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# The certified nurse-midwife as a path to female agency in modern childbirth in the United States

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The Certified Nurse-Midwife as a Path to Female Agency  
in Modern Childbirth in the United States

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## Introduction

Both midwives and obstetricians care for pregnant and laboring women<sup>1</sup>; however, the fields of midwifery and obstetrics approach the care of expectant mothers in significantly distinct ways. Midwifery emphasizes the normalcy of pregnancy, spotlighting the importance of the woman's birthing experience, while obstetrics focuses on the potential problems and difficulties of pregnancy and labor, underscoring concern for the fetus's safety. These differences do not signify a midwife's disregard for safety nor an obstetrician's apathy towards a mother's experience, rather, they convey the distinct focal points in the contrasting models of childbirth under which each field practices: the social model, practiced by midwives, and the medical model, practiced by obstetricians (McIntosh, 25).

Not only do these models embody the difference in care administered by a midwife and by an obstetrician, they also reflect the historical origins of each field. Midwifery arose from the social support female friends and family members have traditionally given to one another during childbirth (Donegan, 1978, p. 12). In contrast, obstetrics developed from the rise of modern anatomical research, surgery, and birthing technology. These distinctive origins reflect the resulting divergent ideologies and conceptual practices of midwifery and obstetrics.

Although women were historically the sole birth attendants in uncomplicated, normal<sup>2</sup> pregnancies, by the eighteenth century, men began infiltrating the midwifery sphere

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<sup>1</sup> While I acknowledge that not only cis-women get pregnant, in this thesis I will use the language of pregnant and laboring "women" and "mothers," as cis-women's health was at the core of the literature I researched. Therefore, for the purposes of this thesis, "women" and "mothers" refer to individuals who can give birth, and since the available literature on this topic overwhelmingly explores cis-women's experiences, I will focus on that perspective. By no means do I intend to represent the experiences of all pregnant people.

<sup>2</sup> In this thesis, "uncomplicated" and "normal" pregnancies refer to cases in which the mother is not considered "high-risk" because she is in good health and there is no indication prior to labor that there will be any interventions needed. Because there is no "typical" birth experience, "normal" refers only to the absence of anticipated emergency medical interventions.

in the United States by attending uncomplicated births (Litoff, 1978, p. 7). Until this point in time, men had only become involved in childbirth as male physicians when complications arose and surgical interventions were needed to save the life of the mother or baby. The inclusion of men in midwifery practices gradually manifested in the creation and eventual domination of obstetrics over midwifery in the U.S childbirth practices. At the start of the 20<sup>th</sup> century, midwives attended over fifty percent of all births in the U.S, and by 1930 that number dropped to less than 1 percent. This drastic decline came about due to a confluence of factors, one predominant reason being that some members of the healthcare community believed that midwives were main contributors to the high rates of maternal and infant mortality. Persons who held this opinion believed that a ‘more’ trained and ‘professionalized’ midwife would ‘safely’ satisfy any demand for midwives by pregnant women, resulting in the inception of the certified-nurse midwife (CNM) in 1925 (Ettinger, 2006, p.15).

Despite these attempts to popularize nurse-midwifery, the CNM was not widely used until the late 20<sup>th</sup> and early 21<sup>st</sup> centuries. During these years, there was a surge in the use of CNMs. In 1975, less than 1.0 percent of births were attended by a CNM (Martin et al., 2007). By 2000, approximately 7.3 percent of all U.S births were attended by a CNM and the number continues to rise, as the CDC reported that approximately 8.1 percent of all U.S births were attended by a CNM in 2013 (Hamilton, Martin, Osterman, Curtin & Mathews, 2015; Martin, Hamilton, Ventura, Menacker, & Park, 2002). Although there are other types of midwives that are not CNMs, because CNMs account for approximately 95 percent of midwives in the U.S, a vast majority of the reemergence of midwifery focuses on nurse-midwifery. Currently, a CNM is a registered nurse (RN) who has a master’s degree in midwifery and certification in accordance with the requirements of the American Midwifery

Certification Board (AMCB) through a certification exam, which differentiates the CNM from the traditional midwife, who learns through apprenticeship. However, the CNM does not simply represent a modification in the educational requirements of midwives in the U.S, but rather, because its position lies at the center of the historical and current controversy between midwifery and obstetrics, its role symbolizes the larger historical and current controversies within the U.S childbirth sphere. In addition to the CNM's unique position between obstetrics and midwifery, the recent upswing in the use of CNMs during the 21<sup>st</sup> century has elevated the visibility of the CNM, raising many questions about the values upheld by nurse-midwifery. These reservations have surfaced due to the fact that the CNM represents the carrier of both obstetrical and midwifery knowledge, and debate has arisen as to whether the CNM can uphold the values of both fields within its practices.

Under the current childbirth model dominated by obstetricians, there has been an increase in the use of cesarean sections, drugs, and other technological interventions in childbirth. However, the revival of midwifery at the end of the 20<sup>th</sup> century and into the 21<sup>st</sup> century has demonstrated a partial rejection of this technocratic model of childbirth. With these heightened sentiments surrounding childbirth, the dual image of the CNM, as both an insider and an outsider on both sides of the midwife/obstetrics controversy, has become increasingly visible. In this thesis I will explore these complexities, examining the CNM's composite role within and between these two fields, while also investigating the larger social and economic context in which midwifery, obstetrics, and nurse-midwifery exist.

Chapter 1 will narrate the historical transition from midwives to obstetricians as the predominant birth-attendants in the U.S. This historical perspective will encompass the controversy between midwives and obstetricians that formed the foundation for the

introduction of the certified nurse-midwife (CNM). I will utilize this historical lens to demonstrate how these changes in childbirth practices have devalued and restricted female agency in childbirth.

Chapter 2 will discuss the current state of childbirth by examining the increased rates of medical interventions including the use of birthing technology such as electronic fetal monitoring. In this investigation of the overuse of birth technologies, I will focus on the obstetrician's increasing control over the female body in the name of safety and technology. This discussion will serve to examine the diminishing agency of the expectant mother and an increased surveillance on and concern for the fetus under the obstetrics model of childbirth.

Chapter 3 will explore the "Renaissance of Midwifery" and investigate what forces and movements led to the resurgence in the use of midwifery albeit in the modified form of the CNM. I will focus on the ways in which social movements, primarily feminist movements bolstering natural birth, home birth, and the reclamation of the female body, have led to a change in women's expectations in childbirth. A discussion of these women-centered movements serves to explore the control and autonomy woman have exerted in shaping childbirth practices in the U.S.

Chapter 4 will scrutinize the CNM as a professional and its relationship to the obstetrician. I will compare and contrast the values of the professional organizations that represent obstetricians and CNMs in the U.S. With this perspective, I will explain the relationship between the CNM and the obstetrician in the context of state regulated practice agreements to demonstrate the marginalized position of the CNM in the obstetrical sphere. Conversely, I will investigate the fragmentation of the field of midwifery, highlighting the contentious relationship between CNMs and traditional Direct-Entry Midwives. In addition,

the chapter will explore the use of collaborative models in hospitals consisting of teams of obstetricians and CNMs as a case study demonstrating the opportune role of the CNM.

The position of the CNM stands at the crux of the controversy surrounding the care of pregnant and laboring mothers in the U.S. Its title alone encompasses the duality of its position, both in the medical mainstream and at the margins of it. In this thesis I will ultimately explore the question of whether the CNM is an asset or a liability to the core values of traditional midwifery, and if its presence has weakened or promoted the principles of midwifery in childbirth in the U.S. Is the CNM a manifestation of the medical sphere's further invasion into the practice of midwifery? Is it a result of the interests of expectant mothers? I will argue that it is a combination of both.

CNMs hold an opportune position for impacting U.S. childbirth in a way that is advantageous to both pregnant women and the U.S. healthcare economy. As healthcare providers in hospitals, CNMs prompt the imposition of midwifery's ethical and ideological frameworks in the obstetrics medical. In this paper I do not argue that the CNM is an immediate solution to the high maternal mortality rates, usage of obstetrics technology, or to high healthcare costs; however, I do argue that the values of nurse-midwifery put a spotlight on these issues in childbirth through emphasizing the mother's voice in childbirth.

To set the stage for these questions, it is crucial to lay out the historical chronology of childbirth practices in the U.S. A systematic exploration of the history of childbirth will provide a framework that is essential in the examination of the change in female agency, an issue that is at the core of my investigations on CNMs and modern childbirth practices in the U.S.



## Chapter I: The History of Midwifery and Obstetrics in the U.S.

At the beginning of the 20<sup>th</sup> century, midwives attended approximately fifty percent of births in the United States, and by 1930 that number dropped to less than 1 percent. Over the course of most of the 20<sup>th</sup> century, midwife-attended birth rates remained below 1 percent. To understand the drastic and sustained curtailment in midwife use, it is crucial to examine the historical chronology of childbirth birth practices in the U.S. Enveloped within this historical narrative, and at the center of these investigations, is the controversy between midwifery and obstetrics in the U.S. This chapter will examine the evolution of this relationship between midwives and obstetrics to create a historical framework for an examination of female agency through out the history of U.S childbirth.

