

Abstract

Throughout human history midwives have played a central role in pregnancy and birth. Recently, physicians with technological skill and standardized education have replaced midwives as the primary health care providers in Western society, particularly in the United States. However, in the twentieth century midwives reemerged into popular culture, not from a tradition dating back thousands of years, but from a rise in sociopolitical awareness and from an outcry for change. The philosophy of American midwifery born of these collective movements has clashed with biomedicine, causing tension and dissension between midwives and doctors, because both sets of healers have very different approaches for the same goal: caring for pregnant women and delivering babies safely. This paper investigates some of these conflicts and assesses them.

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A Middle Ground?: The Divide Between Midwives and Modern Medicine

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Introduction

The goal of this paper is to examine the conflicts between physicians and midwives. By midwives I am referring certified nurse-midwives (CNMs)ⁱ and lay midwivesⁱⁱ within the United States. The literature has revealed three primary sources of conflict between biomedicine and midwifery: economic concerns, education and the question of authoritative knowledge, and ideology and its relationship to authoritative knowledge. This paper will examine the economic concerns from the doctor and hospital viewpoint, the right of authoritative knowledge based on education from the doctor and the midwife perspective, and ideological differences between physicians and midwives from patients' experiences of both disciplines. A brief review of the history of midwifery in the U.S explaining the origin of some midwifery philosophy will also be included. Most of the studies in the literature were conducted in the United States; however, I have included a study from Australiaⁱⁱⁱ and a study in countries being influenced by Westernized^{iv} medicine. The paper will conclude with a discussion about the possibility of collaboration between doctors and midwives in the United States.

Brief History of Midwifery in the U.S.

Before the twentieth century midwifery was not classified as a profession in the U.S.; instead a community of neighboring women bound by experience and knowledge of pregnancy attended each other's births and acted as informal nurses (1997:1052). Apprenticeship could be gained through observation and participation or through more formal training, and payment was frequently through reciprocal services. The rise of the biomedical profession, changes in sociocultural perspectives concerning birth, state health regulations, and the lack of organization among the midwives affected and led to the decline of the midwives' prevalence as birth attendants. This decline reflects a relocation and imbalance of authoritative knowledge. As Brigitte Jordan defines it, authoritative knowledge refers to the system of knowledge that has the greatest influence in a society because of efficacy (the perceived best explanation for the state of the world) or structural superiority (associated with the strongest hierarchal power) although

several domains of knowledge frequently coexist (1992:3). Members of a society do not think of the authoritative system's position of power as natural nor as socially constructed (1992:4), and authoritative knowledge is a position consolidated not simply by those with the "higher knowledge" but with the community's interactions with the authority. To a large degree, a midwife's knowledge was perceived as inferior to the physician's resulting from new cultural and social values placed on birth and pregnancy.

During the early twentieth century a movement for better maternal and infant care led many women, such as Mary Breckenridge and those involved in the Public Health Movement, to conclude that nurse-midwifery would provide the most effective care (1997:1053). In 1920 nurse-midwifery centers opened in poor areas like inner-city New York and rural Kentucky, and in 1932 schools for nurse-midwives were established within the U.S, where previously all schooling and certification had to be obtained in Great Britain. Nurse-midwifery experienced a split early in its history over the question of nurse-midwives as independent health care providers or as physicians' assistants. The two opposing organizations combined in 1969 to form the American College of Nurse-Midwives in order to improve nurse-midwives' legal status and also likely in response to the middle-class Natural Childbirth Movement, which increased the demand for nurse-midwife services. Nurse-midwives began to move from their patients' home to birth care centers, and their training programs became more associated with university-based medical education centers. Nurse-midwives also became more involved in state-sponsored maternal-infant programs, which further legitimized their roles as safe and cost-effective health care providers with positive patient feedback (1053). This legitimization translated into growing support from physicians, with the American College of Obstetricians and Gynecologists officially recognizing nurse-midwives as part of the obstetrical care team, capable of managing normal labor and delivery with physician supervision (1997:1054). However, fear of nurse-midwives displacing family practitioners led to opposition from other medical factions and individuals, expressed by refusing or restricting practice privileges, steep costs in liability insurance, ostracism by

collaborating physicians, and misrepresentation of nurse-midwifery to the public. Despite this opposition, currently all states have legislation recognizing nurse-midwifery as a legitimate practice, although the freedoms and restrictions vary in each state.

