t perform quickly enough. They don’t get sued for performing the surgery,” which encourages the jump to cut (Cassidy 2006:121). The protection from litigation goes back to the early days of physician organizations, when by the early 1900s medical societies, such as the AMA, handled malpractice suits for members (Feldhusen 2000). Even then

³ APGAR tests the physical wellbeing of a baby after birth measuring color, heart rate, reflex, muscle tone, and breathing.

doctors practice what Wagner calls ““tribal obstetrics,” where doctors are quick to defend fellow physicians that most align with the dominant practices of the “tribe” (Wagner 2006:23). In the 1900s, physicians began to form alliances and would testify on their behalf of their alliance members (Feldhusen 2000). Bosk echoes this concept arguing that the profession’s social control of itself, regulation and control of deviance, “finds the profession to be tolerant and forgiving of its own, as opposed to its less tolerant treatment of lay population deviance” (Conrad 1992:219). Additionally, OB/GYNs are trained as surgeons and have little training in normal birth processes. From a professional and business standpoint, C-sections are a quick, convenient, and more expensive procedure (See Chapter 3 for price of care). A reduction in the number of C-sections would reduce a physicians’ autonomy and limit revenue, which is exceptionally dangerous to doctors’ livelihoods in this time of potential health care reform (Sakala 1993). During a two-year programmatic C-section reduction, one hospital lost over one million dollars in revenue (Sakala 1993).

The fact that women are electing to have C-sections speaks to the overall societal internalization of the superior value of technology, the devaluation of bodily experience, and the need for a sense of control. By choosing to undergo a major abdominal surgery, women are accepting the medical discourse that birth is dangerous due to the flawed female form. Electing a Cesarean delivery embodies the issues brought up by other interventions: the notion that technology is superior to a woman’s body, that experiencing labor mentally is more important than experiencing it physically, and that babies are commodities produced by women. C-sections have become “common place” and as such women interpret that the benefits far outweigh the risks (Sakala 1993:1234).

Implications

The National Institute of Health (NIH) discusses the history of Cesarean deliveries, recognizing a shift between saving the fetus and saving the mother. With the rise of imaging technology, the fetus has become a patient, and in some cases, is even named months before delivery, changing the way medical practitioners and parents view the fetus (Sewell 1993). In one case in Denver, an obese woman refused to have a C-section despite potential fetal distress, to which a lawyer and judge were summoned to proclaim the fetus a ward of the state. The woman was subsequently anesthetized and the fetus was delivered surgically (Davis-Floyd 1992:287).

EFM and other modern obstetrical technologies enable doctors to treat the woman and fetus separately, enacting the long-standing paternalistic idea that a pregnant woman carries a man's child (Katz-Rothman 1996:157). Important to note is the fact that most of these technologies are geared towards the delivery of the baby, not the improvement of the mother's experience (Fox and Worts 1999:338). Prior to the development of fetal monitoring, medicine was limited to information provided by the mother's body and the only technique of measuring the fetus was auscultation. Care providers measured "*her* hear rate, *her* blood pressure, the frequency and intensity of *her* contractions" (Katz-Rothman 1996:157). Alienation of the woman from the birth and the baby creates two separate patients, the mother and the baby, and allows physicians to pit the two against each other. Treating the two as separate shifts the gaze towards the fetus and results in an increase social control of women in the name of fetal protection (Cahill 2001). Gregg argues that the acceptance of prenatal testing and monitoring (like EFM) as routine, will have dramatic implications on the future of social expectations about women's behavior

(Gregg 1993). The next chapter addresses how the reestablishment of social support can minimize such interventions.

The rhetoric of choice has played a huge role in encouraging the acceptance of this model. Although, I believe informed choice is integral to providing high quality of care, it is also an issue that demands a level of criticism. Informed choice defines patient autonomy, but, as in the physician model, information provided is restricted to information “deemed relevant” by the health care provider (Leap and Edwards 2006:99). Not only does information have to meet the criteria of the health care provider, but “informed choice places the onus of control on the individual, with little recognition that social inequalities, in particular poverty, play a major role in restricting the ability of women to make changes in their lives, or even to engage in a process of making choices” (Leap and Edwards 2006:99). Although socioeconomic status plays a large role in health care literacy, most patients are less likely to make choices that may antagonize their health care provider, which allows women to remain in control of the decision making process until their provider feels strongly about a decision (Kirkham 2004: 100). This points out an extremely important aspect of informed choice: not only do you need access to accurate information, but also you need to be able to act on that information (Wagner 2001:32).

The interventions describe above are part of the idea of ‘technological progress’ that replaces ‘natural’ (female, polluting, primitive) bodies, with man-made bodies that are advanced, functional, and male (Peter Reynolds as cited in Davis-Floyd 1994). The ritual transition of natural for man-made is described as being a “one-two punch.” Childbirth is an excellent example of this. First, the successful, natural process is made

dysfunctional and then it is “fixed” with technology (Davis-Floyd 1994:1125). Physicians manipulate a normal, physiologic process, and then fix the dangers caused by these interventions with more technology. Professor of Maternal and Fetal Health and Boston University School of Public Health, Eugene Declercq, Professor of Maternal and Child Health at Boston University School of Public Health, describes this saying, “Everybody says, ‘Thank God we were able to do all of those interventions to save your baby.’ The fact of the matter is if they didn’t start the cascade of interventions, none of that would have been necessary” (Declercq).

The understanding and culture of Cesarean delivery symbolizes the main concerns midwives, mothers, natural birth enthusiasts, and social scientist share about modern day maternity care. Currently, the biomedical model of birth teaches highly trained physicians to try and control birth and women through unfounded or invasive technologies out of fear of an uncontrollable disease event, to avoid litigation, and in a basic premise that women’s bodies are flawed and technology can and should “fix” them. By trying to fit birth into our current biomedical model, the quality of care suffers and the cost of services skyrocket.

Acceptance of this expensive and disempowering maternity care system signifies that physicians have been successful thus far in maintaining their monopolization of birth, despite the financial and sociocultural consequences. Davis-Floyd argues that the examination of birth is especially important as a society’s treatment of the human body reflects its core values. This is made all the more important by the fact that birth is not only constantly happening, but it is the means by which new members of the society are created (1994:1125). It is important to recognize that although the rates of interventions,

such as C-sections, continue to increase; feminist, childbirth, and consumer movements are attempting to challenge the medical monopoly of childbirth (Conrad 1992:225). Recent improvements include the development of doulas (labor support providers), birthing rooms, rooming-in of newborns with mothers (as opposed to the nursery), and increased inclusion of the partner in labor (Conrad 1992:225). One such movement is the increase in number of midwife-attended births, which will be explored in the next chapter.

Chapter 3

The Midwifery Model

“It’s not all glory; there are a lot of guts to this. A lot of people are drawn to midwifery. They think it’s just this glorious up on a pedestal, and people do love you and you have these amazing experiences and relationship and perks that come with this role. But it is a life of sacrifice and hard work. There is nothing easy about this. Every midwife you meet I’m sure you will feel a softness and a kindness and a sweetness but there is not one of us that is not stronger than you can imagine that hasn’t walked on fire, that hasn’t been in the bowels of mother nature at some point or another. You have to have it to do this work because it is all of that and even then some. Anyone can teach a blood pressure, a vag exam, a heartbeat, a certain skill, how to suture. To me that is not the embodiment of midwifery. Those are skills that you want them to have. There is a spirit and there is a, I’m going to call it servitude, that is a part of midwifery that I think bring both worlds... We have technology and the 20th century skills set-valuable, but that shouldn’t be the leading edge of how you practice, but there’s a place for it. There is a place for the heart and the hands and the spirit and the servitude, wellness and it’s that balance and bringing it all.”

-Licensed Midwife (LM) Christine

Midwives attend the minority of births in the United States, yet, because of their unique wellness model and woman-centered style of care, I argue that they provide a more sustainable alternative to the biomedical model of maternity care outlined in previous chapters. Because of the influence notions of safety and risk have on maintaining this system, I first will outline how midwifery care, whether in a hospital, birth center, or at home, is a safe option for healthy, normal pregnancies. MacDorman and Singh examined the outcomes of all single baby (not twin), vaginal deliveries between 35-43 weeks gestation attended by Certified Nurse-Midwives (CNM) and physicians in 1991. They found that after controlling for social and medical risk factors, the CNMs had a 19% lower rate of infant death, 33% lower rate of neonatal mortality, and the risk of delivering a low birth weight infant was 31% lower. Additionally, the

mean birth weight of babies attended by CNMs was 37 grams heavier than for physician-attended births (1998: 310-317).

A study in British Columbia compared the outcomes of planned homebirths with a midwife versus planned hospital births with a midwife or physician. Importantly, all of the 7,641 women included in the study were matched and met the health eligibility requirements for a homebirth. They found that perinatal death rate per 1,000 births was 0.35 for planned home births, 0.57 for women attended by a midwife in the hospital, and 0.64 for women attended by physicians in the hospital (Janssen et al. 2009: 379).

Homebirthers were also less likely to have adverse maternal outcomes (e.g., tearing, hemorrhaging), their babies required fewer life saving measures (e.g., resuscitation, oxygen), and were less likely to be admitted into the hospital (Janssen et al. 2009:381).

There are a number of studies regarding the safety of midwives. For a comprehensive evaluation of the safety of midwives and examples abroad I suggest *Birth Models That Work* edited by Robbie Davis-Floyd, Lesley Barclay, Betty-Anne Davis, and Jan Titten.

One of the major tools used by physicians to maintain dominance over maternity services is the question of “what if something happens?” By asking this question, clinicians play off of the concerns of pregnant women. These fears go beyond simple fear of physical damage to their body or their babies’ bodies, but also the possibility of emotional harm to their families and the potential threat to emotional integrity (Edwards 2005). Americans emphasize the idea of leaving no stone unturned, which in maternity care means having the most technologically savvy professional attend the birth (physician) in a setting where these technologies are readily available (hospital).

The argument that hospital births are safer than out-of-hospital births for healthy women due to proximity of surgical professionals and technology is falsely based on three assumptions (Wagner 2001:29). Wagner addresses these three assumptions. First, emergencies in birth arise quickly. Second, out-of-hospital midwives are unable to spot potential problems, and if they do so, are unable to prevent or respond to these problems. In reality, the individualized model of care in combination with the midwife's extensive knowledge of normal birth makes her extremely capable of preventing and troubleshooting problems. Third, clinicians believe that fast action can occur in the hospital. Using the "what if" to keep birth in hospitals, is only an argument that can only be made by someone who is unfamiliar with a midwifery model of care. However, the research shows that midwife-attended births are equally as safe as, if not safer than, physician-attended births for healthy, normal pregnancies.

Money Matters: Cost of Pregnancy

The numerous websites on how to plan for the costs of a pregnancy play are testament to the countless informed women preparing for a pregnancy. However, equally indicative is the lack of information on these websites on homebirth, alternative center birth, or midwifery in general. As apparent from the trends in midwifery clientele, I believe this is because midwife users either come from an exclusive group of educated, wealthy families that are already connected to the alternative birth community or are high-risk populations covered by state sponsored insurance, such as Medi-Cal in California. In this section I outline the costs of prenatal care and birth with a midwife either at home or in a center and the costs of maternity care with an OB/GYN in the hospital.

Obstetrician/Hospital Birth

During prenatal care, OB/GYNs recommend that pregnant women have check-ups once a month for the first 6 months, twice a month for the seventh and eighth month, and then once a week until the baby is born (“Pregnancy: Prenatal care and tests”). These visits total will cost \$1,862, on average. This does not include extras such as laboratory work, ultrasounds, prenatal vitamins (\$15/ 30 day supply), or childbirth education classes (\$50-200/class) (Merrill and Steiner 2003). The cost of the hospital stay depends greatly on the progression of birth and any interventions used. A vaginal delivery without complications costs around \$6,200; with complications it may cost \$8,200. A C-section without complications can be \$11,500, with complications it runs about \$15,500 (“*Design of the HCUP Nationwide Inpatient Sample, 2003*” 2005). From 1993-2007, the cost of an uncomplicated vaginal delivery tripled and the cost of C-section doubled (Hatfield and Martin 2012). The amount a woman will actually pay for these services depend on her insurance. Amnesty International found that nearly 13 million women of reproductive age are uninsured; a disproportionate number of these are minority women (51%) (“*Deadly Delivery: The Maternal Health Care Crisis in the USA*” 2010).