For most of history, the midwife has been the primary birth-attendant in the U.S. However, during the 20<sup>th</sup> century, there was a drastic decline in the use of midwives, resulting in less than 1 percent of all U.S births being attended by a midwife in 1975. By 2013, approximately 8.9 percent of U.S births were midwife-attended (8.1 percent attended by CNM and 0.8 attended by other types of midwives) (Hamilton, Martin, Osterman, Curtin & Mathews, 2015). In comparison, over 80 percent of births in Europe were attended by midwives in 2008. This global disparity suggests that the decline in the use of midwives in the U.S is specific to the historical atmosphere of childbirth in the U.S. In this chapter, I will explore the historical influences that have framed the face of U.S childbirth practices today.

Throughout most of history, midwifery has been a profession occupied and controlled solely by women. Most colonial midwives were well paid and well respected in the American colonies (Litoff, 1978, p. 4). Since medical practitioners were kept under little surveillance and had limited specialized medical knowledge at the time, any woman who

assisted friends and family members in birth was considered a midwife (Donegan, 1978, p. 12). Then, in 1716, in its first formal regulatory law for midwives, the New York Common Council required midwives to, “Be diligent and ready to help any women in labor, whether poor or rich.” Most notably, the law also stated that men were to be excluded from all birthing matters except in cases of an emergency (Litoff, 1978, p. 5). When complications arose, midwives called upon male surgeons. These male physicians knew very little about birth and typically, “Could only extract the child piecemeal to save the mother’s life or perform a cesarean section on the mother after her death to save the baby” (Lay, 2000, p. 46). Therefore, male physicians were purposely excluded from normal birthing labors during the 17<sup>th</sup> century, only to be included during emergency surgeries. However, these attempts to keep men separate from birth did not prevail for long.

Despite previous laws prohibiting the inclusion of men in non-urgent births, in the 18<sup>th</sup> century, men began infiltrating the midwifery sphere, establishing “man-midwifery.” Upon entry into the midwifery profession, male midwives had many advantages entirely related to their gender. For example, as Allotey (2011) writes, “Male midwives had...access to national and international networks of communication and education, and utilized the written word to extend their influence and develop a strong and cohesive public identity” (p. 134). Utilizing these networks, many male midwives, traveled to Europe to learn midwifery and the emerging field of “new-obstetrics” (Donegan, 1978, p. 114). While male midwives utilized their international connections to learn midwifery practices and to promote themselves as midwives, female midwives did not have access to these same networks, as they were founded in male-dominated professional spheres, such as medicine. The advantages that male midwives possessed resulted in the gradual decentralization of female

midwives in U.S childbirth. Although distinguishing between a man-midwife and a female-midwife only signaled the gender of the practitioner, and did not necessarily indicate a difference in training, as men continued to benefit from these national and international networks of communication and education, the difference between female and male professionals began to take importance within the realm of childbirth (Towler & Bramall, 1986, p. 131).

Although there was resistance from female midwives and social conservatives unhappy with the presence of men in lying-in birth chambers, starting in England, male midwives began to attend the births of the upper class. The presence of men in midwifery was heightened when at the start of the 19<sup>th</sup> century, obstetric forceps, invented by an obstetrician of the Chamberlen family, were brought to the public eye (Litoff, 1978, p. 7). The forceps, an instrument to help guide the baby out of the mother's birth canal, was one of the first technological advances in childbirth to foment the beginnings of the field of obstetrics in England, which would later come to America.

In addition to cementing their own position in the field through research and book publications, obstetricians such as Dr. William Smellie and Dr. Colin MacKensie taught male midwifery classes in the 1740s and 1750s to American men attending medical school under programs of apprenticeship (Donegan, 1978, p. 19). These English obstetricians taught midwifery and anatomy classes, bringing their students to live births to get birth experience. Dr. MacKensie allowed American apprentices at his lying-in house to deliver, "indigent parturient women under his supervision or that of a 'very good midwife'" (Donegan, 1978, p. 103). Dr. Smellie's practices were similar, in which, "with his pupils he delivered over a thousand poor women" (Towler & Bramall, 1986, p. 102). In addition to these apprenticeship

programs, American men attended medical schools in England and in other parts of Europe with the intention of returning home to practice as obstetrician in America. Although many physicians returned home to America with knowledge of midwifery and obstetrics, they were unable to practice during normal births that did not require surgical intervention, as the “delicacy” and “modesty” of women were increasingly emphasized in the 18<sup>th</sup> and 19<sup>th</sup> centuries (Dye, p. 112). As Dye (1980) holds, “Conservatives regarded the presence of males in the lying-in chamber as an affront to women's natural delicacy and feared a general breakdown of moral standards” (p. 101). It was believed that the presence of a man in birth would defile the ideal surrounding the image of a ‘proper’ woman.

At this time, America had become independent of England, and immediately after gaining independence, medical schools began opening in the U.S. This meant that American men did not need to seek formal medical training abroad in Europe. Before this, all physicians educated in the colonies had acquired training in apprentice programs, similar to the training of midwives. One medical school that was opened was the College of Philadelphia, where William Shippen Jr., one of its founders, taught midwifery, anatomy, and surgery. These medical schools excluded females, and therefore, prevented female midwives from staying up-to-date on modern practices and advancements in obstetrics (Litoff, 1978, p. 9).

By the late 18<sup>th</sup> century, as more men became trained in obstetrics practices in medical schools, their participation in normal births began to become more accepted, despite its infringement on previously enforced feminine ideals. This acceptance came about because obstetricians began to be viewed as being ‘more trained’ than female midwives due to their attendance in medical school. Donegan (1978) highlights this point in stating, “The initial

position of those seeking change seems not to have been that men were preferable to women as midwives, but rather that the trained attendant was preferable to one untrained” (Donegan, 1978, p. 114). Donegan claims that the transition from women to men birth attendants was not an issue of gender but was rather a question of training. Although it is expected that pregnant women wanted the most highly trained individuals to attend their births, it is imprecise to state that it was not an issue of gender, when, in fact, the marginalization of women as individuals of the female gender is at the center of this transition. All women, including female midwives, were explicitly excluded from medical schools in America. This systematic barrier to training unequivocally identifies the transition from women to men birth attendants, whether these men were midwives or physicians, as an issue of gender. With these obstacles in place for female midwives, men became the image of the ‘professional’ in a field occupied by otherwise ‘untrained’ female midwives. These gendered impediments stifled the advancement of the female midwife and significantly contributed to the transition of childbirth into a male-dominated, medically oriented practice.

As mentioned above, male-midwives had access to international connections and financial freedom. This academic and economic autonomy allowed many to begin publishing works with the obstetrics knowledge they had learned in medical school. These publications continued to make visible the increasing disparities between male and female midwives in the emerging professional field surrounding childbirth. As Allotey (2011) argues:

The literary manifestation of medical professionalism helped to create a form of protective delineation between medical knowledge and other forms of wisdom. The use of complex medical jargon aimed to deter the fee-paying public and midwives from engaging with them on an equal footing. Popular medical chapbooks (handbooks) on childbirth, addressed to midwives and women, gave the impression that midwifery knowledge, unlike medical knowledge, was not specialist knowledge (Allotey, 2011, p. 135).

This dominance of medical literature and discourse by male-midwives again highlights the flaw in Donegan's previously mentioned claim that the transition from female to male birth attendants was not an issue of gender, but rather a question of training. The exclusion of female midwives from medical schools in America culminated in this monopolization of knowledge by men attending medical schools. Therefore, with access to obstetrics knowledge in medical schools, medical publications by man-midwives began to be viewed as the dominant knowledge, which was knowledge inaccessible to the female midwife. As Michel Foucault wrote, "It is in discourse that power and knowledge are joined together" (Foucault, 1990, p. 100). With these written medical texts with content on obstetrics instruments and procedures, subjects that were inaccessible to female midwives, men began to dominate the discourse and knowledge of childbirth, thereafter, gradually, resulting in the transformation of male-midwifery into a new field called obstetrics.

Toward the end of the 18<sup>th</sup> century, obstetricians began attending increasingly more normal births, and in the 19<sup>th</sup> century, they became the primary birth-attendants for upper-class women (Leavitt, 1979, p. 484). The use of obstetricians for normal births was limited to the upper class due to their high fees, as obstetricians typically charged twice as much as midwives did (Litoff, 1986, p. 4). This transition from midwives to obstetricians in normal birth was a gradual change, prompted by the appeal of the professional image created by the opening of medical schools, sustained by the growing volume of literature by men on obstetrics knowledge, and solidified by the promise that obstetricians could make their labors shorter and their births safer with pain relieving drugs and obstetrics instruments. However, during the mid-19<sup>th</sup> century, obstetricians used bloodletting and chloroform to accelerate labor and relieve pain, methods that were soon to be discovered to be harmful to the mother

and the fetus. Additionally, many times when they used forceps, obstetricians ended up disfiguring the mother or baby (Ettinger, 2006, p. 7). Recounts of the procedures and methods of obstetricians at the time demonstrate that they were not as highly trained as the public perceived, and the complications that arose during delivery often resulted in infant or maternal mortality even in the hands of a ‘highly trained’ obstetrician.