In the 1960's and 1970's, born of the counterculture Home Birth Movement, interest in lay midwifery re-emerged (1997:1054). Proponents of home birth emphasized the natural process of childbirth and that it should occur within the familiar environment of the home and not in a medical and technological—therefore unnatural—environment. Mimicking the early community of neighbor midwives, lay midwives gained experience and informal training through observation and participation by attending friends' and neighbors' home births. At first their skills as birth attendants did not equate into a professional career, but the demand for home birth soon brought the lay midwives together to share and expand their education and information and create a social network. This caused immense concern in the biomedical community because of increasing competition, lay midwives' informal education, and the possible dangers of home birth, and since lay midwifery was illegal in most states, they were charged with practicing medicine without a license. The organizations of lay midwives gathered for the purpose of legalization and legitimization. These legal battles occurred simultaneously with activism for women's rights to abortion and contraceptives, and midwifery was seen by activists as another step for women's control over their reproductive process (1997:1055). In terms of current legal status, direct-entry (lay) midwives have regulated legal status (certifications, license, registration, or permit) in twenty-four states, legal status in ten, legal status without licensing options in two, neither legally regulated or prohibitory status in four, and prohibited status in eleven (MANA and NARM 2007). Currently nine of the regulating states offer Medicaid reimbursement for direct-entry midwives.

Background on Literature

Within the literature three themes continually arose: the conflict between medicine and midwifery, the ideology and roles of midwives and physicians, and the empowerment of women through midwife-aided pregnancy and birth. The literature revealed two main sources of conflict

between midwives and physicians: economic competition and authoritative knowledge.

According to Steffie Goodman's research in 2007^v, in order to explain the decline in CNM employment and restrictions on their practice, doctors and hospital officials cited reasons such as patients "too 'high-risk' for midwifery care" or rising malpractice insurance. However, these parties did not provide evidence to support either of these claims, and Goodman concluded that the reasons were related to political economy after interviewing obstetric care employees and employers^{vi} from two different facilities. Hospitals and physicians often viewed midwives as competitors because midwives served a high volume of previously unwanted (low-income) patients and used minimally invasive strategies.

Phyllis A. Langton's research in Washington D.C. also dealt with conflict by investigating obstetricians' reluctance to support private CNM practice or provide CNMs with medical back-up. Medical back-up equates to supervision of allied health care providers (like CNMs) by physicians (1994:32). D.C. legislation has three levels medical back-up: general, direct, and immediate collaboration (33). General back-up, which is the category under which CNMs fall, refers to communication either via phone or in-person; however, health care facilities can require a higher degree of supervision like direct back-up, which requires a physician to be in the facility at the time of delivery. The two major sources of obstetricians' reluctance to support private practice and provide back-up for a midwife were professional accountability and economic restrictions (1994:36). The majority of obstetricians believed that CNMs were meant to be supplements to a physician, that a physician's extensive education better qualified him or her to care for patients, and that CNMs would be reluctant to ask a physician for help (1994:37-39). Also, obstetricians felt there were fewer paying healthy patients available, and competition for them was increasing (1994:41). As for economic restraints, obstetricians feared the high cost of malpractice insurance for providing back-up for midwives and taking the risk of being sued (1994:42-43). Finally, physicians wanted reimbursement for their services, which the obstetricians did not foresee occurring (1994:44).^{vii}

Biomedicine's influence on authoritative knowledge in the Western world and beyond is illustrated by Robbie-Davis Floyd's research on the relationship between biomedicine and midwifery in developing countries^{viii}. The study included in this review explores indigenous midwives' or TBAs'^{ix} views on the hospitals set up to provide better care for women in developing countries. WHO, UNICEF, and SMI^x have courses lasting several weeks meant to educate TBAs in a biomedical fashion, especially detailing when to transport a pregnant woman to a hospital (2000). These programs discontinued the training after mortality rates did not decrease. Blame was placed on the midwives (2000), but in fact the midwives had difficulties and concerns concerning transportation and hospitals that the programs did not address.