Anna Wilde Mathews, a journalist for *The Wall Street Journal*, wrote an article on her experience with insurance companies after the shock of receiving the bill for delivering her baby vaginally in Cedars-Sinai Medical Center in Los Angeles, CA. For her three-day stay in the hospital she was charged \$36,625. On her bill were 14 items for her baby and 34 items for her, including the cost of her epidural, which totaled \$4,121.84: \$530.29 for the sterile equipment, \$2,152.55 for “resources related to the epidural,” and the anesthesiologist charge of \$1,530 (Mathews 2009). This figure is much higher than

the expected financial cost of an epidural which can be anywhere from \$700 to over \$1,200 (Weiss 2011).

Homebirth/Birth Center Birth

A homebirth or birth center birth with a midwife costs \$3,000-\$5,000, not including laboratory tests or ultrasounds. Families will pay most if not all of this out of pocket as most insurance companies will not cover the fees. Midwives use the same prenatal visit schedule, with appointments lasting between 45-60 minutes (Beth, Ellen, Alicia, Christine). Around 36 weeks they also meet with the family to decide who will be attending the birth to prevent problems. For births at home, the midwife will conduct at least one visit at the client's house to make sure they can find it and set up. They conduct follow up visits after the delivery two days and one-week later. Relocating 10% of pregnancies (100,000) to a birth center would save almost \$2.6 billion annually on facilities fees alone ("AABC Press Kit" 2011).

CNMs in the Hospital

I was unable to find sufficient data that spoke specifically to CNMs working in a hospital setting. One study claims that using a CNM saves about \$402 on each hospital bill (Painter 2011). Additionally, a study of two Kaiser Permanente Medical Centers in Southern California demonstrates the money-saving power of a midwifery model of care in maternity services. After incorporating CNMs to the obstetrics team, one center saw a 13% (\$292,000) reduction in costs while the other saw a 7% (\$2 million) reduction in payroll costs ("Choose a Midwife"). I also believe that the use of CNMs by Medi-Cal covered women, despite being a high-risk population, indicates that they provide cost-effective care.

A major reason why midwives are much more economical is because they are less likely to use costly interventions such as those outlined in the previous chapter. For example, women who are attended by midwives have a C-section rate of 13.1%, one of the most costly interventions (Painter 2011). The cost of C-sections includes operating room maintenance, surgeon fees, assisting surgeons, nurses, anesthesia, anesthesiologists' fees, instruments, blood for transfusions, and a longer hospital stay. Wagner argues that in 2004 alone, the United States had a half-million unnecessary C-sections. In 2004, the C-section rate in the United States was 29%, whereas in countries with better maternal and neonatal health indicators it was 12%, within the WHO's recommended 10-20%⁴. As noted above, C-sections cost at least \$5,000 more than vaginal births and if those half-million C-sections were unnecessary, \$2.5 billion was spent for no reason (2006: 49). This does not include the \$750 million spent each year on routine EFM use (2006:244). One study found that physician-attended women are twice as likely to have C-section as CNM attended births (13.1% vs. 26.4%) (Blanchette 1995:1864). Bodner-Adler et al. found a significant decrease in the use of Pitocin, a significant increase in the number of alternative positions used, and significantly fewer episiotomies in midwife-attended births (2004:382).

Table 2: Average cost of care and interventions with a physician

Intervention	Cost (\$)
Epidural	700-1,200+/ dose
Pitocin	100-199/ dose
Vaginal birth	6,200 without complications 8,200 with complications
Cesarean Section	11,500 without complications 15,500 with complications

⁴ Comparing maternal and infant mortality rates between countries is problematic as each country has a unique population. The results, however, still have some value.

One of the key features of the dominant biomedical system is the dependence on technology. As outlined in the previous chapters, this reliance on technology arose from the combined fear of birth and the paternalistic idea that women's bodies could be improved upon by interventions. The exclusive authoritative knowledge granted to physicians by these interventions devalues the bodily knowledge of the woman, making them inactive participants in their own childbirth. By routinizing these interventions physicians have been able to monopolize birth and create a system where they practice defensive medicine. This cycle has created insufficient care where there is a lack of continuity in provider and physical distance in labor support, systematic disempowerment of women, and high fiscal costs.

How are midwives able to avoid using the high-cost interventions so commonly found in OB/GYN practices? Through their unique wellness and woman-oriented model of care they are able to prevent unnecessary interventions through empowerment, support, and a profound level of knowledge of normal births. In this next section I outline how each midwife interprets the midwifery standards of care and how these represent solutions to the current problems found in the biomedical model.

The Midwifery Model of Care™

A main feature of a midwifery model of care is that pregnancy is a normal process, not pathology. It is an opportunity for a woman to find inner-strength through a positive relationship with her health provider. CNM Rachel describes this saying, "Pregnancy and birth is a physiologic process; there is nothing disease related about it. It is not a pathophysiology; it's not an abnormality. It's physiology. Because it takes place in the hospital it becomes a disease state instead of being a normal state." For LMs and

CNMs, providing supportive and consistent care for women is central to their philosophy of care and includes affirming the power and strength of women in their health, their families, and communities. The Midwifery Model of Care™ is “uniquely nurturing,” “hands-on,” and midwives “develop a trusting relationship with their clients, which results in confident, supported labor and birth” (“Definitions” MANA). Midwifery style care gives women more control than a physician, such as the freedom to move, eat, bathe during labor and emphasizes the importance of communication and education. I believe another defining feature of midwifery care is the belief that women’s bodies are capable and strong, both during pregnancy and every day.

While the midwives are as unique as the women they serve, certain themes were present in each woman’s description of and importance of midwifery care. These themes are very much intertwined and include being “with women,” individualism, informed choice, and education. Below I outline the midwives’ journey to midwifery, comments on each of these themes, and how they carry the potential to improve our current system.

Becoming a Midwife: Women Empowering Women

All of the midwives view their experience in becoming a midwife as being a journey guided by supportive women. The three LMs decided to become midwives after being inspired by personal experiences. Alicia, who recently opened a birth center, recounts attending her cousin’s homebirth, saying, “It changed my life forever. I instantly knew that that’s what I wanted to do. I wanted to be a midwife. I wanted to be at people’s births; I wanted to spend time with families during one of the most important and sacred events in their life.” She quit her corporate job within two weeks, enrolled in pre-requisites for nursing schools, and got a job in Labor and Delivery (L&D) working as a

nursing aid. She said, “During my time at the hospital I figured out very quickly that my responsibility, my role, wasn’t in the hospital. I really didn’t feel like I could support them in the way that I wanted in the hospital, the way the families wanted me to, the way they needed me to.” She apprenticed with a midwife, but felt as though she needed more and decided to attend a famous midwifery school.

Like Alicia, Beth felt the calling for midwifery after serving as a labor partner for a pregnant friend in her hospital delivery. Unsettled by the unnecessary interventions done in the hospital, she looked into her options for becoming a midwife. Becoming a Certified Professional Midwife (CPM, LM in California) most appealed to her because she “wanted to have small scientific basis and background in clinical knowledge, and you can’t expect to get that always from particular midwives that you are apprenticing with.” But didn’t want to go to nursing school and learn “four years of learning how to take orders from a doctor when I wasn’t planning on being a nurse in the hospital.” She decided to supplement her midwifery education by becoming a naturopathic doctor, a profession that expands her scope of practice and shares a similar health-focused philosophy with midwifery.

For Christine, delivering her first child set her on a track to midwifery. As a young, single mom she received support from a neighbor who was an L&D nurse who encouraged her to take a childbirth class. The nurse and the childbirth class instructor accompanied her to the hospital and profoundly influenced her birth experience. Because of the L&D nurse her labor was intimate and uninterrupted, even the doctor didn’t participate. Christine admits that 35 years ago “[It] was *radical*. I didn’t even know how radical! I knew that I was kind of a freak in the hospital and that people were talking

about me. It was a natural childbirth no epidural, no episiotomy, I didn't tear, I didn't need stitches." After delivering her son, she continued to be present in the birth community where she was exposed to books, breastfeeding circles, and midwifery meetings. Her neighbor suggested that she teach childbirth classes because, as she says, "I had a real strong conviction for natural birth from having done it... I just know that if they hadn't been with me then it would have been a knock-em-out drag-em-out C-section... These two women were so loving and patient."

Her transformation from class instructor to midwife was gradual and began as an instructor supporting couples in hospitals. She describes her first hospital birth as being "barbaric" complete with leather restraints. Christine remembers it saying, "I've seen a lot of births but I'll never forget, I left that birth, got in my car and just wept the whole way home. It was just so cruel and inhumane and there was no reason except for routine." After comparing the hospital and home births she said, "I understood why women wanted to have their babies at home and I knew they weren't crazy and it made perfect sense." She also recognized that there was a need for midwives in the area because families wanted to have their babies at home. She says:

I couldn't say exactly how it happened because it was something really organic. I would say, 'Well if you are going to stay at home and have your baby at home no matter what,' there were die-hards back then, well there are still are now, the DIYs, 'I'll just come and be a pair of hands.' After a couple of births, seeing the seriousness of it, the responsibility I realized that you really need to know more. So that began my sort of self-study.

She became one of the first licensed LMs in California (see Chapter 4 for more) and has delivered over 1,000 babies. She opened a birth center in 2000 where she employs two nurses as assistants and is currently training a midwifery student. She also serves a non-CNM consultant on malpractice cases.

The CNMs all began working as nurses in basic nursing units and then transferred to L&D or Neonatal Intensive Care Unit (NICU). Each CNM started as Registered Nurses (RNs). Janet says, “I always knew I wanted to be a nurse...I did not want to be a clipboard person. I wanted to take care of patients. I wanted to put my hands on their body; I wanted to put my fingers into their wounds. I wanted to touch, to speak to them, and be an educator. I did not want to be at a desk.” For the CNMs, becoming a midwife was a gradual process and began with contact and support from other midwives. CNM Anna “knew [she] wanted to be a midwife, but that was going to be the end of the line.” A goal she successfully achieved at 45, because, as she expresses, “I had a lot of support with [these other women]. They really supported me. One literally pushed me into the delivery room.” Anna works part-time providing full-scope midwifery at a well-known health provider. She has worked there for 15 years and has delivered over 1,500 babies.

Ellen decided to become a CNM to expand her practice because she wanted to be able to take care of women before and after having their babies, “but I couldn’t do what I really wanted to do...It wasn’t easy. It was a long journey. Switching from being a nurse to a nurse midwife, who is quite independent..., it’s a whole different thing. Being a [CNM] allows me to practice care.” She has owned two birth centers but is now mostly retired and works per diem in labor and delivery. She also works with a CNM group that trains medical school students in understanding normal birth.

They began to investigate the role of the CNM because they saw a discrepancy between the quality of care they believed should be provided and what women were receiving. Witnessing mistreatment of women in labor as nurses encouraged the CNMs to go back to school to become midwives. For some, specific births were inspiring. Rachel

had a patient who was ready to deliver and the doctor was not available. “The woman said to me, ‘Oh, we can do this. Don’t worry.’ And the patient just had the baby and I caught her baby. I thought, ‘I can do this!’ I liked not having someone bursting into the room and turning on the lights and having this moment of glory of ‘they’re here to deliver the baby.’ I felt like it was all about the mom and when she was ready. I just really loved that.” She now works per diem in the same clinic as Linda and also teaches women’s health in a nursing school.