By 1900, obstetricians attended 50 percent of all births in the U.S and midwives attended the other 50 percent of births (Ettinger, 2006, p. 7). At the time, births attended by midwives were mostly in rural locations for poor and middle-class African American or immigrant women. This created a socioeconomic division in the use of midwives and obstetricians. This divide produced the false image of the midwife as the untrained birth attendant of the poor and uneducated, while physicians were portrayed as a symbol of wealth and status (Brennan & Heilman, 1977, p. 20). However, Dye (1980) contradicts the presumptions that deemed the midwives to be untrained, stating that, studies on early 20<sup>th</sup> century midwives show that midwives were highly respected for their work in their own communities and that they generally had mortality records better than those of general practitioners at the same time (p. 104). In addition, these studies demonstrated that black southern midwives often had a high degree of skill and knowledge that they obtained from “highly structured apprenticeship systems” (Dye, 1980, p. 104). Although midwives demonstrated efficacy and competency in their delivery outcomes, because they practiced under a different model of care that was constructed based on rhetoric that conflicted with that of the emerging obstetrics medical model, they became increasingly discredited and devalued in the U.S.

Concurrent with the emergence of the field of obstetrics, hospitals began opening during the mid-18<sup>th</sup> century. However, over the course of the 19<sup>th</sup> century, only about 5 percent of births took place in hospitals, with the vast majority remaining in the home with either a midwife or a physician as a birth-attendant (Leavitt, 1979, p. 485). One reason for low rates of hospital births was that hospitals, most often established by charities, were unsanitary institutions where patients were highly susceptible to contracting diseases or infections such as puerperal fever—a bacterial infection of the genital tract postpartum that often resulted in death. Cases of puerperal fever most likely ran rampant because obstetricians examined women and delivered babies with hands or instruments that had touched other patients, resulting in the spread of infection—a concept that was not discovered until germ theory was accepted during the mid- to late 19<sup>th</sup> century. Because of these conditions, hospitals only birthed babies of destitute women, and therefore, retained reputations as institutions for the poor for the duration of the 19<sup>th</sup> century (Leavitt, 1979, p. 485).

However by the 1920s and 1930s, hospitals were cleaned up and publicized as modern institutions, bringing an increasing number of white women of the middle and upper class to have their babies there (Ettinger, 2006, p. 8). In these hospitals, obstetricians began using different drugs for pain reduction and labor induction, as well as other technological advances such as episiotomy—a surgical incision of the perineum, the tissue between the vaginal opening and the anus, to enlarge the opening for the baby. Instead of using chloroform, obstetricians began inducing “twilight sleep,” which was a combination of scopolamine and morphine—two drugs that cause pain relief and memory loss—and when used in childbirth, led to complete memory loss for mothers. Many women wanted to receive



this amnesia drug combination to avoid the pain of childbirth, and so if they were of the financial means, women went to hospitals seeking painless—and what they believed to be—safer births.

The hospital setting was crucial in securing the prominence of the interventionist medical model of childbirth. However, the increasing number of births taking place in hospitals did not decrease maternal mortality rates. In fact, as Litoff (1978) indicates, “The maternal mortality rate of the United States increased from 61 deaths per 10,000 live births in 1915 to 70 deaths in 1929” (p. 108). These numbers suggest that hospital deliveries were, in many cases, more dangerous than home deliveries, potentially due to patients’ exposure to other patients’ germs, in addition to the novel surgical procedures administered by obstetricians. Despite these statistics, hospitals remained the symbol of obstetrics knowledge within which trained physicians practiced and pregnant women anticipated short labors and painless births. By 1935, over one-third of all American births took place in hospitals (Ettinger, 2006, p. 10).

With the hospital as the obstetrics domain of practice, a number of technological discoveries and advancements resulted in continuing to widen the gap between obstetricians and midwives. For example, ergot was discovered in 1808 and was used in hospitals to induce uterine contractions. The stethoscope was used on the expectant mother’s abdomen in order to hear the fetal heart beat in the 1820s (Litoff, 1978, p. 19). Instruments were devised to dilate the cervix to make it easier to present instruments into the uterus. With a number of other advancements, the obstetrics field began publishing its findings for these new techniques. The first publication of *The American Journal of Obstetrics* in 1868, coupled with the establishment of the American Gynecological Society in 1876, and the American

Association of Obstetricians and Gynecologists in 1888, promoted the professional image of the field of obstetrics. Additionally, these organizations marked the expanse of obstetrics into the practice of gynecology, focusing on the health of the female reproductive system, and therefore, solidifying obstetrics' foothold in normal births (Litoff, 1978, p. 20).

With the confluence of all of the aforementioned developments in the field of obstetrics, childbirth began to be viewed and treated as a highly complicated medical procedure that required medical specialists with instruments and drugs. This view resulted in questions being raised surrounding the lack of 'professional' training of midwives (Litoff, 1978, p. 23). Most midwives received training from older, more experienced midwives in apprenticeship programs. A few physicians opened schools for midwives, such as the College of Midwifery of New York in 1883 and the Playfair School of Midwifery in Chicago in 1896, however, many of these schools lacked quality in the training programs despite the high entrance fees (Litoff, 1978, p. 136). Although members of the obstetrics field created programs such as these to professionalize the female midwife, because they were women, female midwives were often perceived to fall short of the obstetrics field's professional and intellectual standards.

The image of women in the 19<sup>th</sup> and 20<sup>th</sup> centuries contributed to reinforcing the shift in childbirth from a female-dominated to a male-dominated practice. Women were viewed as incapable of being professionals because of characteristics perceived to be inherent in their biology. Litoff (1978) describes these assumptions:

Many doctors were convinced that the uterus and central nervous system were closely connected. Shocks to the nervous systems, such as prolonged or intense study, might, in turn, prohibit a woman's reproductive organs from growing to full maturity. Physicians argued that those women who dared to engage in serious intellectual pursuits,

such as the study of medicine, faced the grave risk of being unable to produce normal, healthy children (p. 25).

Comments such as these made by ‘experts’ in the sciences and medical fields were used not only as ways to further discredit the agency of the woman as a professional, but also as a patient competent in making informed medical decisions. These sentiments contributed to the rise in the power of obstetricians over women’s medical decisions, as women were seen as inept as both providers and consumers of healthcare, a concept that will be explored in later chapters. Sentiments such as these surrounding the perceived inferior biology of women demonstrated the ways in which the male body was emphasized as the norm while, as Rothman (1991) states, women’s reproductive processes were seen as, “stresses on the system, and thus diseaselike” (Rothman, 1991 p. 36). This overarching attitude in the emerging field of obstetrics that compared the woman to the man, contrasts to the sentiment within midwifery in which, “A pregnant woman is compared only to pregnant women...Pregnancy, lactation, and so on, are accepted not only as nominally healthy variations, but as truly normal states” (Rothman, 1991, p. 38). These words demonstrate the philosophical underpinnings of midwifery practices that so firmly celebrate the diversity of women’s birth experiences and emphasize the normalcy of pregnancy.

Although the debate surrounding childbirth in the U.S gradually unfolded, and the division between midwives and obstetricians steadily widened throughout the 19<sup>th</sup> century, the atmosphere greatly intensified during the first two decades of the 20<sup>th</sup> century when attention was drawn to the soaring morality rates of mothers and infants (Dye, 1980, p. 104). Consistent with the marginalization of the midwifery field over the 18<sup>th</sup> and 19<sup>th</sup> centuries, the high mortality statistics were deemed the “midwife problem.” This came at a time when physicians attended 50 percent of births in the U.S and midwives attended 50 percent of

births (Ettinger, 2006, p. 7). However, since many midwives were African Americans or immigrants and the beginning of the 20<sup>th</sup> century was marked by anti-immigration sentiments and legalized racial segregation and discrimination, midwives were an easy scapegoat on which to blame the high mortality rates, (Ettinger, 2006, p.10).

Another factor that contributed to the increase in obstetricians and the drastic decline in midwives during the beginning of the 20<sup>th</sup> century was the publication of the Flexner Report. In 1910, the Flexner Report called on medical schools to sanction higher standards for admissions and graduation. Additionally, it focused on the need for medical schools to submit to stricter scientific protocols in teaching and research (Ludmerer, 2011, p. 8). When held up against these standards, many American medical schools fell short, resulting in many closures and merges of schools. Alongside these reforms came a return to male-only programs, which was claimed to be a measure to shrink the admissions pool for ‘quality assurance.’ The conditions from the publication of the Flexner Report, alongside claims of a “midwife problem,” resulted in an adverse environment for the female midwife.

Despite the prevalence of obstetricians, midwives did not disappear in the U.S. During the early decades of the 20<sup>th</sup> century immigration from eastern and southern Europe surged. In Europe, midwives are highly respected, and so, many immigrants continued to employ midwives for their births in the U.S. In addition, many of these immigrants used midwives because they were able to find a midwife who knew their home customs and language (Litoff, 1986, p. 4).