Another major conflict is due to the ideological differences between doctors and midwives. In 1995, the rising trend of lay midwives becoming CNMs was examined. At first, many lay midwives believed nurse-midwifery was not compatible with their philosophy because of its reliance on and alliance with medicine and doctors (1995:431). Her surveys of these lay-turned-nurse midwives revealed that most of them did not feel their certification was necessary although it was useful in practice and allowed them to provide more service to more people (1995:434-435). However, an even greater number of them felt that lay midwifery had been a positive experience, and that a tenet of midwifery—home birth—was not covered adequately in nurse-midwife training (1995:436).

The midwife's feminist approach seems to have a certain appeal to women giving birth. In Karen Coyle, Yvonne Huack, Patricia Percival, and Linda Kristjanson's research of mothers in Western Australian, birthing centers patients who had experience with hospital births were contrasted with midwife-aided births. The authors identified four key elements in their interviews (2001:183-185). The mothers believed in birth as a natural process, a view which they thought midwives shared and which caused the midwives to intervene as little as possible (2001:185-186). However, the mothers felt that doctors, and even midwives within a hospital, viewed birth as a disease that must be cured, and that is why intervention was much more frequent in hospitals

(2001:186-187). Finally, mothers felt that they were the equals of midwives and that midwives educated them so that they could arrive at their own decisions (2001:188), whereas doctors were the experts, and they decided what was best for the mother (2001:189-190).

Discussion of the Literature

Conflict between Physicians and Midwives Due to Economic Factors

Maternity care constitutes one-fifth of health care expenses in the U.S. (Goodman 2007). In comparison to the U.S.'s 7.45% of midwife-attended births^{xi}, other industrialized countries have 50-75% of births attended by a midwife and report lower infant mortality and lower overall maternity care costs, which result from midwives' general avoidance of technological intervention unless absolutely necessary (2007). In general, midwives present several financial difficulties to physicians and hospitals. Midwife's cost efficiency could lead to an increase of previous hospital patients seeking cheaper obstetric care or, if midwives are employed with the hospital, a decrease in funds received from the hospital's billing patients for intervention and technologically dependent procedures, which the midwife generally avoids. The traditional patient demography of midwives is frequently low-income, immigrant, or uninsured women, which according to Goodman have become more valuable to physicians as Medicaid reimbursement has improved (2007). In Goodman's study, one hospital stated an increase in high-risk patients as a reason to limit midwifery, which Goodman rejects as a façade (2007). He/she stated that the obstetrics department had to pay a fine because doctors were billing patients for midwifery services inappropriately, and physicians felt they were losing patients to the midwives. However, in Langton's study, obstetricians cited high-risk patients, like Goodman's two facilities did, as unsuitable for midwife delivery (1994:41), which will be discussed in the next section.

Also, both a hospital in Goodman's study and obstetricians in Langton's study cited rising insurance costs as reasons to not endorse midwifery, although Goodman doubted the

hospital board's veracity because of announcement's abrupt nature. However, Langton's obstetricians stated that their premiums would increase if they filed claims to back-up midwives or if they were sued (1994:42-43). It seems that the insurance companies do not value the professional midwife and the physician cannot defend supporting a midwife who usually has less training and therefore more liability. Langton's obstetricians desired reimbursement for their back-up service, but since midwives typically serve low-income patients, the midwives saw no way to afford back-up themselves and keep costs low for their patients (1994:44). Obstetricians state that the monetary amount of reimbursement is not equivalent to the amount of time back-up takes because while obstetricians are supervising midwives it puts strain on their schedules. In this case Medicaid does not provide sufficient funds for the "best" midwifery services, or with physician back-up. This contrasts with Goodman's belief that physicians wish to take Medicaid patients in their practice, and one D.C. obstetrician even states that back-up and Medicaid are not financially worth the amount of time and risk necessary (1994:44). This could indicate that sometimes physicians' fiscal value exceeds Medicaid reimbursement. The portrayal of midwives serving low-income patients could reinforce a social standing of "lower class" health care providers among the medical community.