Providing woman-centered care, like the midwifery model, also inspired CNM Janet. She says:

I found that I really hated the way physicians took care of women in labor...there were some physicians there that were absolutely brutal and mean and ugly and, for lack of a better word jerks...I was absolutely shocked that women who wanted certain things were patronized and subjected to such horrible, physical abuse. You couldn’t put it any other way. It was just physical abuse. And women who wanted to get out of bed and needed to move, and who were...and I won’t use the word suffering because I hate that word for labor, but that were undergoing such physical pain were not allowed any freedom to get up...they would say, “All I want to do is stand up.” “No you got to lay in bed. No, you got to lay flat on your back.” And no one was being asked permission to have their vaginas examined. No one was being asked anything...You could go to all the Lamaze classes you wanted but if your physician was a jerk it wasn’t going to help you. And in the office, you know, “Oh yeah, I’ll do this. Oh yeah, I’ll do that. I’ll do this, I’ll do this.” Well come down to the time where you’re the most vulnerable and he says, “Oh no, that won’t work for you.” And I saw that and I thought, “oh, no.” This is not what I want.

Janet became a CNM and practiced in private practice until recently becoming a hospital midwife. She works full-time in a large hospital in downtown Los Angeles that sees around 200 deliveries each month from women who have received CNM prenatal care at surrounding clinics.

Regardless of their journey, each of the midwives described midwifery as being part of them or as being part of their destiny. Anna believes that “nothing happens by chance.” She had always been an activist for women so when traveling and she met a couple of British midwives she was inspired to become a midwife. As Janet put it, “I *needed* to be a midwife.” After her first delivery at the hospital the nurse on duty said to her, “That was so beautiful. How long have you done this? That was fabulous. I’ve never seen a birth like that. That was incredible.” Janet looked down at her watch and said, “well, what time is it?” Being a midwife just came to her.

Both Alicia and Linda believe that having a family history of midwifery partially led them to find their calling. Alicia said, “I’m very very fortunate and blessed to have a grandmother who attended births, an aunt that was a midwife, and a cousin that is a midwife. I feel like it’s in my genes. It’s been very difficult for my life, but I can’t *not* do it.” Linda had a familiarity with midwifery since childhood. She says, “I grew up in Mexico, in a pretty small, rural, agricultural place. So my grandmother had all of her babies at home, one of my great aunt was the midwife who would go around here and there. So I just grew up hearing it and seeds were planted along the way. It just kind of happened and here I am.” At the time of her interview, Linda was on maternity leave. She is now back providing full-scope midwifery at a federally qualified clinic.

Being “With Women”

Regardless of how they came to midwifery, whether through nursing or personal experience, all of the midwives believe that the midwifery model of care provides the best care for healthy women. Since the origins of the word “midwife,” a main focus of midwifery is being “with women,” which directly opposes the currently technology-

dependent maternity care system where women are monitored from afar and physicians arrive simply to catch the baby. Being “with women” means creating a real connection with their clients and developing a confident, supportive, and empowering relationship. CNM Linda describes it by saying, “I feel like I want to provide an environment during birth that is calm, trusting, and one that they feel some sort of connection with me. We don’t have to be the best of friends, but just so they feel that I’m there for them and that they’re not just another patient.” She goes on to say that she believes this is one of the primary differences between physician and midwifery labor support. LM Alicia agrees that support and collaboration are primary differences between OB/GYN care and midwifery. She says:

As midwives we are supposed to be dedicated to care, not just taking people’s vitals and doing people’s blood work, we’re supposed to be giving care. So we want to know about a woman’s family; we want to know about her diet, how much is she eating, how much water is she drinking, is she exercising, how’s her stress level. We want to know more than the information we can pull from your body via blood or urine or stool or anything else. We really want to know what’s going on with that woman psychologically, emotionally, financially...It is little things like that that really change the way a woman gives birth. Having a relationship, *a real relationship*, with their health care provider is the biggest difference between an OB/GYNs and midwives.

Pairman et al. argue the relationship between a woman and her midwife is like “a professional friendship,” where each places each other in a biographical and personal context (2000:339). The midwife is able to support a woman to the best of her ability to have a positive birth experience if they share a connection. All of the midwives cited the relationship with their clients as their favorite aspect of practice, for the homebirth midwives this included not just the client but also her family (Christine, Ellen, Janet). Christine believes that “women have to feel safe and trusting and respected by you.” She

goes on to describe how her “professional friendship” spans generations: “I love my families. I know them. It is such a private, intimate [thing]. I have babies now who were born at home with me, giving birth with me. It’s generational and you have a history and richness. I don’t know if it’s to that extent the whole hospital scene.”

Janet and Ellen both left private practice for a more regulated hospital practice, but miss the relationships formed in that setting. Janet says of private practice, “[I] loved it. Absolutely loved it. Miss it. Miss the families that you become part of.” Ellen echoed that retiring from private practice “was a lot of load off my shoulders, but still I missed it a lot.” As can be seen through the strength of the relationship between private practice midwives and their clients, these midwives fulfill the “professional friend” role. This begs the question, can and how do the CNMs working in hospitals build this relationship and support women if they do not have consistent clients?

CNMs working in the hospitals depend on their ability to connect quickly and engage with women that they do not know which is potentially equally as important as having a “professional friendship” previously established (Lee 1997). This contrasts with the extremely professional role of physicians, as CNM Linda points out, “Doctors feel like they need to be very professional and have to just give the facts.” Leap and Edwards argue “even in situations where this relationship was built in a hurry because the midwife and woman do not know each other, the midwife can engender a sense of ‘safety’ that could be described as ‘midwifery watchfulness’” (105). Midwifery watchfulness is more than just having a constant or consistent presence; it’s about really *being* with the woman. As LM Alicia put it, “When I’m at a birth, I’m at a birth.” LM Christine describes this:

We tell women, ‘Trust your body; trust the process.’ Midwifery is very much like that. You have to trust. Things that you don’t have control over. It’s not a recipe;

it's not a blueprint. Labor and birth is like a river and sometimes there are rapids, sometimes it's really calm, sometimes it's dead. You just have to go with the flow... When you enter that woman's room in labor all of your plans go out the window. You're on labor time. You're in labor/birth world and normal things don't apply, or apply very differently. Not that they don't apply because you're always aware and observing, but you're on a different paying attention, a different schedule, a different timing.

In the hospital, CNM Anna feels similarly:

I've always felt that the older you are it's more of an asset in this particular career. I've become more grandmotherly. The perception that the patients' have of me is only enhanced because of my age, more motherly, more midwife-ish. I mean I kiss every one of my patients after they've delivered. I give them a kiss on the forehead and I tell them how proud I was of them. It's not particularly professional but I mean it! And once I leave the room they forget about me, I forget about them. But for those hours we are so intimate. I'm intimate with them; I'm intimate with the family, you know. I watch them cry, I've seen them naked. It's such an intense interaction of souls of lives, but once I leave the room I probably couldn't even tell you their names, but when I'm there, I'm there.

Another important aspect of women-centered care and building a trusting relationship quickly is recognizing that each woman is an individual. This allows midwives to provide personalized attention, unlike the routinized care provided in the current model. LM Beth believes this is a main appeal to women seeking a health provider. She says, "They chose a midwife because they want the freedom to make their own choices; they don't want to be treated like everybody else." The hospital setting has a dehumanizing effect on most patients as you are stripped of your clothing and your autonomy, but by emphasizing the individual, midwives in the hospital give women back some of this control. Homebirth midwives believe that respecting a woman's individuality is best done in her own space, or in a space where she feels in control, as LM Christine describes:

It's so different when you're in their home, their turf, their nest, each one figures out what they want. You really get to match, that's part of that it, that you match your clients' needs, level of how much you're in there, how much you're not.

Everything is individualized. You're not on a rigid 'Oh, I have to do this, this, and this. Why? Because that's the way I've always done it.' Wrong!

One of the flaws of our current medical system is failing to recognize the role factors other than physiology have on labor and birth. By recognizing that patients are individuals, midwives honor a woman's feelings, emotions, and fears. For midwives, these "outside" influences are a driving factor of how they individualize their care. CNM Ellen describes how "each birth is so different, and each woman that is having the birth is so different that there are a lot of like things, but it's all so creative. What a woman brings to her birthing process is pretty complex." Recognizing these other factors inspired her to become a CNM. LM Christine discussed how midwifery takes these things into consideration to support laboring women. She says, "We don't put people in boxes. It's not a one-size fit all. You think you know [what's going to happen] and then nature goes, 'Ha-ha! I got you.' You're weighing all of these things out, what's medical, what's not medical, what's fear, what's emotion, what's exhaustion, what's real, what's do-able. You're motivating her. You're being real. You can't just tell her what she wants to hear, tell her the truth."

Integral to truly being "with women," is recognizing and minimizing those extenuating circumstances that negatively influence the birth. LM Beth believes that having a birth at home or in a center can eliminate the fears and emotions brought on by being in a hospital. She says:

Choice is important because everybody feels safe in different places and a feeling of safety is so important in terms of how a labor is going to go. That and just her feeling empowered to make choices. When she's in a hospital where she's wearing their gown and does not know who the nurse is going to be--it's really hard for her to feel safe and for her to feel like she's the one in charge. Whereas at home she's automatically the one in charge...I think having a birth center is another important choice because

sometimes, one or more of the parents is not particularly comfortable with a home birth, but they really want the idea of more choice and a place where they are going to have less possible intervention. For some people having a birth center birth makes them feel safer, you can have the same skills and the same supplies and the same emergency equipment at a birth center as you would at home, but for some reason dads especially feel like it's safer to have a birth at a birth center. So I think they're a great in-between place.

By taking birth out of the hospital the homebirth midwives return it to a more social sphere. LM Christine describes how much less disruptive a homebirth is, "You go into labor, work one day and one night, two nights of work and nothing is disturbed. You're home in your own bed, your own shower, your own bathroom, the kids wake up and they come and go and it's normal." The theme of space and space ownership is a popular topic in medical anthropology and sociology, and as Davis-Floyd describes, the midwife holds a conceptual space where the woman is in control and where care is focused on supporting her (2006:511). This space allows women to embody a sense of power by having a transformative birth experience. I believe that both hospital and non-hospital midwives can develop this conceptual space. However, it is a greater challenge to do in a hospital.

Being in a hospital raises the risk of being put into a patient role, an "infantilized" role, where our gender and socialization makes us easily coerced by the institutional power (Belenky et al 1986). By returning birth to the home or birth center, the social sphere is integral to its demedicalization (Fox and Worts 1999:344). As independent practitioners, the homebirth midwives reconstruct the meaning of birth outside of the biomedical world, which allows them to practice care that incorporates this non-medical definition (Sakala 1993:1237). Although homebirth midwives may be more successful in socializing birth by taking it out of the hospitals, all of the midwives attempt

to socialize birth. They do this in a number of ways, such as including family members in planning for the delivery (Christine, Beth, Alicia, Ellen), by having the husband cut the umbilical cord (Anna, Alicia), or by encouraging the use of a doula to provide extra emotional support (Beth, Christine).

In stark contrast to the physician model, the midwives attempt to keep the woman the center of attention while they themselves remain somewhat “invisible” during the birth. I want to clarify that the invisibility of the midwife is distinct from the “invisibility” awarded by the convenience and hierarchy of authoritative knowledge provided by interventions to the physician. The midwives believe that the midwife should support the mother in whatever way she needs and then step back, as opposed the reverse, which frequently happens in the hospital. For CNM Rachel, it was one of the aspects of midwifery that most appeal to her. Alicia describes her role in births at home and in the center:

The family is just there all together with their relatives and their support people and I’m doing my best to be invisible so that I don’t interrupt a labor process, but if the family needs me or the mother needs me, I’m there with whatever she needs, whether it’s a massage or some encouraging words, or just some direction. Letting her know where she’s at and where she’s going. Not to give up. When the babies are born, I hand the babies directly to the mom and I just give them time. I let the mom and the baby and the partner bond. If I don’t have to I don’t cut the cord, most of the time I don’t...Give women the space to birth the way that they want to and most of the time they do. And I’m just there to support that.

The same philosophy holds true for Anna in the hospital.

Always the father cuts the cord, or some significant other cuts the cord. When the baby comes out, as long as everything is OK, I put the baby on her tummy and I step back and let them do whatever it is that they’re doing. I am no longer there. After a couple of minutes I ask who wants to cut the cord, give the nurse the cameras, set up the Kodak moment, and once the cord is cut I’m delivering the placenta and doing any repairs. I’m not even there. Our nurses are also very much into leaving the mother alone, put the baby on her tummy and let them do what they want to do. So yeah, the family is very important.