However, due to the bad press surrounding midwives and the eventual decrease in immigration, births attended by midwives began to plummet. In 1903, midwives attended 50 percent of births in Washington D.C., but by 1912 that number fell to only 15 percent; and in

New York City, in 1919, midwives attended 30 percent of births, but by 1929 only 12 percent of births were attended by a midwife (Ettinger, 2006, p. 11). Although midwife-attended births greatly decreased during the first two decades of the 20<sup>th</sup> century, infant and maternal mortality rates did not decrease. This demonstrates a contradiction in the reasoning of those who claimed the midwife to be the cause of the high mortality rates, because as mortality rates were increasing, the attendance of midwives had decreased drastically from what it was just years before. Therefore, individuals placing blame on midwives had made unsubstantiated claims, as the high mortality rates were more likely from a confluence of factors unrelated to the midwife, such as poverty, inadequate prenatal care, and other complications in pregnancy and during labor (Litoff, 1986, p. 8).

These debates at the beginning of the 20<sup>th</sup> century were not polarized between midwives and obstetricians, but instead consisted of an array of arguments put forth by a variety of groups. One side, mostly consisting of obstetricians but also state officials such as the State Legislature in Massachusetts, supported the abolishment of midwives (Lay, 2000, p. 61). Supporters of this action argued that the normalcy of birth could not be determined before labor and therefore birth with a midwife could never be considered safe. In the *Boston Medical and Surgical Journal*, one physician supporting this claim, wrote, “The trained obstetrician knows that no case is normal until it is over” (Lay, 2000, p. 63). Another group, mostly made up of general practitioners, voiced that until ‘better’ trained substitutions could be made, midwives should be tolerated, as they had the experiential knowledge of birth, and because there were not a sufficient number of physicians trained in birth to fully replace them at the time.

Other state legislatures and public health officials argued for the regulation and education of midwives, similar to the English Midwives Act of 1902, which had been successful in decreasing infant and maternal mortality in England through the education and regulation of midwives (Litoff, 1978, p. 138). In reference to the public health officials that supported the regulation of midwives, Litoff (1978) argues that, “It was not always easy to distinguish the midwife opponents from the proponents” as “the ultimate goal of these officials... was to regulate the midwife out of existence” (p. 139). However, the proponents of midwifery training did make some honest attempts to contribute to the midwife’s education, one being that, in 1911, the Bellevue Hospital School for Midwives opened in New York City, the first municipally sponsored midwifery school in America (Ettinger, 2006, p. 13). In eight month long sessions, midwifery students were taught prenatal and postnatal care, normal labor and delivery procedures, and housework duties by physicians and nurses. In addition, students were required to have clinical experience by assisting or witnessing eighty normal deliveries and delivering at least twenty babies in order to pass (Ettinger, 2006, p. 13). Many proponents of the regulation of midwifery claimed that the Bellevue Hospital School for Midwives could be used as a model to expand midwifery training programs (Lay, 2000, p. 63). Although the ultimate goal of these midwifery programs was to ‘train’ the midwife, to accommodate the increasingly medicalized conception of birth, additional measures took this ‘professionalization’ a step further, most notably, the introduction of nurse-midwifery.

In the 1910s, nurse-midwifery was proposed as the solution to the “midwife problem” (Brennan & Heilman, 1977, p. x). With the introduction of the nurse-midwife, many public health officials hoped that the midwife would eventually become absorbed into the nursing

sphere. Mary Breckinridge became the first certified nurse-midwife in America, trained in Britain (Litoff, 1978, p. 142). She established the Frontier Nursing Service in 1925 (FNS). Although FNS was successful and effective in maternity care, it failed to spread the model of nurse-midwifery throughout America, and instead, remained confined within rural Kentucky. The Maternity Center Association (MCA) also opened a nurse-midwifery program in 1931 in New York City (“Childbirth Connection's,” January 22, 2014). However, nurse-midwifery schools established at this time were not successful due to the lack of effort of public health officials to encourage the practice and the competition with obstetricians in dense urban areas. Although maternal mortality rates fell after 1935, it was could not have been because of nurse-midwifery, as there were not many nurse-midwives, but rather it was most likely due to the development and use of antibiotics and blood substitutes to combat infection and hemorrhaging, which were main contributors to the high rates of maternal mortality (Litoff, 1986, p. 13). Therefore, the position of the nurse-midwife was a transitory image in the early to mid 1900s in America, which would not be called back until later in the 20<sup>th</sup> century (Ettinger, 2006, p. 15).

The above section examined the historical chronology of childbirth birth practices in the U.S with the controversy between midwifery and obstetrics at center. In this chronology it is demonstrated that the rise of obstetrics and the decline of midwifery resulted from a confluence of both the explicit devaluation of midwifery and the increased valuation of technology-based birthing. Although a statement cannot be made about the intentionality of this devaluation of midwifery by the obstetrics field *as a whole*, it is has been demonstrated in the preceding historical chronology that an atmosphere of sexism and an emerging hegemonic professionalism contributed to the devaluation of the practice of midwifery over

the course of U.S history. The next chapter will continue the chronology of childbirth into current day, illustrating the ways in which the historical marginalization of midwives has contributed to the diminishing agency of the woman in maternity care today. This investigation of the current state of childbirth practices in the U.S will demonstrate that as the midwifery field was phased out, obstetrics technology began to dominate birthing practices, contributing to the shift in focus away from the mother unto the fetus.



## Chapter II: The Current State of Childbirth in the United States

The shift from midwifery to obstetric practices in the history of U.S. childbirth has both created and reinforced a cultural inclination towards the use of birthing technology. As demonstrated in the preceding section, obstetricians pushed the notion that technology is a crucial element in securing safe childbirths. These technological developments in obstetrics were imperative to advancing the obstetrics sphere and devaluing midwifery. For this reason, the development of birthing technology is inseparable from the historical conflict between obstetricians and midwives in the U.S. With these obstetrics interests behind the development and promotion of birthing technologies, there has been a resulting overuse in obstetrics technologies for low-risk pregnancies and uncomplicated births in the U.S.

Upon investigation into the obstetrics technology that has permeated the childbirth sphere, it is clear that there are many benefits from the advancement of technology for pregnant and parturient mothers. However, a less anticipated consequence of these technological advancements has been the overuse of these technologies, which has resulted in an increased risk for expectant mothers. Although only 17 percent of U.S. births are high-risk, and obstetricians are specialists trained for high-risk deliveries, obstetricians attend over 90 percent of U.S. births (“Deadly Delivery,” 2010, p. 80). This disparity in the American childbirth system lies in deep contrast to many European countries’ models, in which midwives attend over 80 percent of births. The reliance on obstetricians in the U.S., and consequently that on obstetrics technologies, has contributed to the rising cost of hospitalizations related to pregnancy and childbirth, which amounts to US\$86 billion a year. Even though these medical costs for pregnancy and childbirth are the highest medical costs out of all areas of medicine in the U.S. healthcare system, according to Amnesty

International, U.S. women have a greater risk of dying of pregnancy-related complications than women in 40 other countries (“Deadly Delivery,” 2010). These disparities highlight an inconsistency in the effectiveness of these birthing technologies, as despite higher rates of usage, women’s health has not benefited in the U.S.

One factor that contributed to the overuse of technology has been a “cascade effect,” in which the use of one technology has resulted in the ‘need’ for another technology. The following chapter will explore the advancement of the interests of the obstetrician that promote obstetrics technology despite the lack of benefits, and even drawbacks, for pregnant and laboring women’s health in the U.S. Through this discussion, I will demonstrate how obstetrics care and technologies have negatively affected the natural relationship between the mother and the fetus through a focus on ‘fetus-centered’ care. Additionally, I will highlight the ways in which obstetricians and healthcare organizations have harmed women by making medical decisions based off of non-medical reasons, such as concern about personal schedules and medical liability.

A cesarean section (c-section) delivery is when an obstetrician cuts into the lower abdomen and uterus of a woman to deliver her baby. In 2008, the World Health Organization (WHO) reported a c-section rate of 22.0 per cent in the United Kingdom, 25.9 per cent in Spain, 18.8 per cent in France, while the U.S. had the highest rate of 30.3 per cent (Gibbons et al., 2010). In 2014, 32.2 percent of births were reported by the Centers for Disease Control and Prevention (CDC) to have been delivered by c-section (Hamilton, Martin, Osterman, Curtin & Mathews, 2015). WHO states that a c-section rate above 15 percent has no added benefit to health outcomes, therefore questioning over half of the c-sections performed in the U.S. (Gibbons et al., 2010). This rise in c-sections has resulted from a focus on ‘evidence-

based obstetrics.’ Evidence-based obstetrics knowledge hierarchically ranks randomized, double-blind, controlled trials as the most ‘objective’ form of scientific conduct. However, this approach fails to recognize the paradigmatic assumptions, or in other words, the prior-commitments to the effectiveness of the obstetrics model, under which obstetrics research exists. This is to say that the selection of research problems, the choice of what is to be considered data, and the interpretation of that data are all greatly impacted by the interests of the obstetrics researchers. This paradigmatic influence does not result in ‘objective’ or ‘neutral’ knowledge, but rather knowledge that is prefaced with preconceived motivations and commitments. This is demonstrated in the following case studies of obstetrics technologies used in the U.S.