Conflict due to Authoritative Knowledge in relation to Education

In the past, authoritative knowledge of pregnancy and birth has belonged to women and midwives. According to the Midwives Model of Care^{xii} the role of the midwife includes educator, attendant during pregnancy, delivery, and post-partum; adviser; and support system (1996). The midwife sets up prenatal visits and regular check-ups and is available to answer questions. The midwife also helps the mother to set up an emergency birth back-up plan, any necessary diagnostic testing, or appointments with other health care specialists. The midwife provides the mother and family with information about pregnancy, birth, infant care, breastfeeding, any recommended procedures, tests, and treatments (1996). Throughout the process, the midwife emphasizes the natural process of birth and the capability of a woman's body during birth. The

midwife provides the mother with information about good nutrition and lifestyle choices to make intervention procedures less likely (1996). The midwife respects the mother's and family's informed birth plan and supports their decisions. Because of the relative freedom of the delivery setting^{xiii}, the midwife encourages the mother to move into comfortable positions, to eat, and eases the discomfort of labor with massages, labor in water, and other methods (1996). Whether a lay- or nurse-midwife, this summarizes and generalizes the environment and philosophy midwives try to foster, usually in the more independent settings of homebirth or birth centers.

Still, the physician with extensive educational training and technological skills in Western society has become the main authority figure in health care. Generally, midwives are seen as inferior health care providers because midwives' less formal education significantly reduces their abilities in the eyes of medical doctors. Davis-Floyd highlights the difference between biomedical education and midwifery education as didactic versus experiential (1998), with biomedicine emphasizing the didactic and midwifery the experiential although both incorporates each. In Langton's study, the obstetricians thought the role of the midwife was a supplement and not substitute to the doctor's role (1994:37). A major issue was that these obstetricians had spent years and large sums of money to become what they are, and a midwife is required to do far less training (1994:38). It seemed unfair to them that midwives could provide the same service that the obstetricians had labored more intensively to achieve. Obstetricians also had concerns that midwives would do anything to achieve a natural process of birth, even if at expense of risking the life of mother and infant by not calling a doctor as soon as they should (1994:39). As mentioned earlier, doctors are concerned about high-risk women and a midwife's ability to provide for them. In Langton's D.C. study, some examples of high risks are women waiting to have their first child until their late twenties or early thirties, pregnant women abusing drugs, and teenage pregnancy (1994:41). While the first group is fairly stable except for their age, the last two groups frequently do not have check-ups regularly or follow directions as well as they should, resulting in high-risk pregnancies and low birth-weight babies. While technological skill

may prove effective in safely delivering this category of high-risk pregnancy, the midwife offers a different option. Langtons' obstetricians did acknowledge that the effectiveness of CNMs in pregnancy education, especially for difficult-to-reach women (1994:40), and obstetricians defined CNMs' roles as mainly counselors, educators, outreach administrators, prenatal caretakers, and health providers for noncompliant women. This gives CNMs a predominately preventative role in high-risk pregnancy situations, at least from the physicians' point of view and likely from the midwives' as well. The Institute of Medicine and Office of Technology Assessment has found that CNMs can effectively care for at-risk^{xiv} patients and are more capable than physicians when providing services dependent on communications with patients and preventative measures (1994:28).^{xv}

Robbie Davis-Floyd presents an interesting perspective on biomedicine's clash with midwifery by taking the stand that the biomedical system infringes on the traditional systems of midwifery and healing. She claims that frequently the midwives and women are not at fault for not choosing the biomedical birth care method; the hospital system is. In this situation, it was midwife against midwife—the licensed versus the local midwife. Many midwives reported a reluctance to transport women because (1) they do not have reliable transportation and (2) they did not want to subject their patients to the hostility, disrespect, and pain received at the hospital (2000). Frequently hospitals in developing countries outside of the U.S. do not have sufficient funds or staff to provide adequate care and therefore were not necessarily better environments to give birth in (2000). The mothers opted to stay at home with a midwife instead of traveling to a hospital, where they could not be sure of their treatment.