By remaining invisible, midwives socialize birth by deconstructing the medical hierarchy and focusing on the family bonding process. The setting of practice for the homebirth midwives makes re-socializing birth more easily accomplished. They do not have the pressure of the medical environment that automatically frames birth and pregnancy as pathology; instead they are reaching out to women in their own space. While the homebirth midwives view the hospital setting as a barrier to providing midwifery care, the CNMs that work in the hospital have been able to adapt their style of midwifery care to best utilize their environment, which is discussed in the next section.

Interventions and Being “With Women”

In a homebirth or birth center, midwives, depending on licensure, are able to administer IVs, oxygen, and Pitocin to manage the third stage of labor. The CNMs practicing in a hospital have much greater access to biomedical interventions and attempt to be “with women” by both using and avoiding these technologies. When a laboring woman first enters the hospital, the midwives choose to be “with women” by not routinizing these interventions. As CNM Ellen describes, “Letting the woman do her work is the easiest and safest way, not to have that aggressive way.” They trust the woman and the information provided by her bodily experience to subvert the hierarchy of authoritative knowledge.

For Anna, she says, “I try best to not do any interventions if I don’t have to. I’m not interested in rushing anybody unless they want to be rushed. I’m not into augmenting, unless they need to be augmented...If somebody is making good, steady progress there’s no reason to intervene.” CNM Janet begins to support a woman by not starting an IV, by letting her eat and drink (it is standard for women in labor to be limited to ice chips), and

by encouraging them move around. Although she doesn't use technological interventions, she understands the value of purposeful action. She says:

I think the most important thing about midwifery is that we don't intervene, but we know when we need to. It's not about just: 'Well, let her do whatever,' and let that go on indefinitely. It's knowing when intervention is appropriate, as opposed to just starting with the interventions...I do a lot more labor support, rubbing people's backs, encouraging different positions...It's not just, we'll put her on her side. It makes a difference if you put her on her right side of left side. It makes a difference that she gets up and walks and that she does things to help rotate the baby.

Although Janet also doesn't routinely use interventions, she also believes that it is a woman's right. She says:

My whole goal is that a mom can leave here with a healthy baby, a healthy mom, and a healthy, intact family... For me, it's not so much the journey that she chooses; it's the destination. And the destination is a healthy baby and a healthy mom. I would love to enjoy the scenery along the way, but if she's not into the scenery; it's not my birth, it's hers. She wants to do it with an epidural? She wants to do it walking, kneeling, squatting? I'm there; I will support her either way she chooses.

None of the midwives start with interventions, but using the rhetoric of choice and individuality, they all argue that sometimes being in a medical setting and having access to interventions, specifically the epidural, allows them to be "with women." Rachel describes this:

I feel like that is one of things that I've learned as a midwife is that if I truly want to be 'with women' then I have to be with whoever that woman is. And if they are someone who has been sexually abused and their body has been harmed by that and they have a high fear level and they need an epidural, then that might be what gives them the sense of 'I just did this. I just had a baby and something good came out of my body and it wasn't a terrible experience.' On the other hand, you can see women who are completely redeemed in the experience of their body because they have a natural birth. You can't choose for them... We don't do a good job of recognizing that there are these kinds of people and these kinds of people...My friends say to me, 'You give people epidurals? But you're a midwife.' and I say, 'Absolutely I give people epidurals *because* I'm a midwife. I want to be *with women* in the way that they need to be cared for'...Overall, I think that most midwives want to support women to have the kind of birth that they want to have

in order for it to be a restorative, redemptive process and not be something that they look back on and regret.

Even CNM Linda, who describes herself as one of the least intervening midwives in her practice, recognizes the role an epidural can play in allowing a woman to have a personally successful birth experience. She says:

I've never done an episiotomy and I hope not to...I have no qualms about the epidural, if the woman wants the epidural she can have it, we are in a setting where she can have it...It's not my choice; it's their choice. With the epidural if you want it or don't want it, I will support you. Usually I tend to ask people at the beginning when they aren't in so much pain if they want it, and if they say no, but ask for it later I try to work with them to not get it. It's not my decision though.

Anna echoed the other CNMs sentiments:

I don't have a preconceived plan for somebody. My job is to give them what they want. You want to do hippie dippy birth ball, doula, oils, look at the moon? I'm totally with you...On the other hand; if you're not having fun and you want an epidural, get an epidural! You could smile the baby out. I don't see any harm in epidurals. I think the main thing should be that the woman feels good about herself, she should have a safe, healthy, beautiful delivery, and she shouldn't feel like she failed afterwards because she had an epidural. Because of that [an online forum] derogatorily called me a 'medwife' [laughs].

Although all of the CNMs believe that avoiding interventions can be empowering for women, the only intervention mentioned by the midwives as potentially empowering is the epidural. While Anna briefly mentions labor augmentation as being acceptable, the other interventions were seen as hindering a woman's ability to have a transformative birth experience. The midwives talk more about these interventions in Chapter 4.

By being "with women," the midwives recognize the individuality of each of their patients, support them in whatever way necessary, and build a strong rapport with the woman and their families. The trusting and confident environment created during this process encourages women not to fear childbirth or pain. Eliminating, or at least

minimizing, the fear of birth or pain, while recognizing the complexities and uniqueness of each woman as unique allows midwives to give women a greater sense of control while preventing the use of unnecessary and costly interventions. In a culture where women are so fearful of vaginal birth that they elect for an expensive and potentially dangerous C-section (Silverton 2001), it is even more vital that women are able to discuss fears about birth with a trusted provider. Evidence exists demonstrating that some women who are given the opportunity to talk over worries about labor decide against the procedure (Bewley and Cockburn 2004). Midwives attempt to provide an open space for discussion by focusing their care on education, which is discussed in the next section.

Education and Informed Choice

Another key aspect of the partnership between midwives and women is education. A midwifery-based system challenges the delicate dynamic of exclusive authoritative knowledge we currently see in United States women's health services. Contrary to the current technocratic model where interventions have become routine and standardized, midwives allow women to make their own informed decisions about their health. Regardless of the some of the problematic implications of informed choice described in Chapter 2, because the midwives focus much of their care on education and support, I believe that, for the most part, they successfully allow women to make the important decisions in their health. By allowing women to take on an active role in their health care, they feel empowered as patients.

CNM Janet believes that increasing the number of midwives will help promote the autonomy of pregnant women. She says, "I think once we get more midwives in the clinics doing more of the prenatal care where the educational piece comes into play, the

patients will come to us better educated, more informed, and more independent and more autonomous.” The evidence demonstrating that feeling in control during pregnancy and labor increases the confidence felt by the new mother is overwhelming (See Leap and Edwards 2006:98). Providing women the opportunity to make decisions about their health and family has been shown to have short-term and long-term impact on health and social wellbeing of the family (See Leap and Edwards 2006:99). Using prenatal care and labor attention as a tool to promote a positive self-image, the midwives are helping to create strong mothers, who are capable of making the tough decisions and strong families (Leap and Edwards 2006:98).

All of the midwives discussed the value of educating women and encouraging them to make their own informed decisions, which contrasts the biomedical model where protocol and machine output dominate decision-making. Education and communication is important to providing high quality and empowering care because those who control information control power (Wagner 2001:28). CNM Linda physically gives her patients this control by giving them their charts because “it’s their information and they should have the right to see it.”

According to LM Beth, “Informed consent is a big piece of midwifery care.” Women don’t need to follow the standards of care, but “they need to be told what the standards of care are so that they can make informed decisions about that.” LM Christine agrees, “People just need to have true informed consent. So if you’ve been informed of all the possibilities then whatever choice you make is good, but it can’t be biased one way or the other. That’s a big difference between midwifery care and doctor care—we really give true informed consent.” Both of these women touch upon a very important

aspect of informed decisions. Not only do you need to be provided with accurate and complete information, but also the ability to act on that information (Wagner 2001:32). As CNM Janet describes, “[Birth is] one of the most intimate and passionate experiences of their life...it isn’t me making it passionate or intimate it is their passionate and intimate moment. I just need to give them the freedom to do it.”

The empowering relationship between a woman and her midwife can have long-lasting effects on the quality of life of women and families. Leap, describes this saying, “Clear messages to women that the midwife trusts their ability to make decisions, and to monitor their baby’s wellbeing during pregnancy and after birth go a long way to building up women’s confidence in their ability to be experts about their own bodies and babies and to cope with looking after their children” (2000). From a biomedical perspective too frequently it is forgotten that birth is not just about making babies, but is also about making families and mothers, “strong, competent, capable mothers who trust themselves and know their inner strength” (Katz-Rothman 1996:254).

All the midwives I interviewed share the goal of healthy mothers, babies, and families. The way that they reach this goal is as diverse as their personalities. For some, interventions can be empowering, for others they are a last resort. I believe that the care provided by both CNMs and LMs is essential to creating a strong, supportive maternity care system. LM Christine speaks to the value of midwifery care regardless of the setting in which it is provided. She says:

I want it to be a positive experience wherever they are. I’m not attached to their baby being born outside the hospital or in the hospital or in the operating room. I always tell them, ‘Your baby will be born in the right place if we’re paying attention, respecting, believing, reacting to what’s happening in the moment...’ [Hospital birth] is not less than out of hospital birth; it’s just as beautiful. It’s not the wallpaper on the wall that makes your birth. It’s the spirit, it’s the team; it’s

the support. It's having people listen to you, honor you, respect you, keeping your dignity, your power, your say, your voice. All of that is held intact through the process.

Although she believes that it is easier to provide true midwifery care outside of the hospital, Christine also believes that both types of midwives are necessary because women in the hospital deserve woman-centered care. This is especially true considering the exclusivity of out-of-hospital birth because it is financially not an option for most families, including CNM Linda. She says, "Financially, we didn't want to spend that money and I felt that if I'm meant to have a beautiful, gorgeous birth it could happen at home or it could happen at the hospital. And it was beautiful. It was with a midwife that I wanted and it just worked out perfectly." It is important to give women the option of an alternative type of care provider, such as a midwife, even if they cannot afford receiving care in a specific setting.

CNMs working in clinics and hospitals primarily care for underserved populations in downtown Los Angeles that either live in a high-risk area (Anna) or qualify for Medi-Cal (Linda, Rachel, Janet). These midwives provide high-quality care at a low cost to women who have been mistreated or ignored by government in the past, who have emotional issues, or who would be considered too high-risk for a homebirth (e.g. gestational diabetes). Also, as the midwives discussed, everyone feels safe in different places. CNM Rachel describes this:

There are moments when I think, 'Why am I doing this in the hospital?' It's where I am right now, but I think there are also real benefits to being in the hospital...Some patients actually do better having their babies in hospitals than they ever would at home because they are so afraid at home. Whereas in the hospital they think, 'OK everything is at our disposal if we need it.'...The way that a woman is psychologically prepared for birth is going to really affect their birth. So if they are so scared about having a homebirth they probably will have a very difficult time giving way to labor and birth because they are scared.

Providing the type of care that will allow a woman to have a transformative birth experience is the goal of midwifery. Having these midwives work in a clinical setting allows them to provide high-quality care while considering the fears of women who have never been exposed to the idea of an out-of-hospital birth. Midwives who work in the hospital walk the fine line of encouraging women in a medical setting, while not perpetuating the fear of pain, birth, and a lack of control that dominates our technocratic model of birth.

By having a clinical presence in communities, the midwives actively participate in community development. Kaufman argues that too frequently midwifery care is focused on the three Cs: choice, control, and continuity, and ignores the importance of community (2000:26, 2002:23). Community-based care works in three ways to provide women with high-quality care. First, because the care is based in the community it is more likely to be culturally relevant. Second, midwives can work towards public health goals and focus on prevention (Kaufmann 2000:28, 2002:26). And third, through providing an empowering and personal space, they help to promote community development.