In the U.S., the leading indications for c-sections, starting with the most prevalent, are, “dystocia,” a previous c-section, and fetal distress (Bassett et al., 2000). “Dystocia,” or failure to progress, is an indication for an induction. An induction often consists of a mother receiving a drip of pitocin—a synthetic form of oxytocin that increases the severity of her uterine contractions—for a labor that has stalled or completely stopped. Although increasing the intensity of contractions will prompt the labor to continue, induction also increases maternal pain, thereafter leading to a cascade of interventions for pain relief, such as an epidural—a spinal anesthesia to provide pain relief (Edwards & Waldorf, 1984, p. 209). These analgesic agents—pain relievers—can transfer through the placenta into the fetus. With this potential risk, epidurals have been associated with neonatal respiratory depression (Kumar, Chandra, Ijaz & Senthilselvan, 2014). Although artificial induction is a technological advancement that has allowed many women to give birth vaginally despite a natural stall or stop in labor, it has also contributed to the prevalence of the domino effect of

medical interventions previously mentioned. In addition, the use of pitocin in obstetrics has contributed to the creation of stages and ‘time-frames’ in labor in which a mother’s birth must fit. This highlights a predominant thread of the medical model of childbirth in the U.S—standardization of birth. Although childbirth is a process in which each woman has a distinct experience, pitocin has contributed to the effort by the obstetrics field to standardize labor. This standard model has been imposed on the labors of many women in order to fit their births within a predetermined obstetrical timeframe. The issue of timing will come up again later in this chapter when I scrutinize how obstetricians’ medical actions that are made based on nonmedical interests that do not contribute to the well being of the mother or fetus.

Similar to the ways in which pitocin necessitates the use of more medical interventions such as epidurals, the rise in electronic fetal monitoring (EFM) in the 1960s and 1970s has demonstrated this same “cascade effect,” greatly contributing to the increase in c-sections conducted with the cause “fetal distress” (Wendland, 2007, p. 220). EFM is used to monitor uterine contraction patterns and relate them to the baby’s heart rate. EFM was introduced as an alternative to auscultation by a handheld Doppler device, which can be used intermittently during a woman’s labor to monitor the baby’s heart rate (Banta & Thacker, 2001, p. 707). To measure the uterine contractions in EFM, a pressure button with an attached band is placed around a woman’s abdomen to measure the strength, duration, and length between contractions, while the baby’s heart rate is measured either externally, by placing another band around the mother’s abdomen, or internally, by placing electrodes on the baby’s scalp to measure the frequency and variation of the heart rate (Morris, 2013, p. 8). In 2006, a survey showed that 93 percent of women who gave birth in the U.S. have continuous EFM during labor (Morris, 2013, p. 8).

EFM is utilized to indicate if there is an inadequate oxygen supply delivered to the fetal brain, called “hypoxia” or “fetal distress.” Despite the high frequency use of EFM, there is limited evidence that the mother or child benefit from the use of EFM. Instead, there is substantial evidence of harm and financial costs due to an increased rate of cesarean sections from the use of the EFM. These disparities between frequency of use and outcome effectiveness are most likely due to the fact that 50 percent of EFM readings are false-positives for fetal distress (Bassett et al., 2000). Bassett, Iyer & Kazanjian (2000) indicate that 20 percent of first c-sections are performed under the indication of “fetal distress,” a result of the reading of an EFM. Therefore, it is estimated that 50 percent of c-sections performed due to “fetal distress” are unnecessary.

In addition, EFM is meant to note any late decelerations or variable decelerations. Late decelerations can indicate that a baby is unhealthy or that the placenta is compromised. When the uterus contracts, blood vessels are cut off from oxygen during that contraction, however, if the baby and placenta are uncompromised, the baby uses stored energy during the contractions. A heart rate deceleration may indicate that the baby is not able to maintain adequate oxygen levels during these labor contractions. Another concern is if the baby’s heart rate changes randomly, not in-synch with the contractions. This random heart rate could be a sign that the umbilical cord is compressed, and that the baby is being cut off from the oxygen and blood supply from the mother. A late deceleration or variable deceleration can be indicative of an obstetrics emergency requiring a c-section (Morris, 2013, p. 9). Having a c-section in the face of these indications is to prevent injury to the baby from an inadequate oxygen supply. The permanent injury that results if a fetus is cut off from the mother’s blood supply is called, “significant reversible fetal hypoxia.” Although this is a real concern for the

mother and the birth-attendant, “significant reversible fetal hypoxia” occurs in only 1-2 percent of births. Although the above scenarios deserve serious consideration for the safety of the fetus’ health in labor, the harm inflicted upon mothers by false-positives in EFM does not match the harm ‘prevented’ by the EFM readings, considering the extremely low likelihood of permanent damage from fetal hypoxia alongside the existing presence of unnecessary injury to mothers.

As mentioned above, there is substantial evidence of harm and financial costs associated with the increased use of the EFM (Bassett et al., 2000). These findings suggest that the rise of technology is not necessarily indicative of the effectiveness of the technology, but rather parallels the rise in power of the groups that invent the technology. This is to say that studies supporting the use of EFM are backed by a concentration of obstetrics interests that greatly restrict the mother’s voice in her own medical care, as evidence-based obstetrics research is viewed as more accurate and useful than that of the woman’s experience. However, because this research fails to acknowledge the woman’s narrative, it does not consider the cesarean section itself to be injurious to the woman. Wendland (2007) explains this chasm between c-section research and the woman’s experience with a c-section: “Unintended wounds—cervical lacerations vaginal hematomas, or fracture of a newborn’s clavicle—count as major morbidity, but the intentional wound is exempt by fiat. Only unintended complications of the cesarean are weighed in the balance” (Wendland, 2007, p. 223). This is to say that obstetrics research fails to highlight the injury that is guaranteed with a c-section, which is the large surgical incision that *is* a c-section. Since this research does not take into account the standpoint of the woman, it diminishes the importance of the woman’s agency and experience in childbirth.

One of the main problems with the evidence citing the effectiveness of c-sections is that the research studies often only consider complications to the woman during the short-term, which is limited to the hospital stay for labor and delivery (Johantgen et al., 2012). Wendland (2007) points out that there are many long-term complications that are not typically considered in current research on the success of c-sections. Wendland states, “Formation of adhesions (internal scar tissue), hysterectomy or massive hemorrhage in subsequent pregnancies, or even the delayed thromboembolism (clot formation) risks are the major cause of cesarean-related postpartum maternal death in the First World” (p. 223). However, these long-term complications are not considered when making the decision to order a c-section in a hospital or when empirically evaluating the effectiveness of c-sections. In addition, the obstetrics field depicts c-sections as controlled, while vaginal births are portrayed as unpredictable. This medical narrative leads to the overuse of c-sections in the name of safety.

Although safety is their top priority, obstetricians are greatly influenced by the institutional structures, such as the hospital, in which they practice. Since hospitals are concerned with the legally liability surrounding the care of its patients, the practices and technologies that hospitals promote are not always a reflection of measures most advantageous to the mother and fetus, rather they often reflect the safest legal route, leaving hospitals least liable if anything were to go awry. For this reason, the narrative of the c-section as safe and vaginal birth as unpredictable is promoted and upheld. Along these lines, Morris (2013) argues that the interventionist ways of obstetricians, and the resulting high rates of c-sections, are not a result of doctor’s interests or medical beliefs, or the desires of pregnant or parturient mothers. Instead, she argues that the hierarchical structure of hospitals

determines the choices of mothers and maternity providers. This is to say that the constraints of the organizational structure have led to the skyrocketing rates of c-sections. Morris writes, “Hospitals are organizations with fixed rules to guide individual behavior” (p. 22). She describes the informal consequences for obstetricians for deviating from the norms, which may include isolation from colleagues or formal consequences of being reprimanded by a supervisor, or having a malpractice insurer deny coverage as a result of a poor outcome.

Another common cause for the rise in cesarean sections is a previous cesarean section. Vaginal birth after previous cesarean section (VBAC) has been discouraged in obstetrics practice due to the fear of the rupture of the previous scar, or uterine rupture. A popular phrase surrounding the obstetrics protocol for c-sections is, “Once a cesarean always a cesarean” (Cassidy, 2006, p. 128). This has led to an increase in scheduled C-sections, as opposed to emergency C-sections (Rabin, 2015). However, the risk of uterine rupture is less than 1 percent (Morris, 2013, p. 3). Despite the lack of evidence for the benefit to the mother or baby, VBAC deliveries dropped from 28.3 percent in 1996 to 9.2 percent in 2004 (Yang, Mello, Subramanian & Studdert, 2009). Yang, Mello, Subramanian & Studdert (2009) corroborate the arguments of Morris (2012) in their investigation on VBACs. They found that malpractice premiums were positively associated with rates of cesarean sections and that malpractice premiums were negatively associated with VBAC rates. These findings indicate that the fear initiated by the liability environment in the obstetrics field influences the type of delivery that obstetricians perform, leaving obstetricians more likely to perform a c-section if the malpractice premiums are higher in order to minimize the chance of liability for a poor vaginal birth outcome. In this way, obstetricians are making medical decisions based on non-medical, or legal, rationale. Hospital administrators and risk managers put measures in place



to decrease uncertain, unpredictable situations to decrease liability that would put themselves and the obstetricians in their hospitals at risk. These measures are to make malpractice claims less likely, however, they often promote the overuse of technology that has contributed to the c-section epidemic. As a result of these protocols, liability concerns instead of concerns for the mother or fetus' health remain at the center of obstetrics care.