Although CNMs could be considered a successful integration of midwifery and biomedicine, frequently CNMs are under the supervision of a doctor and the biomedical system. Many lay midwives feel that nurse midwifery is at odds with their ideology: CNMs are the bottom of a hierarchal team, limited in services and patients by their employers, and too dependent on biomedicine. Several studies^{xvi} mentioned hospital midwives acting more like

nurses than midwives. The lay-turned-nurse midwives in Ventre's study were asked to prioritize why they became certified; their top four reasons were to impact the system, to be legal, to serve a more diverse clientele, and to gain more skills, expertise, and education—particularly gynecologic (1995:433). They wanted acceptance into the health care community because fighting against it seemed counterproductive to their goals, and generally they reported being accepted in a positive light by classmates and teachers (1995: 433-444). Despite attempts at reconciliation or tolerance of lay midwifery on the part of CNM organizations, CNMs fear the same displacement by lay midwives that physicians do (1997:1056). CNMs are the middle ground between midwifery and biomedicine, and instead of combining the two professions CNMs must choose where their loyalties lie and allow one discipline dominate the other.

Conflict due to Authoritative Knowledge in relation to Ideology

U.S. lay midwifery arose in conjunction with other sociopolitical movements for change and became a part of the feminist movement, challenging women to take control of and understand their own bodies again (Ventre et al. 1995:428-429). Since most physicians refused to attend to pregnant women in their homes, and nurse midwives had legal restrictions and regulations, lay midwives became the solution as home birth attendants (430). Midwifery views birth in more a social context, rather than medical (Coyle et al. 2001:182). Therefore, the mother is the focus of the pregnancy and birth, and the midwife acts as a knowledgeable and respectful support system for the mother. Midwifery returns authoritative knowledge to the mothers, educating them so that mothers may make informed decisions concerning her pregnancy and delivery. Instead of emphasizing the complications of birth, midwives insist it is natural and therefore requires only enough technological aid to ensure success.

Midwives emphasize the role of the woman, and the physicians emphasize the role of the infant. This gives midwives a fairly egalitarian relationship and shared responsibility of choice with their patients while physicians become the authority because they will usually know more about birth and pregnancy than the mother. For example, one Australian mother said a doctor

pressured her into giving her child a vitamin K injection after the birth when she had previously decided against it (Coyle et al. 2001:190). The mother certainly is an important component in birth and pregnancy to a physician, but she is usually seen as a vehicle for a potentially dangerous and fragile living being. Therefore, the doctor is the ultimate deciding factor for what will be best for the infant.

The mother's safety is a primary issue, and physicians frequently express that homebirths could be potentially hazardous if complications occur. Midwives' commitment to natural birth makes doctors regard midwives with suspicion. Transportation could arrive too late and the midwife would have little to no technological training or equipment to save the two lives at stake. Doctors believe that midwives simply do not have the correct equipment or the capacity to deal with unforeseen issues. Even though 70-80% of births occur without complications, the possibility that a mother could fall within the other 20-20% (Goodman 2007) is too much of a risk for most doctors' preference.

Conclusion

The majority of literature regarding midwives and doctors has a bias in favor of the midwife. The marginalization of midwives within the American medical system has impassioned and infuriated several of the authors, and they cannot completely veil their frustration with the biomedical system. This frustration can occasionally color the objectivity of their criticisms, particularly Davis-Floyd and Goodman. In addition, all of the authors included are females, and they all focus on the conflict between the biomedical system and midwifery. I do not question the validity of their research or that the views expressed in their research extends outside that small pool of women because as a U.S. citizen myself, it seems discontent with or mistrust of doctors and biomedicine is fairly prevalent, something which should be addressed by the health community. This slant in the literature toward conflict obscures or even omits examples of collaboration between the disciplines, although suggestions do follow in some of the articles' discussions.