CNMs Linda and Anna, both of whom work in clinic and the hospital at least part-time, spoke about the personal joy they feel working in their communities. Anna says, "I love working in the community that I live. My daughter gets jealous, she says, 'I'm your daughter! They're not your daughters, why are they calling you all the time?' She calls them my groupies. And I love them. I love them. I love them." She goes on to add how this helps her to provide the highest quality of care. An example of her incorporating the community's culture into her practice was when she received the lab reports of a married patient diagnosing her with an STD. Instead of giving the news

herself, she asked another midwife to do it. Anna said, “I don’t even want her to know that I know. To even worry that somebody in the community knows about this.”

Like Anna, Linda has her own “groupies” with whom she has built the professional friendship. She describes it:

You tend to get your own little group because we all have different personalities. For me, my niche is probably Latinas, Spanish-speaking only, who prefer someone who speaks Spanish...The patients I love because it really is a population that really needs us and appreciated us. I’ve had patients that have sent me their cousins or their aunties. Or patients who say, “You know, I came here because I had friends who say it is a good place.

Part of the reason Linda first decided to become a midwife was because of a professor who told her how much her community would appreciate receiving care from someone who understands them. She points out how all but one of the other midwives she works with are Caucasian, but her boss is hoping to hire an African-American midwife because a number of the patients served by the clinic are African-Americans and she wants “to have her patients feel like they have someone from their community there to take care of them.”

Recently group prenatal classes have grown in popularity, a service provided at the clinic where Linda and Rachel work. The group prenatal care differs from traditional childbirth education classes because pregnant women come without their partners and because a nurse-midwife present at the meetings serves as a facilitator, not a leader. At each session, when the women first arrive, they measure and record their own blood pressure, weight, fundal height (belly size), and heart tone of the baby with midwife assistance. The rest of the session is spent on various topics including breastfeeding, pain relief during labor, or discomforts of pregnancy. They share information they’ve heard, tips they have, and general experiences and the nurse-midwife serves to clarify any

misconceptions. The clinic first organized group prenatal care to connect women to other women in their community that may be going through a similar experience. They support each other. So far the clinic has received only positive evaluations of the programs, which is reflected in the research. Bringing women together is essential to returning birth to a social model (Leap 2005), and group prenatal care has been shown to encourage women to network and bond with other women (Leap 1991). The clinic plans to make group prenatal care the standard for healthy moms and CNM Rachel hopes this model will be used to encourage women who are thinking about pregnancy to come together.

The clinic serves as a positive example of hospital and clinic based midwifery care. It provides traditionally underserved women an opportunity to receive high-quality, empowering, and culturally relevant care. Because she works with a high-risk and a frequently underserved population CNM Janet recognizes the role of providing information in a sensitive way, taking into consideration their socioeconomic status. She says:

Many of our women have no education, no formal education. Some have up to a third grade level. Our women don't read or write...they don't trust formal government; they don't trust formalized institutions. They don't understand the language; they're afraid; they're here illegally; they don't have a trust. How do you get someone who's living on no money, very little money, to incorporate nutrition into their plan?

Although Medi-Cal directs many of their patients to the clinic, they also receive a number of referrals from friends or family, which Rachel believes is positive. She says, "We have a presence in downtown LA. I think it's kind of cool that it's word of mouth. It's not like you pick us off of a list and go, 'Oh, I want to go there.' It's feeling like, 'OK this is a place that someone else that I know felt like they were safe and cared for.' I'd rather have it be word of mouth. They buy into you a little bit more." Such a model is

extremely important in health care and because midwifery recognizes the role of psychosocial influences on pregnant women, rooting midwifery care in a woman's social context is especially important (Leap and Edwards 2006:116).

The CNMs fill an important role in increasing access to quality maternity and women's health services for underserved populations, but the homebirth midwives also do their share of community development and outreach. Maybe one of the most important features of out-of-hospital midwifery is that it provides an alternative to the biomedical model. The more women that elect to use an alternative system and abandon the disempowering biomedical system, the more hospitals and physicians will need to incorporate higher standards of care for women (Sakala 1993). We have seen this happen in the recent past where dissatisfied patients campaigned for partner incorporation in labor and for "rooming in," where the baby sleeps with its mother as opposed to the nursery. If hospitals see that women are seeking out midwifery services, they will have a strong incentive to incorporate midwifery into their maternity teams.

The LMs recognize that out-of-hospital birth is something reserved for the elite. As a one of the few midwives of color in California, LM Alicia emphasizes community engagement in her own practice, with a focus on minority women. She says:

My responsibility and goals are to serve the community. I work really hard to make it accessible to all people. Unfortunately, in the United States, homebirth is something that is for the elite, the wealthy, for those that have a stable, steady income...I'm working really hard to change that...We have the worst statistics in the world as minority women and I'm trying to make up for that in just being able to provide midwifery services to low-income, minority families and just in doing that change the statistics regarding premature babies and sick moms, dying moms, dying babies. I'm trying to do my part.

She focuses on outreach and education, using her status as a mother to connect with pregnant minority women she sees on the street. Additionally, she takes on student

midwives of color because she recognizes the struggles she faced in becoming a midwife and how important it is to support minority women, because pregnant women “want to receive care from someone who looks like them” (Alicia). However, because she runs a solo practice, balancing her home life and work life can be a struggle, which was a common theme among the midwives (see Chapter 4). She tries to overcome the limits of her energy by educating women about out-of-hospital options and “set them on the path.” By doing this she hopes to strengthen the community of midwives and mothers, to create awareness, and ultimately encourage women who otherwise wouldn’t, to have the transformative homebirth experience.

Implications

“The overall goal has to be that women are enabled to make decisions that make them feel powerful, wherever they are and with whoever attends them when they give birth. They can only feel safe, secure and protected if they know that their concerns will be respected and that their integrity and autonomy will be preserved.”

-Leap and Edwards (2006:103-104)

Midwives represent a sustainable and empowering potential addition to the current maternity care system in the United States. By providing midwifery care that reflects their diverse personalities, they are able to emphasize individuality, education, choice, and support to empower patients as women and mothers. By truly supporting and creating a “professional friendship” with women, they circumvent the hierarchy of authoritative knowledge found in the current medical setting. They encourage women to be confident in their bodies and their provider and to have a positive experience with their provider both in pregnancy and intrapartum care. Although midwives provide high-

quality care both in the United States and around the world, their future is in jeopardy.

Challenges to midwifery and potential solutions are outlined in the next chapter.

Chapter 4

Challenges to the Future of Midwifery

Despite the high-quality and low-cost care provided by midwives, they have yet to be incorporated in a major way into the maternity care system of the United States. All of the midwives agreed on the major challenges to midwifery, each of which manifests itself uniquely based on their practice setting. These challenges include systematic limitations to midwives' autonomy by the ACOG and the AMA; a general lack of understanding of the different types of midwives and their credentials; and litigation and insurance.

Awareness and Visibility

Something that originally attracted me to this thesis topic was my own ignorance about midwifery in the United States. The confusion about and lack of recognition of the different types of midwives limits their ability to organize and conduct strong political campaigns to lobbyists, insurance companies, and politicians. Because midwives are not visible practitioners, women are not fully aware of their options in maternity care. LM Alicia addresses this and her personal attempt to promote midwifery:

The first thing that has to be done is they have to see us. If you don't see something then how do you know either A) that it exists or B) how do you go about doing it. I've used that example for a lot of things in life, like breastfeeding or birthing...it's all about getting the information out there. From the moment that I started studying midwifery I made it my personal goal to do community outreach... To say, 'these are the options that you have'...really just talking about it, simple as that, just talking about it...Not from an area that's critical, but from a loving place. Just trying to give them information, but without seeming judgmental or pressuring.

The invisibility of the midwife is unique to the United States as CNM Rachel describes, "Most of my patients come from Mexico and Guatemala and they don't even bat an eye,

they totally know what a *partera* is... ‘Oh yeah! That’s what I want.’ They think it’s kind of odd if they get sent to a doctor. So it’s for our culture...that we are an anomaly.”

Midwives are a diverse group of professionals, which is part of the richness of midwifery care. However, this diversity also prevents a uniform understanding of the types of midwives regarding where they can practice, how they practice, and their licensure. CNM Janet believes that:

What confuses midwifery is that here in America we have so many different midwives. And that makes it very confusing for a lot of people, and I’m not sure we’re ever going to get just one type of midwife in the United States. In England if you’re a midwife; you’re a midwife; you’re a midwife. There aren’t 12 different types of midwife. And in the United States there are so many different types, some are legal some are not, some have hospital privileges some have malpractice insurance. It’s confusing.

LM Beth seconds this idea and believes that one solution is having a standardized education for midwives. She says:

One [challenge] is the fact that people don’t know what midwives are or what our training is and that leads to the question why not all midwives are trained in the same way... I know a lot of midwives that would disagree with me, but I think that we need to have more consistent education standards for midwives. I think we need to be able to support them with knowing what standard of care is.

All of the midwives recognize that standards of practice are integral to not only successfully providing women with high caliber care but also in legitimizing midwifery. However, creating a standardized midwifery education or licensure could potentially eliminate the richness of midwifery and play into the current biomedical model where a certain type of education is valued over experience. Also, as is addressed later in this section, the CNMs, who have the most medical expertise of the midwives, run the risk of being co-opted by the medical establishment that they work in. Having multiple options increases the quality of the options, as described in Chapter 3.

LM Christine's experience with becoming a licensed midwife demonstrates the benefits and problems with midwifery licensure in the United States. When she first began attending births the only legal way to become a midwife was to go to nursing school and then midwifery school. "If you were an unlicensed midwife you ran the risk of being charged with criminal prosecution for either practicing midwifery without a license or practicing medicine. A very underground, very stressful role," she said. After being arrested for practicing medicine without a license she began to work closely with other midwives on five bills to promote the licensure of non-nurse midwives. In 1996, because of her efforts, the first licenses were issued to midwives. She describes her career:

From around 1979-1996, I was attending births as a completely illegal, underground outlaw unlicensed midwife, completely and totally self-taught. Did I want training? Yes. Did I want to go into a nursing training program? Not really. Not that there aren't valuable things to glean from that. I have the utmost respect for the medical skills we can use in our practice, but it just didn't seem right that for the ten things you learn in nursing school that you'll learn in midwifery that you had to do that whole deal. Over the years we worked hard to learn what we could learn and at some point we decided that if the state wasn't going to recognize us then we were going to create our own accountability and protocols and guidelines.

With the California Association of Midwives, a grassroots organization, she helped design an exam for certification, which corresponded to the creation of the Certified Professional Midwife role by MANA. She was one of the first licensed in the state of California.

After we became licensed we had a title and you traded the perspective of 'Well I could be criminally prosecuted and go to prison as an unlicensed midwife, now I could be sued.' But I was all about getting some sort of accreditation in that you have to be accountable for what you do and you're not in a vacuum.... So really, over those many many years we did self-training and gained the training and ability to do [medical things]...I was probably in self-taught school for the first probably 20 years. No formal training. I don't have a degree. I'm very old school.

Prior to this licensing program, the three LMs I interviewed would have been considered

to be illegally practicing midwifery in the state of California. For all three, they felt that becoming a CNM would not allow them to practice midwifery and truly be with women in the way that they wanted. I believe that Christine and the other LMs' experiences highlight that a rigid educational program does not suit everyone, but there is a need for licensure to ensure a standard of care and that midwives portray themselves accurately to clients. CNM Ellen reflects on this:

I think we have to raise the standards for all midwives. At first people wanted all these midwives to become nurse midwives, and so many of these young women who are talented don't want to be nurses. Where do you go with that?...I embrace all midwives, but also you want to have people that are reaching certain standards to be able to be able to be in that community and be well thought of, I think.

If midwives can accurately publicize their practice and women become aware of the different types of midwives, successful integration of midwives on a larger scale into the maternity care system may be possible. CNM Rachel highlights this, "[The biggest challenge is] being understood for what we can do and can't do and the idea of people knowing about us. So I think that is the biggest challenge, educating people about midwives, because once they are educated about midwives they have the option of choosing and they can choose appropriately." Getting to a point where women are both aware of their choices and able to carry out their decisions will require a restructuring of the current medical system, starting with the physicians and the organizations that dominate it.