One way to demonstrate the influence of hospital protocol is in comparing the variability in c-section rates across different hospitals. For example, one study indicated that in California hospitals' rates for cesarean sections performed in low-risk births ranged from 11.2 per cent to 68.8 per cent (Rosenberg, January 19, 2016). This range and lack of consistency in c-section rates across Californian hospitals suggests that procedure decisions are based in large part on hospital regulations (Rosenberg, January 19, 2016). At one hospital, a result on a fetal heart rate monitor might prompt a C-section, while it won't at another hospital. For this reason, the 'evidence-based' obstetrics, under which obstetricians claim to practice, falls short in both acknowledging the voice and protecting the health of the woman, as it fails to correctly illustrate the woman's experience and is often swayed by the protocols of the larger organizational under which obstetricians practice.

In 1988, the American College of Obstetricians and Gynecologists (ACOG), the professional association that upholds standards for education and training for obstetricians and gynecologists in the U.S, issued physician guidelines supporting VBACs, a measure they hadn't supported prior due to the fear of rupture of the previous scar or uterine rupture (Cassidy, 2006, p. 128). With this decision, women were able to choose to use CNMs for vaginal births, instead of being restricted to having a cesarean section with an obstetrician. However, this guideline recommendation by the ACOG changed by the end of the 1990s, in

which the new guidelines again cautioned against the safety of VBACs. Since the 1990s, c-sections have drastically increased, which as mentioned earlier, has not been met with a lowering of infant or maternal mortality rates. Then, in ACOG's 2010 VBAC guidelines, reaffirmed in 2015, ACOG urged providers to let women spend more time in labor to avoid an unnecessary C-section (Caughey, Cahill, Guise, & Rouse, 2014). These guidelines support, "Trial of labor after previous cesarean delivery" (TOLAC) to provide women who want the possibility of a VBAC ("Clinical Management," August, 2010). Although these guidelines *technically* demonstrate ACOG's approval of VBAC, the language of the guidelines that label VBAC as a "trial" that a woman needs to "achieve" continues to depict the vaginal birthing process, especially after a previous c-section, as an uncontrollable, unpredictable, and arduous 'task' in comparison to the c-section. Along these lines, although ACOG does acknowledge that, "VBAC is associated with fewer complications" than an elective c-section, the ACOG also emphasizes that, "Failed TOLAC is associated with more complications, than elective repeat cesarean delivery" ("Clinical Management," August, 2010). This comparison continues to demonstrate the language used to promote the conception that the elective c-section is the most 'certain' procedure.

Another example of the way in which obstetrics technology and research has negatively affected the mother is through its focus on 'fetus-centered' care. The discourse and research of obstetrics creates a mother-fetus dyad, in which obstetricians become, as Bassett et al. (2000) labels them, "fetal champions." This role as a "fetal champion" stems from the nature of the obstetrics technology that places the fetus at center. This focus materializes explicitly in the name of obstetrics technology, such as electronic *fetal* monitoring, highlighting 'fetal' as opposed to 'maternal' technology, therefore, separating

the fetus from the mother and making the care of each separate but unequally valued (Lay, 2000, p. 23). In this way, the EFM satisfies, “the social needs rather than the patient’s needs,” in which social needs refer to obstetrics interests in “direct medical responsibility for fetal outcome,” as well as the application of obstetrics technology (Bassett et al., 2000).

Additionally, the role of the obstetrician as a “fetal champion” is made visible in the legal system, in which lawsuits have been filed against women who do not follow their physicians’ medical orders. The existence of such lawsuits demonstrates that physicians often have *legal* control over the decisions that affect the female body, thereafter, highlighting the unequal power dynamic between patient and physician that prevents women from being more involved in their own care (Driessen, 2006). Additionally, these lawsuits have eroded the confidence in the patient-physician relationship, a crucial aspect to ensuring the well being of the fetus. As stated in Driessen (2006), “All enforcement actions have the effect of interfering with the confidence women will have in safely confiding the information needed to provide meaningful medical care to their health care providers” (15). The presence of such lawsuits creates a toxic social environment for the care of the fetus, and fabricates the false image of the mother as a hazard to the fetus and the obstetrician as its protector. With the obstetrics field’s focus centered on the fetus, the agency and the autonomy of the mother is disregarded or violated in obstetrics care.

This lack of female agency has resulted in an imbalance of power between the mother and obstetrician. To cite an example in which obstetricians abused this power, Gans, Leigh, & Varganova (2007) found that the number of births drops by 2–4 percent during the days in which obstetric conferences are held. Since it is unlikely that parents take obstetric conferences into account when conceiving their child, this drop suggests that obstetricians

are timing births to suit their professional conference schedule (Gans et al., 2007). These findings further demonstrate that many physicians are making medical decisions based off of non-medical reasons. In 1999, another study showing pregnant women's lack of agency under the care of obstetricians, demonstrated that about one-fifth of women who gave birth via elective c-section reported that they were not involved in the decision, and that the decision has been made by the obstetrician (Gans et al., 2007, p. 1459). In addition to the lack of control that a woman holds when having a c-section, obstetricians also push many women to take drugs to speed up labor in order to fit labors and births into their own personal schedules (Driessen, 2006). This push has not only contributes to and reinforces the image of the female during childbirth as incapable and dysfunctional during childbirth, but also demonstrates the lack of power given to the woman in making decisions about her body during labor. Minkoff & Paltrow (2007) argue that respecting the mother's autonomy is not an option, but rather, it is a doctor's obligation:

It is important to highlight that accepting the principle of maternal autonomy is not supererogatory, nor does it require obeisance to an autonomy that differs in type or degree by dint of a woman's pregnancy. Rather, respecting a woman's right to corporal integrity during pregnancy merely reflects physicians' obligatory fealty to autonomy as required in interactions with all adult persons.

The pregnant woman is an autonomous adult who not only has the mental ability to make her own decisions but also the right to do so. Although the above statement reflects a widely held desire of all women to have rights to their bodies in their birth, the practice of obstetricians and the portrayal of birth in popular culture have instilled the mindset of the medical model of birth upon the self-image of many women, resulting in an acceptance of the paternalistic nature of the obstetrics field out of fear of birth.

Women are increasingly encouraged to believe that childbirth is a medical condition that is critical and complicated, making them fear childbirth and accept medicalized childbirth as a norm. This perpetuation of fear instilled by the obstetrics field's constant practice of interventions on the unknowing woman poses the question of how informed or available a woman's choices are in childbirth. This medicalized image of childbirth is not only perpetuated by obstetrics norms, but also images in entertainment media, such as movies and TV shows, depict childbirth as an emergency, typically showing a laboring mother being rushed down a hospital hallway. These images give women false perceptions of the urgency of labor, and may influence the ways in which they make medical decisions or view their own abilities to give birth. As stated by Wendland (2007), "The mother's (natural) body becomes the site of risk" and "doctor's (cultural) body as the site of safety" (p. 225). These norms are instilled in the mindset of expectant mothers by obstetrics practices and the cultural images displayed in popular media. Despite, the influence of these forces, the medical model of childbirth has not gone unquestioned in the U.S.

By the beginning of the 1970s, the medicalization of childbirth began to be greatly challenged by American women, most notably natural childbirth supporters and feminist health advocates. The critique that formed around childbirth during this time prompted a reemergence of the practice of midwifery. Although midwives had been seen during the mid-20<sup>th</sup> century as the birth attendant of the lower class, this objection to the medicalization of childbirth precipitated the use of midwives by middle-class and upper class women (Litoff, 1986, p. 19).

This chapter predominantly focused on the interests of the obstetrics field; however, the narrative of the obstetrics sphere does not depict the whole story, as it fails to portray

women as autonomous, decision-making beings. In order to obtain a fuller image of the factors that shaped the history of childbirth in the U.S., it is crucial to examine how women's expectations of birth have impacted birthing practices over the course of history. In the next chapter, I will explore the role women played in defining childbirth practices over the course of history and today.

### Chapter III: The Renaissance of Midwifery

Through the examination of childbirth in the U.S it is clear that an array of different individuals and groups contributed to shaping childbirth practices over the course of history into current day. In *The History of Sexuality*, Foucault examines the origin of power, explaining, “Power is everywhere; not because it embraces everything, but because it comes from everywhere” (Foucault, 1990, p. 93). In this way, power is a sphere of force played from innumerable points in the matrices of society. Despite the powerful impact that the medical sphere has had on childbirth practices in the U.S, obstetricians did not solely determine the current state of childbirth—women had a decisive role. This chapter will center on the influential role women played in molding childbirth practices in the U.S.

Due to the amount of literature that male obstetricians published during their careers, it appears that they were the only influence shaping the sphere of childbirth. As McIntosh (2012) writes, “Given the volume of print and vitriolic opinions generated by doctors particularly, in the medical and lay press, it is easy to overlook the views and influence of women themselves” (p. 64). Therefore, the importance of women in shaping childbirth may not be apparent due to the large amount of writing done by male professionals within the medical sphere. However, upon closer examination, it is clear that women also served an immense role in molding childbirth birth practices over the course of history.