One consequence of some of the authors' biases is an absence or skewed representation of the physician's point of view. Langton's study presents a rational depiction of obstetricians' reluctance to support midwives. A loss of income due to competition with midwives is a comprehensible reason for obstetricians to be wary of midwives. Immediate midwife integration could have a range of repercussions on the medical and healthcare community. For example, the endorsement of midwifery limits the market for doctors, and also—if it is as cost-efficient as studies say—it could become the new preferred method of birth, putting these highly specialized professionals out of work. Since physicians provide a service it could be inferred that they view their patients solely as sources of income. However, job security is a concern of all employees, not just doctors, and competition will rationally cause discomfort. Perhaps because of midwives' tendency to serve low-income patients they have escaped the idea of viewing patients as a source of income. However, physicians have a more expensive practice to support as well. It's true that some doctors may go into their profession for economic gain, but the amount of study, time, and money necessary to attain that goal could deter the truly selfish. Physicians likely believe their method provides the best care for the mother and her infant, unaware that in part their authority is a social construct. None of this means that midwives are not deserving of their own economic niche. In fact, it seems midwives can fill in the gaps that physicians feasibly cannot, like areas without enough patient density to merit the building of a birth care facility. Also, I do see the advantage of having a variety of options, and the midwife is certainly one of those. However, more than economics, I believe the hostility towards midwifery occurs because of ideological differences.

I included Davis-Floyd's research on TBAs and hospitals implemented by Western organizations in order to demonstrate an example of biomedical bias against midwifery. It exemplifies a common perception of the irrationality of local people when, as in this situation, there was a good reason to reject the new way and continue with their traditional one. The TBAs were not even reluctant to institute biomedical procedures or practices into their own; their

environment simply limited them. Since many TBAs did accept Westernized medical practices, it would be interesting to see if these medical organizations could also respect the TBAs' intuitive knowledge, not so much in the spirit of camaraderie or another abstract principle but because the TBAs have a much better knowledge of their environment than the organizations that wish to assist their communities. Reciprocal communication could offer clarity on both sides.

Birth has the dual properties of a natural and potentially life-threatening process so it is difficult to ascertain how much or what kind of education should be required for an individual to deliver babies. Interestingly, biomedicine *does* incorporate experiential learning into physician education in the form of residency; however, experiential learning is applied with a firm didactic foundation. It seems midwifery—especially when it incorporates home birth—has a more experiential (tactile and kinesthetic) approach where the midwife touches the mother's stomach to determine knowledge about the infant, although legalization has required didactic learning as well (1998). However, the different emphases of each discipline may place midwives and physicians at odds to a certain extent because their education has taught them the importance of their own, very differing approaches. Overall, the doctor's education is most respected in the U.S. As shown by Davis-Floyd's article, the immediate conclusion of international biomedical healthcare officials is that the problem lies in the indigenous system and not within its own ranks. Within the medical community, I've discerned a certain disdain or wariness of the midwife's education. In order to be accepted as viable birth care providers, lay midwives have become CNMs and surrendered homebirths—a foundation of traditional midwifery—which reveals the bias of biomedicine and the perceived superiority of hospital birth within our society. However, Davis-Floyd brings up an excellent point: why are we promoting biomedicine in developing countries when it is too costly, too invasive, and too technologically and drug dependent for our own culture? (2000). I ask in addition, "Why are we not changing our own system to be more efficient in cost and care?" Biomedicine is not an end-all solution to birth difficulties. I cannot say which method of education has more validity because they both have strengths and weaknesses.

Completely eradicating midwifery from the healthcare system removes a successful birth alternative to hospital care. Although I do not believe lay or nurse midwifery are in immediate danger, some of the research has suggest marginalization of even the most highly certified nurse midwives, which is concerning. Neither can biomedicine be disregarded because improvements in this discipline have led to medicinal breakthroughs, longer life spans, and the potential for better quality of life.