Sacrifice: Physicians and Autonomy

The main factors preventing midwives from becoming widely recognized are highlighted in Chapter 2, one of which is the professionalization of obstetrics and the creation of the American Medical Association and the American Congress of

Obstetricians and Gynecologists. When asked why midwifery is not common in the United States, when in the rest of the world they are a popular care provider, the midwives unanimously blamed the politics of ACOG and the AMA. LM Alicia said, “ACOG is gunning for homebirth midwives. They don’t want us to exist, they don’t want us to practice, they don’t want us to support the families that are really fantastic candidates and that’s just not OK.”

They believe that the same mechanisms used to originally medicalize birth keep physicians in control of maternity care. For CNM Anna, one of these factors was the pathologization of birth. “They have set up a culture where pregnancy has become an illness, and as doctors they are there to protect you from illness.” She continues to point out another major theme brought of by the midwives: money. She says, “I know it’s their bread and butter: pap smears, breast exams, deliveries, but my feeling is that doctors are trained for illness. I mean God bless them; we need them. But...you don’t need a doctor for healthy women.” CNM Janet agrees that physicians have a place, but they do not belong attending normal births. In response to why there fewer midwives practice in the US, she said:

The AMA. It really is sharing a piece of the pie, an elitist attitude. If you have money, why would you get a second-class provider? I believe physicians have a place. I am not against physicians, but I think we need to understand that physicians really spend very little time in residency learning about normal birth. Physicians belong taking care of high-risk patients. *I am* an expert in normal birth. I don’t want to deliver the high-risk patients; they can do that, but leave me to do what I’m an expert at. It’s really interesting because we recognize that people are experts in certain areas of all other professions. Why can’t we recognize that midwives are experts at normal births? But it’s the AMA, cold pure simple truth...I think it’s very hard especially in these economics. They don’t want to share a piece of the pie. And not only do they not want to share a piece of the pie. They don’t even want us in the bakery. And you know, trying to convince them that it was midwifery that designed the bakery to begin with, but you know, they don’t want to go back there.

LM Beth agrees that money plays a large role in the monopolization of birth, like it did when the barber surgeons first began competing with midwives for deliveries.

I think it's because of the political climate and the American Medical Association. The way that medicine and insurance work in this country, one of the most common medical things that happen is that women have babies. When doctors were trying to become more prevalent they really tried very hard to take the whole concept of childbirth away from midwives and bring it into the hospitals. That makes a lot of money, so it's really hard to get them to bring it back out of the hospital. I've read research that says that the maternity wing of hospitals sometimes funds the entire hospital. When you look at stuff like that and you think, well, it's about the money. Then all of the insults and claims that midwives are dirty and risky and that you're going to kill your baby, a lot of those started when they were trying to convince women to come to the hospital to have their baby rather than go down the street and call the local midwife.

Although the midwives believe that the institutions behind physicians and physicians as a whole need to be re-educated about midwifery, they make exceptions for individuals. These individuals understand and respect the midwifery model of care, honor midwives' autonomy, and truly care for their patients. In her practice CNM Anna believes, "Our physicians love us. I have no problems with any of the physicians nor have I ever had any problems. They treat us with respect; they love us. I mean we do all the work! I would imagine outside doctors, midwives are taking work away from them, but our doctors we're just doing our thing." CNM Anna calls one physician "an honorary midwife" and compares how she loves and cares for her patients in contrast to "the stupid old guys that want to get the job done and go home."

CNM Linda also believes that the physicians she works with understand and appreciate the midwives. She adds, "We don't always have the friendliest relationship just because there are always conflicts. But they do support us because they know that we lightened their load...they're very supportive." Rachel admires a particular physician

who “honors midwifery care and does everything possible to support the midwives and recognizes that her role is to come in when there is a situation. But when everything is going normally she’ll back off and say, ‘I don’t want to do this. She’s your patient.’”

CNM Janet agrees: “*I am* an expert in normal birth and the physicians that I work with recognize that.” Janet believes that communication with her physicians helps her maintain autonomy and circumvent the time constraints and protocols:

I think there are ways to work around it. I find rules to be merely suggestions [laughs]. My whole life has been like that. I mean I can give somebody more time. If I have somebody that’s kind of fallen off the Friedman Curve, I call the physician and let them know...It’s the way of telling somebody, “I got it. I’m not going to hang both of us out to dry.” I’m not going to leave somebody to flounder for hours and hours, but somebody who is doing OK, I’ve very easy to say, “Step away, I will let you know about what’s going on.” I’ll monitor them according to the guidelines here at the hospital, but there are ways to follow the rules and get the job done without being quite so stringent.

The fact that the physicians that respect the autonomy of these midwives work directly with them is good evidence that if midwives were made more visible then they could potentially be incorporated into the maternity care system.

The homebirth midwives, in some ways, have a greater level autonomy because they are able to provide consistent midwifery care. LM Beth believes that by not having to follow the strict hospital protocols, she has more autonomy. In contrast to hospital midwives, she says that she can: “at homebirths I can say, ‘Well the standard of care is to try and have the baby born by 24 hours, so what do you want to do? We can try several different types of induction techniques at home and if those do work we can consider going into the hospital, but you also have the choice to not.’” LM Christine emphasizes the importance of being able to select clients that are truly a good match and are flexible. Unfortunately, this autonomy has its own drawback: the strain it puts on the non-hospital

midwives and their families.

Personal sacrifice was a huge theme for the private practice midwives. LM Beth struggles to balance her social life and describes how she is “practically attached” to her cell phone and pager. For CNMs Ellen and Janet the strain of private practice encouraged them to transition to working exclusively in the hospital. Like Ellen, whose husband didn’t like that she would leave for 3-4 days to be at a birth, Alicia and Christine described tensions with family or partners as the result of their demanding midwifery schedule. Alicia describes explaining midwifery to her then husband:

‘I’m not going to make that much money, and I’m going to be gone for days at a time, and be exhausted, and I’m going to use all of our resources to support these families, and it’s going to make me really really happy and make them really really happy.’ It’s hard to explain that to people...Unfortunately, the life of midwives and partners is hard so he and I divorced and a lot of it came from him being fed up with midwifery [laughs]. And that’s fine. It’s not fine, but it’s definitely part of the life of being a midwife—having someone who can support you in that, in being gone for hours and hours and being away from your family, and being tired, and sometimes needing to be taken care of because you’ve expended yourself with others.

Throughout their interviews, the midwives described how they join families, play a “grandmotherly” role, and generally care, nurture, and guide their clients. Their language and descriptions imply that they take on the mother or motherly role in these outside families. Unfortunately, providing this sort of support for other families can detract from your own, as Christine testifies:

You’re *never* not on, even if nobody’s due...it doesn’t matter what day of the year it is your birthday, Christmas, or your child’s birthday. If you’re on, you’re on. It is a selflessness. Other than being a parent nothing else will require or take that much out of you. You have to pull it out, a 6th, 7th, 8th wind. It’s that type of work. Endless sacrifice. You can’t not do it if you’re supposed to do it. It gets in your blood. Short of dying I can’t think of what else would take this out of my being...It’s so hard on your family, it just is. I’m not married now, but I was and my husband and both my children know that they are always second. They will never be first.

Here Christine directly compares midwifery to being a mother and has even placed her midwifery families higher than her own family. In a culture that devalues motherhood, it's almost as though they are filling the strong, motherly figure void, but sometimes at the expense of their own families. Like the systematic depreciation of motherhood, the homebirth midwives who fill this void must constantly battle against the forces of the paternalistic medical system, where professionalism, distance, and hierarchy are valued above all. For the midwives who continue to practice outside of the hospital, this sacrifice is worth being able to maintain the autonomy and provide the midwifery care that they feel women deserve.

Although the homebirth midwives have a certain level autonomy that the hospital midwives do not, both hospital and homebirth midwives are required to work under the supervision of a physician. In a political move by ACOG reminiscent of early licensure laws limiting midwives' jurisdiction, midwives are required to subscribe to the medical hierarchy by practicing under a physician, which in turn, limits their autonomy.

Homebirth clients must meet with a doctor once during pregnancy so that doctor will have chart saying that they are their patient, but they still receive all of the prenatal care from the midwife. If the doctor has this chart it means that they will attend that patient in the hospital if the midwife feels they need to be transferred. Similar to the CNMs in the hospital, the homebirth midwives described a positive relationship with the physicians who were willing to serve as backup for them. Beth describes this relationship, "They feel that they need to support us. There aren't very many of them in every area and most of the midwives use the same doctors...We have a lot of respect for them because we really appreciate that they are helping us out because nobody else will." LM Alicia

describes her first physician backup, who was on the state midwifery board, as being “very supportive, ready and willing to help as long as [she] acted in a responsible way.” LM Christine believes that she’s “been fortunate to find the occasional doctor here and there that has been at least behind the scenes supportive and provided some sort of collaboration.”

Although some physicians privately support homebirth midwives, they are hesitant to do so publicly due to the phenomenon of “tribal obstetrics” (described in Chapter 2). LM Christine spoke about a physician friend of hers that was ostracized from the hospital where he worked because he supports homebirth. She describes:

Technically we are supposed to have a supervising physician, but most OBs don’t want to step up to that for fear of liability from their malpractice or the rest of the physician community will not work with them, will make it so difficult, that’s what happened to my doctor. Because he was willing to help us, because he believed in midwives, and he didn’t think we were crazy and he would receive our transfers in the hospital and help them...They hated him and they made it so hard on him...So it’s very difficult for a midwife with any sort of out of hospital practice to find support from physicians. Even the ones that want to help you are not supported enough within their community to do it openly.

The homebirth midwives’ relationship with physicians is more complicated, which I believe is due to the more direct opposition to a medical model of birth. By not having birth in the hospital, homebirth midwives almost completely circumvent the medical hegemony. ACOG and the physician community send strong anti-midwifery messages in two ways. First, by requiring midwives have a physician backup, they make the statement that midwives are not experts and require the support, however superficial, of a physician. Second, the physicians that step up to support midwifery are ostracized from their community sending a warning to any other physicians that may believe in midwifery.

All of the midwives believe that having a team of different providers is the safest and best way to structure maternity care. They recognize that each professional from doulas to nurses to physicians play an important role and have an area of expertise. If this chain is broken then women no longer receive high caliber care. For the homebirth midwives this is significant if they transfer a client into the hospital. They describe their relationship with the hospital staff as potentially demeaning and demoralizing because the midwives and their clients are dependent on the hospital.

[In an emergency] we call 911 and they will take us to the nearest hospital and it's whatever doctor that's there... In those situations we just have to grit our teeth and deal with it... When we are going in we know that we need some help so we are not expecting that we are going to have a natural birth in the hospital; we're expecting that we're going to get some intervention, but hopefully they're not going to treat us with *disrespect*.

What the homebirth midwives find is that not only is it difficult to find supportive backup, but that when they do have to transfer someone to the hospital, they receive punitive care just for being homebirth clients. Christine and Beth both commented on how this makes homebirths less safe.

It's really sad, because from my perspective having a team is what makes out of hospital births equally as safe as being in a hospital. That you have a team of collaborative providers that respect the skills and expertise and scope of practice of a midwife knowing that at a certain point I can't help her and I need to transfer her to the hospital and relinquish care to a more expert provider. But if I don't have that person to refer her to then you run the risk of delaying care or bad care, it's a whole interruption in the continuum. It should be seamless. All of your resources should be available to you whether you are choosing to birth out of the hospital with a midwife, at home, or in a the birth center, or choosing to birth in the hospital. However, the out of hospital clientele, families, babies, mothers, midwives, often receive punitive care because they didn't choose to be in the hospital. That's where the chain gets broken and you have more bad outcomes because, from my perspective, things are not done quickly, easily, seamlessly.

Beth echoes this:

You really need to incorporate the current medical establishment with midwives

because it's been shown time and time again that when we have an easy way of transporting the mom with a complication to the hospital, midwives are more likely to do it. When it's really hard to get a mom in, or the midwife is likely to be arrested for bringing the mom in, she's going to keep that mom at home longer than she should...It makes it much safer to do a homebirth when you know that you have an easy plan to get to the hospital when you need to.