Obstetrics developed during a time in which there was extreme concern surrounding female modesty and delicacy (Dye, 1980, p. 101). For this reason, many social conservatives, health reformers, and feminists rejected male physicians who practiced obstetrics during the 19th century. To lessen these conservative blows, many male physicians involved in obstetric rarely examined women and conducted deliveries in darkened rooms with women fully

covered. If they did examine women, male physicians used devices such as the vaginal speculum to open the vagina as to not come into direct contact with the woman (Dye, 1980, p. 101). These cautionary measures taken demonstrate that obstetric practices were partly shaped by the cultural values and societal expectations of the 19<sup>th</sup> century. Although the aforementioned practices came from a preoccupation with female modesty and delicacy within a patriarchal society, women's own social values and expectations also greatly impacted childbirth practices over the course of history.

### *Twilight Sleep Movement*

At the end of the 19<sup>th</sup> century, the belief that obstetricians could make childbirth less painful became a widely held in U.S society. With this notion, many women began seeking treatment from obstetricians to benefit from the analgesic—pain relief—drugs. The knowledge of such drugs generated expectations that birth could be painless, which set the stage for the Twilight Sleep Movement. The Twilight Sleep Movement describes the time period marked by the widespread use of a combination of scopolamine and morphine during childbirth to obliterate women's memories of pain during labor. Many women saw the use of this combination of drugs as a manifestation of their right to a painless childbirth. Under the auspices of feminism, many women demanded that physicians do everything in their power to obliterate their birth pain (Dye, 2011, p. 107). For example, freelance science writer Ann Finkbeiner (1999) writes, "The New York Times, The Ladies' Home Journal and Reader's Digest ran articles praising the removal of 'the primal curse,' and increasing numbers of patients demanding Twilight Sleep." In other words, many women believed it was their right



to choose a birth with twilight sleep, thus making twilight sleep a common occurrence from the 1930s until the 1970s.

Despite the many feminists who championed twilight sleep, there were also strong opponents within the feminist movement. Many who opposed twilight sleep viewed it as an unnecessarily brutal process:

Once she was under the spell of Twilight Sleep, the doctor would bandage her eyes with gauze and stuff oil-soaked wads of cotton in her ears, so her own screaming would not wake her up. Her arms would be strapped down with leather thongs (Cassidy, 2006, p. 91).

Despite the brutality that was revealed to these mothers, many continued to seek twilight sleep for their labors, as the fear of the pain they would remember superseded their fear of the brutality that they would not remember. Since twilight sleep required constant restraints and monitoring, many women advocated for hospitals, serving as another factor that prompted the mass migration of births into hospitals. Therefore, expectations for a less painful labor resulted in the movement of pregnant and parturient women from drug-free home births with a midwife to hospitals with obstetricians and medical interventions.

Additionally, at this time, during the beginning of the 20<sup>th</sup> century, the geographic mobility of many in America increased, resulting in the pregnant woman losing the familial and social support from female relatives and friends in close proximity who would have typically assisted her in labor (Ettinger, 2006, p. 9). This increased movement resulted in many women seeking support elsewhere, most notably in hospitals. Many described the experience positively, as their time in the hospital was time away from housework and childcare duties. One woman who had given birth in a hospital claimed, “The nurses here wait on me hand and foot. You don’t know what a comfort it is to have your baby in the hospital” (Ettinger, 2006, p. 9). Therefore, the success of hospitals came, in great part,

as a result of the desires of women for a less painful birth provided by twilight sleep with social support in a hospital setting. However, the expectations of women evolved over the 20<sup>th</sup> century.

During the late 1940s, the natural birth movement arose. This movement demonstrated a shift in women's expectations away from a drug-induced painless birth to a natural birth. The publication of Grantly Dick-Read's *Childbirth without Fear* in 1932 became popular in the 1950s, and was partially responsible for women's newly found focus on a search for personal pleasure and satisfaction through natural birth (Litoff, 1986, p. 13). Dr. Dick-Read posited that the fear of childbirth is connected to bodily tension and that this corporeal tension supposedly intensified the pain of childbirth. To reduce fear, he believed women should be educated about the birth process and exercise during pregnancy. Concurrently, the Lamaze technique of "childbirth without pain" was introduced by Dr. Fernand Lamaze. It is most known for the breathing techniques during contractions. In the Lamaze technique the woman was expected to be awake and aware during labor. (Rothman, 1991 p. 30; Brennan & Heilman, 1977, p. 76). Although the obstetrician was still in charge, with this technique the woman did not have to be passive during her labor. This increased autonomy of the woman during birth went hand-in-hand with the feminist movement that followed, and thereafter questioned the prevalence of the woman's voice in childbirth history.

Prompted by the Second Wave Feminist Movement of the 1960s into the 1980s, a number of feminist intellectuals including researchers, sociologists and anthropologists began to examine the history of midwifery from a feminist standpoint (McCool & McCool, 1989). The hope of these investigations was to counter "the empiricist; reductionist and

romantic medical narratives evident in the modern obstetrics texts of the 19<sup>th</sup> and 20<sup>th</sup> centuries” (Allotey, 2011, p. 136). As mentioned earlier, the amount of literature generated by male obstetricians was much greater than narratives published by women about the experience of childbirth. Through these investigations, feminist intellectuals uncovered that the narrative of the woman had been silenced in the historical texts of maternity in the U.S. By bringing this to light, researchers began seeking out the narratives of women, discovering that women had played a larger part in shaping the sphere of childbirth than the published literature had revealed prior to their research. In 1980, in her work “History of Childbirth in America,” American historian Nancy Schrom Dye echoes notion that female narratives had been greatly restricted in the published literature on childbirth. She writes, “Until a few years ago, the history of childbirth could more accurately be termed the history of obstetrics” (Dye, 1980, p. 97). Dye and the feminist researchers challenged the portrayal of American childbirth history as a linear timeline of progress, in which it is claimed that birthing practices were systematically enlightened by scientific discoveries in obstetrics. Instead, they posited that women’s actions contributed in large part to shaping childbirth practices. One example of the way women contributed to shaping childbirth practices was through the push for birth centers.

### *Home Births and Birth Centers*

Although hospitals were unsanitary in the 19<sup>th</sup> century, in the beginning of the 20<sup>th</sup> century, hospitals’ cleaner environments, in which aseptic conditions could be maintained, offered greater safety. In the 1920s, nearly three-fourths of American births took place at home, but with the improvement of hospital conditions, women began giving birth in

hospitals, resulting in 96 percent of births taking place in hospitals by 1960. Therefore, the success of hospitals came, in large part, because the refined sanitary conditions met the standards of and were approved by pregnant women. However, the hospital also began to be seen by women as an unnerving, strict environment, which eventually resulted in the many pregnant women disapproving of the hospital.

Cassidy (2006) describes the birth conditions in hospitals that resulted in a shift in women's approval. She writes:

[Many women] had endured the ordeal of having their babies held back from being born because the doctor was not available. Others recounted how they had their wrists, legs, or shoulders strapped to the table or stirrups because the hospital was worried about the mother contaminating the 'sterile field' they had worked so hard to achieve (p. 66).

Many women's perceptions of the hospital greatly shifted away from an image motivated by freedom from pain and responsibility to one tarnished by horror stories such as these. Another issue associated with hospitals was pubic hair shaving, a common procedure for hospital births. Feminists and natural birth advocates considered the act to be dehumanizing to the female body. Rejections of hospital practices such as these came around the period of the Second Wave Feminist Movement, which prompted women's health movements across the country. These women-centered movements encouraged women to regain control of their bodies in childbirth.

Hospital horror stories such as those described above, in conjunction with the feminist, homebirth, and natural birth movements of the time, led to many women wanting to escape the *literal* binds of birth in a hospital in the 1960s and 1970s. In her book *Birth*, Tina Cassidy tells the story of nurse Noreen Mattis from Rhode Island who had been unconscious for the birth of her own child when many physiological complications arose (Cassidy, 2006,

p. 66). Her personal birth experience propelled her to become a childbirth educator and advocate. Through her work she began helping women to give birth at home, mostly in secret. Cassidy describes, “Mattis would get a call in the middle of the night, meet a midwife and a liberal obstetrician at the house, and cheerfully help bring a new life into the world” (Cassidy, 2006, p. 66). Negative sentiments surrounding hospital practices resulted in a small but noticeable shift from obstetricians to midwives. In the early 1970s, midwives attended only 0.5 percent of births, and by 1982 that number had risen to 2.1 percent (Litoff, 1986, p. 14). Coupled with the increasing disapproval and difficulty to find nurses to attend homebirths, women began seeking alternatives methods—marking the emergence of birth centers.