Successful integration of, or at least coexistence between, midwives and physicians has occurred in other industrialized nations, with impressive results. If the physicians and midwives in the U.S. look beyond their ideological differences and realize their common goal of providing the best care as possible for pregnant women and their infants, the medical community as a whole could gain much. However, some significant philosophical shifts need to occur before the two disciplines can truly respect and work with each other. Until midwifery and modern medicine can move beyond their differences, I believe each discipline has a niche that is necessary for healthcare. In Tennessee, obstetric and birth centers are not sustainable in poor, rural areas and are being discontinued, leaving pregnant women with only a family practitioner (personal communication with Mark Farber^{xx}). Midwives, who have traditionally gone where doctors are not willing or cannot go, would be a perfect solution because they require less technology and, therefore, fewer expenses. For now, I believe that midwives should have some kind of relationship with a hospital or physician in order to have biomedical back-up in case of an emergency, along the lines of D.C.'s general collaboration, but I also see the benefit of independent midwife practices. The healthcare system should have options besides hospital birth for informed mothers. Not all women would choose midwifery, but at least they would have a choice.

An integration of biomedicine and midwifery has potential benefits, especially in the establishment of patient relationships. What makes midwifery so unique is the amount of communication between the patient and the midwife; as the Australian study showed, these

mothers were so much more satisfied in their birthing experience with a midwife than with a doctor. A midwife's communication with her patients is a valuable skill often missing in biomedicine. With a free flow of information between the two disciplines and an exchange of skills, a better healthcare system with more satisfied mothers, more communicative doctor-patient relationships, more cost efficiency, and lower infant mortality could be achieved.

ⁱ The international definition of a midwife is an individual who has attended a nationally accredited educational program and qualified to practice through successful completion of the program (Davis-Floyd 1998).

ⁱⁱ The definition of a lay midwife is complicated. My definition of one is an individual who is a private practitioner with education by apprenticeship, self-study, midwifery school, or sometimes a nursing school and who usually delivers outside of a hospital setting, in the home or a birth center facility (MANA). This may more formally be known as direct-entry (Davis-Floyd 1998). For simplicity's sake, I will use lay midwife here since it is used the most in my sources. Another term TBA (traditional birth assistant) will also be used briefly; these are midwives who do not meet the international definition of midwife because of less formal education (like no license or certification) and generally work within a community. This former definition is another frequent use of "lay" midwife, also known as granny or traditional midwife or birth attendant.

ⁱⁱⁱ On the assumption that Australia is considered Western in cultural background and influence

^{iv} By Westernized I mean biomedical and am referring to Davis-Floyd's article on global issues in midwifery.

^v Within the U.S.

^{vi} CNMs, physicians, hospitals and service administrators, nurses, childbirth educators, and policymakers

^{vii} Also, the physicians mentioned the overabundance of obstetricians in the D.C. area, but it may be a regional instead of national concern of doctors (1994: 42).

^{viii} Papua New Guinea, Tanzania, India, Mexico, Haiti, Egypt, Uganda, and Brazil are all examples in Davis-Floyd's article (2000).

^{ix} As defined by WHO and UNICEF (2000)

^x Safe Motherhood Initiative

^{xi} According to a 2004 study

^{xii} A definition of the midwife's role meant for consumers created in May 1996 by national organizations such as Midwives Alliance of North America (MANA), the North American Registry of Midwives (NARM), the Midwifery Education Accreditation Council (MEAC) and Citizens for Midwifery (CfM).

^{xiii} i.e. birth center or home

^{xiv} Due to social and economic problems

^{xv} In this case, the CNM and lay midwife differ mainly in legal stature because the services they provide are comparable.

^{xvi} Davis-Floyd's "Mutual," Ventre, and Coyle

¹⁴ Particularly lay midwifery

^{xx} Mark Farber is a state health care employee who reviews hospital plans, etc.

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