The homebirth midwives face a very tempestuous relationship with physicians and hospitals. They need and value the level of care that they provide, but frequently are forced to accept less than optimum care for their clients because of this dependence. When Alicia transfers a client to the hospital she says, "I feel like I work really hard to stay on the hospital or OB/GYN's good side so to speak. I've definitely encountered some that don't understand homebirth, they don't support homebirth, they don't like homebirth, and I just try to be patient with them as well."

Christine recounts a story about a recent transferred mom, during which a nurse filed a complaint about her. After the baby was born, Christine helped the mother start nursing when the nurse comes in and yells at the woman to be careful otherwise she'll suffocate the baby. Christine recounts, "So I said, 'Wow, the baby is doing great. Look at it's little jaw moving, and its pink and breathing. She's doing really well.' I'm so non-confrontational in the hospital, I have to go there, *and I need them*...But I wasn't going to let this woman feel like maybe she was going to go home and maybe suffocate her baby." Unfortunately for Christine, the nurse cited her for wrongly coaching the patient. She adds:

I'm not anti-doctor; I'm not anti-hospital, I so appreciate that environment, that technology, those providers when we need them. Hospitals are really helpful for trauma, injuries, serious complications, medical conditions, probably 80% of all births require minimal to no assistance, but there is that 20% that range from some mild interventions, to moderate, to intense, to critical, lifesaving. You want to have that option for all of those scenarios. I really value having a working relationship with the provider and facility that will take good care of our families

and understand that we're there appreciating them.

By making it difficult for midwives to find supportive doctors and then punishing the doctors for being supportive, the current maternity model condemns homebirth midwives and their clients to lower quality care in the case of a transfer. This makes a self-fulfilling prophecy where homebirths are portrayed as less safe, when if a seamless, tiered system were incorporated, women could expect to have the highest quality and safest care possible. Another key force that may prevent high-quality care by limiting a midwife's autonomy, especially a hospital midwife's, is the fear of litigation, as described in the next section.

Litigation, Insurance, and the Cooptation of Midwifery

Our society is very litigious. If we feel we are wronged, we have the right to sue and make that wrong a right. In Chapter 2, I describe this as defensive medicine, but it does not exclusively affect physicians. For the homebirth midwives and the CNMs, litigation and malpractice insurance represent a major challenge to their ability to practice midwifery. The hospitals and clinics where the CNMs work provides them with malpractice insurance, but for the LMs it is a costly part of owning a practice. CNM Ellen, during the 20 years of private practice, had two lawsuits. She says:

I ended up going to court and going through that whole terrible situation. I was found not negligent and theoretically I had won my defense, but that was years of torture...The government wants a lot of money from a private practice. I've lived through two other birth centers and there were times when I didn't take my paycheck. I paid everybody else but didn't pay myself.

Because of her experiences going to court she decided it was worth it to pay for malpractice insurance, which she calculated cost her 40% of what she was making. She knows some out-of-hospital midwives who don't have malpractice insurance because it is

too costly, but she warns that you never can tell who will sue you.

This is the case for LM Christine. She does not have malpractice insurance because she cannot afford it. She has become extremely good at selecting clients that share a philosophical ideal with her, she says, “You have to be able to stand by your decision and your people and you hope that they will do that as well, and if you don’t have that rapport, you don’t want to throw yourself in that situation. Over the years I’ve learned how to keep my people skills onto knowing who I’m a good match for.” However, malpractice is still a fear for her. She says, “The malpractice is just terrifying. I grew up in an era where you were terrified of going to prison. Now you’re terrified that one lawsuit will wipe you out...it’s financially devastating.”

Even for the midwives in the hospital malpractice is a major threat. Anna describes:

In the back of our minds is always that if you don’t practice within the scope of practice agreed upon and mandated by ACOG if you want to go off the curb because a woman wants or because you and the woman have decided you got to chart like crazy all the risks have been discussed because if God forbid you do something against the scope of practice and something bad happens they’ll sue you in a second. They’ll sue you even if it had nothing to do with you...So you are taking a risk upon yourself to deviate from the community standards... It’s a drag, but it’s reality. It’s what has kept me from doing homebirths all these years because here I want to give you what you want but if something turns out wrong...I’ve got three kids to worry about.

Through their own experiences and witnessing the treatment of other midwives, they believe that midwives, when they do deviate from the physicians’ standard, are judged more harshly than their MD counterparts. CNM Linda spoke of an incident in the hospital where a midwife was under committee review and the punishment was “almost more extreme than what they would have done for a doctor.” She continues, “We’re not the same as doctors and we probably don’t expect to be treated as doctors, but sometimes I

think we get the harsher treatment from administration, just because they don't always understand what we bring into the hospital." The same is true for homebirth midwives. Christine believes, "When you choose an out of hospital birth everything is going to be microscopically examined, you're going to be put on the hot seat, and you're going to be examined way harder." This goes back to the notion of a woman's risk perception as being not just about physical harm but also about maintaining family integrity (Edwards 2005).

The cooptation of midwifery by this fear of malpractice is true for both homebirth and hospital midwives. However, since the hospital provides a midwife's malpractice insurance, they are under a greater strain to follow the physician protocols. This may limit their ability to provide true midwifery care, a major concern for CNMs and a major criticism of CNMs by non-hospital midwives. CNMs are described as being slaves to their environment, the hospital protocol, and their physician supervisor, all three of which the CNMs attest to (Ellen, Linda, Janet, Rachel).

For CNM Linda, the attending physician affects the way she provides care. She says:

I'm probably one of the ones who does the least [intervening], but I think we're really patient. We do have our limits and our physician attendings that we have to report to, so I feel like my interventions depend on my attending physician. If I know that an attending physician is there who is a little more conservative, I tend to intervene a little more as opposed to someone who is a little bit more laid back...I think for me it depends on who I'm working with.

CNM Rachel who also has the experience of working in a birth center in Haiti, believes that her style of midwifery care does not change from center to hospital. However, she is also critical of the ability of CNMs to practice true midwifery in a medical setting. She says:

Here the culture of the hospital is that you can go in and try and labor and have a baby and breastfeed normally, but things kind of get in the way. IVs get in the way and medication and that sort of thing. I have a personal belief that if it is necessary then we need to do it, absolutely. But if it is all for the sake of us feeling more comfortable or us getting things done quicker then it's inappropriate use of medicine in my mind. Pregnancy and birth is a physiologic process, there is nothing disease related about it. It is not a pathophysiology, it's not an abnormality; it's physiology. Because it takes place in the hospital it becomes a disease state instead of being a normal state.

The midwifery model of care is partially co-opted by the fact that midwives report to physician attendings, whom ultimately have the decision making power (Taylor 2002).

Additionally, the homebirth midwives criticized the effects having a nursing background can have on a midwife's ability to view birth as a normal process (Christine, Beth, Alicia). Training in the hospital and the exposure to high-risk and complicated births can distort a CNMs perception of birth as being normal, making them turn into "mini OB/GYNs." CNM Anna demonstrates this through her internalization of the fear of birth.

She says:

I'm thinking maybe it's the time for me to start doing the alternative stuff that I wanted to do in the beginning, the out of hospital stuff, birthing center, that kind of stuff which was the original dream. But because I had seen so much high-risk, seen so many sick babies and so many high-risk pregnancies, plus we've got some money, that I never thought I should risk the liability of doing anything outside the hospitals. [Where she works] I'm completely covered for malpractice, so, you know, liability is an issue. Where I work I always have two obstetricians with me at any moment if something goes wrong, I've got 24-hour doctor care, 24-hour anesthesia, 24-hour NICU, a bunch of nurses, so do I want to take the risk of doing something that's in a birthing center or a home where my responsibility is 150%, I don't have any backup.

The rhetoric of risk played a large role in the medicalization of birth, and potentially in the medicalization of midwifery through the role of the nurse-midwife. As Anna testifies, she struggles with the idea of an out-of-hospital birth because she has seen so many high-risk patients. When this exposure to problems in labor is coupled with the pressure to practice defensive medicine, to follow the strict hospital protocols, and collaborate with

physicians that do not respect the philosophy of care, CNMs run the risk of being forced to surrender their standards of care in order to keep afloat in the hospital scene.

Other than following strict hospital protocols and reporting to physicians, the CNMs' ideal midwifery practice is inhibited by the simple structure of their practice. All of the hospital based CNMs work more regimented hours than the LMs making it less likely that they will be on duty when their mothers go into labor. Janet, who used to work in a private practice and now does not see patients for prenatal care, struggles with the lack of a relationship with her patients. She says:

Here we're not bonded to the patients at all. They come in and don't know us from anybody and they come with lots of misperceptions...They come with old wives tales and in a few minutes time they're supposed to trust me. And that doesn't happen. So I miss the families, but I don't miss driving two cars to go to the movies, and two cars to go to dinner because that pager could go off at any moment in time. So I love it.

CNM Ellen also made the switch to a more structured work setting at the request of her husband. She says, "In the hospital you're really a slave to where you are and what you're doing." All of the CNMs and LMs recognized the trade-off between working a more structured schedule and having the freedom to provide the style of midwifery care that they would prefer. Linda describes this as being like "mini-OBs." She says, "Sometimes I can have 5 births in 12 hours, so for that I am a mini-OB/GYN, I'm running from one birth to another to another and I don't always have time to give the care that I want, hanging out, labor sitting."

CNM Anna believes that she provides a high-quality care based on the rapport she builds with her patients and the evaluations she receives, but that she could provide even better care if she had more time. She says:

The worst for me are the miscarriages or the fetal demises. You have a patient and

she lost her baby. You're not leaving that room; I'm sitting there crying with her. On the other hand I'm aware of the fact that I have a waiting room and those ladies are waiting...I'll stay hours longer. I will not leave a patient until I feel I've given her what she deserves...What kills me, is that I think it's very unfair for the patients to have to wait because their time is just as valuable as mine. If it were a private practice I wouldn't book so many patients in such a short period of time.

Another aspect of midwifery care that Anna wishes she could provide is continuity of care. She describes her ideal client as someone whom she has seen throughout the pregnancy and the mom, baby, and family are all healthy. However, because she cares so much for her patients occasionally she makes exceptions:

I can never promise anybody that I'm going to be at the delivery, because we don't work that way. However, when I've bonded with somebody, when I love somebody, I give them my home phone number and I say, "I can't guarantee that I can come, but if I can I will." And so I have come in many many times without getting paid just because somebody loved me enough to keep coming to me and who I wound up bonding with. I feel like that's my community service, my volunteer work.

Although the practice of midwifery in a structured hospital setting compromises some of the features of midwifery, as outlined in Chapter 3, I believe that midwives in both settings are capable of providing high-quality midwifery care that serves distinct populations. Additionally, by institutionalizing birth any capacity, carries the potential to disempower the birthing woman, giving control to the institution itself (Simonds et al. 2007:69). Preventing the medicalization and/or cooptation of midwifery is integral to the preservation of the best features of a midwifery model of care.

Implications

All of these challenges prevent midwives of all types from being able to provide the quality of midwifery care they want. In the hospital and clinic, the CNMs are held to much higher standards than the physicians, must report to physicians, and are not allotted enough time to provide the level of care that they feel women deserve. The homebirth

midwives face the constant stress of malpractice claims, strain on their social lives, and the need to find supportive and scarce backup. Malpractice insurance, the need for clients to pay out-of-pocket, and the social strain of having a solo practice prevents the midwives from taking on women who are excellent candidates for homebirth, although they try to take on these cases (Christine, Alicia, Beth). Additionally, they are concerned for the future safety of homebirth midwifery because physicians in the hospital do not respect homebirth midwives or mothers and give them punitive care, which fragments the tiered system that makes homebirth a safe option. These challenges also keep the CNMs who are inspired by homebirth from practicing outside of the hospital (Anna, Rachel, Linda).

Overcoming these challenges is not only integral to providing women safe options in a high quality maternity care system, but is also important in supporting these talented female professionals. In my conclusion, I outline the necessary steps to overcome these barriers.

Conclusion

Changing Medicine: The Future of Midwifery

“We have a secret in our culture, and it's not that birth is painful. It's that women are strong.”

-Laura Stavoe Harm

Hospitals, physicians, birth centers, and midwives don't make a baby come out, they are merely there to support the woman in doing her own work. While the model of midwifery care that is aligned most closely with traditional midwifery is the out-of-hospital model, both LMs and CNMs are important, whether they practice inside or outside of the hospital system. Because a variety of forces are in effect in the maternity care system in the United States, the only way we can begin to transition to a more women-centered model of care is by having both types of midwives. The hospital midwives can be involved on a larger and more immediate scale and can improve the quality of care for underserved women or women who have internalized societal fears of birth. Out-of-hospital midwives can continue to provide an alternative to the biomedical model with personalized and empowering care.

Improving the quality of maternity care in the United States is not optional. We cannot afford to spend the amount we do on maternity care. Luckily, in this case, the most cost-effective solution also happens to provide quality and empowering care. The future of midwifery may appear to be bleak as the medical hegemony of birth has become so engrained. As a culture we devalue bodily experience and believe that technology and training can keep us safe. The media and our culture teach us that childbirth is painful and scary; that avoiding pain and using interventions is empowering and will keep us safe; and that if you opt out of this standard you are an irresponsible, feminist hippie.

While some of these themes reflect broader cultural constructs, the integration of midwifery into the mode of maternity care can begin to address them on a small scale. In order to transform the current system the following things need to happen.

1. Collaboration and Outreach: Midwives and mothers need to collaborate and campaign for state recognition and insurance company reimbursement because midwifery care is a safe, sustainable alternative to physician care.

In Chapter 4, I outlined the struggle for recognition that these midwives face due to their diverse licensures, training, and areas of practice. While from Christine's example, having just one track to midwifery is not sufficient, midwives need to come together to create a uniform standard of practice. Christine helps to fight for this high standard for midwives by serving as a malpractice case expert. "I feel like I can be an outside, objective opinion, on what the role of the midwife could and should be based on the standards of care and where we are now." Since she has had both experiences, being sued and reviewing cases, she seeks out justice, whichever way that falls.

However, the current culture of maternity care is able to pit hospital midwives against homebirth midwives. Janet isn't sure of the history between homebirth and hospital midwives, but admits, "We're divided, we're hugely divided...I think part of it is because we as nurse-midwives in the hospital are struggling to be recognized." LM Alicia addresses this issue daily. She says, "That's something that I'm working really hard on in our community is everyone respecting what everyone else does. Because our goal as midwives should be the same: safe and healthy moms and babies." Midwives need to come together in order to make a united case for insurance companies. The struggle to be recognized poses a huge challenge for midwives, who need to collaborate with other

types of midwives to do community outreach.

Mothers

Reaching out to mothers is another important step in mainstreaming midwives because for many American women midwifery care is not discussed in their pregnancy education. If more women experienced midwifery care, more women would ask for midwifery care, and potentially, these women could lobby for insurance coverage and more support for midwives.

LM Alicia reaches out to mothers, frequently talking with people on the street to put people on the “path to midwifery.” Additionally, the CNMs in Alicia’s community do periodic health outreach and prevention work, which “helps get the word out. That’s what helps women know that this is an option.” For the midwives that work in the clinic, awareness of their quality care is spread via word of mouth. Linda believes that reaching out to mothers is the most important step in bringing midwives into the maternity care system and that this will have a snowball effect. She says,

More women need to experience the care of midwives, if more women did, more [midwives] would have to be available. Friends who have gone to midwives tell friends about their midwife. I think the women who are getting pregnant or having births, need to ask for midwifery care because the ACNM said that they want to have X number of CNMs graduating each year but you can produce CNMs but if there is no demand for them from the public then what difference does it make? I think the more women that experience care with CNMs, the more demand there will be.

Reaching out to women and encouraging them to fight for what they want was a common theme for the midwives. Some of the midwives believe that insurance companies will be more likely to listen to the consumer than the provider, especially when it comes to midwifery coverage. Ellen believes that responsibility is on the women. She says:

You have to look at it and say, ‘What do women want out of their birthing

process?’ and ‘Are they willing to step-up and fight for what they want?’ Because you can’t do it alone...I don’t think that insurance companies will ever realize that [midwifery care is more cost effective] I really don’t. I just think we just have to be ever present. We need to keep giving mothers quality, individualized care, and they’re the ones who are going to have to ask insurance companies to allow this.

Insurance coverage plays a large role in limiting homebirth midwifery care to a very elite class of women. Because of this small number of women who have experienced a homebirth, Beth believes it will be a challenge to get insurance coverage of midwifery care. She says, “It costs a lot less to have a birth with a midwife but the insurance doesn’t cover our fees...in the end it would save the insurance companies money [to cover our services]. But we’re such a small number of people...it’s really hard to get enough people to be able to make change.”

By continuing to provide the quality of care that they believe women deserve, midwives hope to encourage midwifery use through outreach and client word of mouth. They hope that by collaborating with women they will be able to lower the cost of homebirth and make it more accessible to all types of women, which, as outlined in Chapter 3, will increase the quality of care provided by midwives in the hospital because hospitals will need to respond to this new midwifery demand.

Changing Expectations

By doing community outreach and banding together with mothers, midwives have an opportunity to profoundly change the way women feel about their bodies both during pregnancy and after. The midwifery model of care frames pregnancy as a normal, natural process, and the female body as powerful and strong. By reframing birth for their clients, midwives are best able to change the way women feel about their bodies. Christine believes that to normalize birth we need to start with the next generation. She says:

Awareness, education, and through really modeling it with the younger generation...Like I tell people when they have little children around for their birth or in the vicinity of pregnancy, birth or breastfeeding, that's the best example that you can give them. They grew up in a household where that's normal. It may not be the choice that they are going to choose but they will have an understanding that that's normal. Hospitals are for complications, illnesses, diseases, and sick people...It's not necessarily the healthiest place to have a baby, although you have to understand, with the culture mindset the way it is, people are brought up fearful. They have no connection to their bodies and trust and are brought up with birth as an emergency and as something that you have to be on a machine pinging, that's what you think then being out of the hospital would be upsetting for you. You wouldn't feel safe or comfortable. **It's redefining the normalcy of birth,** having people grow up with that understanding and perspective, I don't know that it's going to be an instant, quick-fix, but maybe the health care crisis will bottom out before people will go back because sometimes less is better. There is nothing wrong with simple. You don't have to overcompensate it.

For CNM Rachel, who volunteers in a birth center in Haiti, changing the expectation women have of their maternity care is essential. She says, "The way I practice midwifery doesn't really change from hospital to birth center. But what the patients come to expect and what's going on around us is very different." If women came to expect a supportive, caring provider, who respected the information provided by the woman's bodily experience, the overall quality of maternity care would improve.

2. Transform Physician Education: Physicians must incorporate midwifery into medical schools so that they begin to respect normal birth processes, psychosocial factors that influence labor, and the hard work midwives do. Only when a true team is created will women receive the highest quality of care.

As demonstrated by the positive, or at least respectful, relationship between the midwives and the physicians that work directly with them, I believe that midwives, physicians, and women would benefit if midwives were involved in physician education. If midwives trained physicians in normal birth during medical school, they would respect

midwifery more, they may come to fear birth less, and overall the quality of care provided by both parties would improve.

I would say the majority of [physicians] are so engrained in their training and their looking at birth from a medical model that they have no concept or appreciation of a wellness model or midwifery model and they don't believe that midwives have much skill. They're really ignorant about what it is we provide in terms of prenatal care and screening abilities at birth. The majority [is] just uncomfortable because of their training and what has been ingrained in them and their lack of education, pure ignorance, around midwifery.

The CNMs in the hospitals provide some level of midwifery education because they work in university-affiliated hospitals and are responsible for working with residents. This is important because it increases the respect and awareness physicians have for midwives. By having midwives teach medical school students, they are teaching them about normal birth, a process that they may or may not be very familiar with. LM Beth comments:

[OB/GYNs] just don't know what normal birth looks like and if you don't know what normal birth looks like, you don't know how to support it... The way OBs are being trained right now they end up having this artificial picture of what birth should like, so if it doesn't fit into that then they think that they need to pull out their interventions right away to make it fit into that picture...I think oftentimes their interventions are their attempt to feel safe, but not always necessary.

If midwives were to be incorporated into a physician's education, the normalcy of birth could potentially be redefined, while creating a respectful and collaborative team of midwives, physicians, and mothers. Inclusion of midwives in medical schools also may interrupt the masculine justifications for female inferiority and the intense socialization processes inherent in medical school and the practice of medicine (Cahill H. 2001)

A respectful collaboration between physicians and midwives also could serve as a force to campaign for insurance coverage of homebirths. As Janet recognizes, "[Health care] is so structured by insurance, I mean politicians don't run the United States, insurance and lawyers do." However, these insurance companies and lawyers also depend

on the word of high-power experts to make their decisions. They depend on physician advice and standards set by the AMA and ACOG when considering what services to cover and at what cost. If physicians were taught that midwifery care is high quality, they may be more likely to “share a piece of the pie.”

“In the US culture, I think the biggest challenge is being legitimized, respected, valued, and embraced as part of a valuable team member,” Christine concludes, a sentiment echoed by the other midwives. If the above suggestions can be implemented, we can begin the gradual shift towards making birth safer and more empowering. The midwives unanimously agreed that each member of the maternity team, physician, midwife, doula, nurse, etc., play an important role in providing safe, empowering care. They also believe that the safest, most empowering care will happen when this team works together seamlessly. The goal for Alicia is:

That doctors would support midwives, would understand what homebirth is about and that midwives are responsible and capable and that the families that we are working with are responsible and capable. And that midwives do the same, respect the doctors and know that the work that they do is very important and that when their assistance is needed they are perfect for the women that need help. Really that there is no attacking, there’s not maliciousness between the two of us.

The midwives are somewhat skeptical about the acceptance of midwifery by the medical system, while I am more optimistic. As our nation begins to recognize the unmet health care needs of millions of Americans, I believe midwifery will begin to gradually become more mainstreamed. If President Obama’s Health care bill remains in force, the midwives believe that more midlevel providers will come into the forefront, which Janet believes will encourage a team model of care. She says, “I think that those people will utilize the physicians as the expert in the high-risk cases as consultants, and really that tiered system will be so much better. The care will just be so much better. It’ll really be a

team.” Creation of a team-like system will give midwives more autonomy and ability to practice midwifery the way they feel is best and will also encourage our current medical establishment to become more transparent.

Implications and Conclusions

Changing maternity care in the United States is important not only for the future of American families but all for the American economy. Financially we cannot afford to systematically disempower women with the “one-two punch” of fear and interventions. We cannot continue to over-utilize expensive interventions simply because we are afraid of what our bodies can do or because physicians are afraid of litigation. Women in the United States, *families* in the United States deserve better. Beyond our borders, we cannot afford to set such an expensive yet low standard of care. The United States plays a huge role in determining what is considered high quality, especially in terms of medical care. Right now, our system shouts: “Midwifery care is second class care. If midwifery exists it’s because physician care is not affordable.” If our current system continues on this path, the autonomy, traditional knowledge, and practice of midwives around the world will be threatened. From bottle-feeding to Cesarean sections, we cannot afford to tell women any longer that their bodies are less capable than technology.

Future Studies

Throughout my thesis I have focused on the medicalization of birth, but have largely ignored an important aspect of this theme: the acceptance and individualization of problems. Instead of treating an overall societal problem or the subordinate position of women, we have decided to individualize these cases and give them a medical solution. In terms of birth, I believe a deeper investigation of the medicalization of birth by

physicians and the re-socialization of birth by homebirth midwives from a feminist perspective could provide insight into the current position of women and mothers in the US. Although I did not explore the impact ethnicity has on access to midwifery or becoming a midwife much, I believe this area deserves more attention. Additionally, the midwifery cause would benefit from an analysis of the treatment of midwives as female workers. Comparing midwives to other predominantly female occupations, such as nurses, teachers, or childcare providers, would provide an understanding in the overall treatment and view of “feminine” qualities. One particular theme that I believe could be very interesting in this type of investigation would be an analysis of the idea of midwives (or other female occupations) as this sort of replacement mothers, as a commodification of motherhood.

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