The birth center was meant to be a compromise in which women who opposed giving birth in a hospital could have a safer alternative to homebirth. In 1975, Ruth Lubic opened the first birth center in a town house on the Upper East Side of New York (Cassidy, 2006, p. 68). Lubic was also the director of the Maternity Center Association (MCA) (now called Childbirth Connection), which is a non-profit organization that has promoted natural childbirth practices since the 1930s, and now works to, “improve the quality and value of maternity care through consumer engagement and health system transformation” (n.d.). As women continued to question the medicalization of birth over the 20<sup>th</sup> century, more birth centers were opened. Around the same time, nurse-midwifery began to gain visibility and popularity in the U.S. The MCA’s state-licensed facility, called The Childbearing Center, opened in 1975, and was staffed by nurse-midwives and obstetricians who allowed women to give birth in any safe position they wanted without the conventions of hospitals, such as stirrups, general anesthesia, cesarean sections, enemas, pubic hair shaving, or episiotomies

("Childbirth Connection's," January 22, 2014). The charge for prenatal care, childbirth classes, and postpartum care in birth centers was about half the cost of doctors' visits and hospital deliveries, making birth centers hubs for the uninsured. In 1985, the MCA established the Commission for the Accreditation of Birth Centers (CABC) to ensure that out-of-hospital birth centers in the United States were up to standard ("Childbirth Connection's," January 22, 2014). The CABC provides measures of how birth centers adhere to national standards, providing safe and high quality choices for women. The existence of an agency such as CABC that reviews birth centers on a national level, demonstrates that structures surrounding childbirth were taking form according to the interests of women and their desire to give birth outside of a hospital.

In 1989, the *New England Journal of Medicine* published a landmark survey that followed 11,814 low-risk women admitted for labor and delivery to 84 freestanding birth centers in the U.S. The outcome results were similar to those of hospital births, demonstrating that birth centers were a safe alternative to hospitals, as well as, economic competition for hospitals (Cassidy, 2006, p. 70). In response, hospitals began trying to adopt the cozy environments of birth centers, creating their own birthing rooms or suites. In addition, hospitals began opening birth centers on or near their grounds. For example, in 1997, Cambridge Hospital in Massachusetts opened the Cambridge Birth Center right across the street from the hospital (Cassidy, 2006, p. 71). Today, birth centers must pay high malpractice insurance rates, culminating in many independent birth centers struggling to cover the costs that has resulted in them linking up with hospitals or closing. These circumstances have resulted in many women going back to home births or hospitals. In this way, the closure of birth centers has not come as a result of a failure to accommodate the

needs of pregnant women, but rather, conversely, financial hurdles have thwarted the proliferation of birth centers despite the success of the open birth centers.

Highlighting this success, Stapleton, Osborne, & Illuzzi (2013) conducted a prospective cohort study of women receiving care in 79 midwifery-led birth centers in 33 US states from 2007 to 2010. Of the 15,574 studied women who planned and were eligible for birth center births at the onset of labor, 84 percent successfully gave birth at the birth center. About 12 percent of the birth center mothers were transferred to hospitals during labor, mostly due to women seeking pain relief, the study reported. As of 2015, there were 313 birthing centers nationally, of these 113 opened since 2010, which is approximately a 57 percent increase (Galewitz, October 12, 2015). These statistics demonstrate an increase in the number of birth centers in the U.S, which is a direct result of the reaction of women to the medicalization of childbirth and their attempt to regain autonomy in birth. Another women-centered movement prompted by similar motivations was the doula movement.

### *Doulas in the U.S*

Doulas were introduced into the U.S in 1992 when two American physicians, John H. Kennell and Marshall H. Klaus, helped to create the organization Doulas of North America (DONA) International (Cassidy, 2006, p. 196). Doulas are persons trained to provide nonmedical support to a mother throughout her pregnancy, labor, and postnatal period. Doulas are equivalent to labor coaches, monitrices, childbirth assistants, labor companions, mother assistants, or patient advocates (Klaus, Kennell & Klaus, 2002, p. 4). In 1994, there were 750 doulas in the U.S, and by 2006, there were nearly 6,000 (Cassidy, 2006, p. 196). The introduction of the doula may be a reaction to the medicalization of birth;

however, it also demonstrates a return to traditional midwifery customs in which female family members and friends supported each other during childbirth.

A doula is not trained to make medical decisions; however, a doula has extensive knowledge of the medical interventions typically available. Because she is only supporting one laboring woman at a time, the doula can explain these procedures in a more in-depth manner, as opposed to an obstetrician who might have more than one patient to attend to in the hospital. Accordingly, the doula serves to relieve anxieties and uncertainties of the mother, reassuring the mother of her natural abilities during labor (Klaus, Kennell & Klaus, 2002, p. 15). Typically, the doula meets the mother during the third trimester of pregnancy. This is when the doula will learn the expectations and desires of the mother during her birth. It is in her contract that after 37 weeks of pregnancy, the doula is on-call to the mother 24/7, which means they are accessible at all times and are available to the mother when she goes into labor (Personal communication, January 12, 2016). In a study that compared birth with a doula and without a doula, the outcomes for doula-group mothers showed fewer deliveries by forceps and vacuum-extraction and less need for oxytocin to stimulate labor compared to groups without doulas. Additionally, doula support has been associated with shorter labor lengths and lower c-section rates (Klaus, Kennell & Klaus, 2002, p. 84). Medical studies such as these that reveal lower rates intervention for women with a doula reflect the role that many doulas hold while in the context of large medical structures, such as in hospitals. This role is that of the *protector* of the laboring woman, which lies in contrast to the obstetrician as the protector of the fetus.



Jane Doe<sup>3</sup>, a doula who is part of a renowned doula collective in Manhattan, elaborates on her belief in her duty to protect her clients. Attending births in hospitals, homes, and birth centers, Jane explained in an interview, “When I’m at a hospital, I take on a protective role. I am protective of my client, but in a home birth I don’t have to be that way; I’m more just support” (Personal communication, January 12, 2016). Like many doulas, Jane feels a responsibility to advocate for her client’s values voiced in her client’s birth plan. She described using efforts to relieve pressures on the mother to accept interventions from the doctor or nurse by reminding the mother of the different risks and benefits associated with each intervention and how they align with the values in her birth plan.

Due to the nature of the doula’s advocacy, some opponents believe that doulas unreasonably persuade mothers to reject all medical interventions in order to uphold their own personal values. These views demonstrate the assumptions made surrounding the values of doulas, in which opponents assume that doulas solely support ‘natural’ birth without medical interventions. However, this presumption falsely categorizes doulas as advocates of natural birth, failing to see them as advocates of the birth experience that their clients desire. In response to this claim made by opponents, Jane argued, “To me, supporting one type of birth goes against exactly why I am a doula. I am there to let women know that they have choices and that they are entitled to have the birth that they want to have. I don’t like to use the word ‘natural’ because to me that shames women who have had epidurals” (Personal communication, January 12, 2016). Morton (2002) echoes these sentiments expressed by Jane, explaining that, “Providing labor support means first of all, unconditionally supporting the woman's choices, even when that conflicts with the doula’s own values about the ‘ideal’

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<sup>3</sup> Interviewee’s name has been changed for the purpose of this thesis.

birth” (p. 155). Jane continues to express her commitment to the mother’s vision for birth over her own beliefs about birth. She explains:

I am not a trained medical professional. I would never tell my client to do something. All I can do is present my client with the information and it is up to her to decide what she wants to do. If my client was being advised by the doctor to do something and she asked me what I thought, I would explain to her the pros and cons, but it’s not my job to dissuade my client from doing what the doctor is advising. If I present information and my client decides for herself that she doesn’t want to go with what the doctor is saying, it’s within her right. I think there’s this conception of doulas being kind of like rogues or troublemakers and that we are there to bring down the hospital system—that’s not my agenda. It is just to make sure that my client feels happy and supported with her birth. I am not anti-doctor or anti-hospital (Personal communication, January 12, 2016).

On that account, Jane’s presence serves to enhance the mother’s choice and awareness during labor by presenting the mother with as much information as possible so that the mother is best able to make an informed decision based off of her own values. In a hospital, the doula becomes a steady, familiar support system in an atmosphere that may bring the unfamiliar faces because the mother mostly has not met the on-call obstetrician and nurses before going into labor. In this instance, the doula becomes, as Jane named it, a “constant” that has known the mother for the longest time and understands what the mother’s birth expectations are (Personal communication, January 12, 2016). The doula movement that has emerged during the last decade of the 20<sup>th</sup> century and into the 21<sup>st</sup> century has manifested along side nurse-midwifery, a profession that also emphasizes and advocates for the importance of the mother’s birth experience.

## *Revival of Midwifery in the 21<sup>st</sup> century*

At the start of the 21<sup>st</sup> century, midwife-attended births become increasingly common in the U.S. This recent reemergence of midwifery has consisted of the rise in the certified nurse-midwife (CNM), as CNMs account for 95 percent of midwives in the U.S (Martin, et al., 2007). The increased use of midwives for childbirth has come in tandem with, and as a result of many women-centered organizations, advocating for women's choice in childbirth, one being Choices in Childbirth (CiC), a non-profit that started in 2004 to fight for maternity transparency in childbirth practices ("History & Success," n.d.). In addition to organizations such as CiC, the popularity of films such as *The Business of Being Born*, which premiered in 2008 criticizing the medicalization of childbirth in the hospital setting, demonstrates the rising awareness and concern surrounding the proliferation of medical interventions in birth. With the increasingly pervasive nature of these birth advocacy groups and popular media productions in the U.S during the early 2000s, the face of childbirth has been modified in accordance with these new expectations. In 2012, births at home and birth centers made up 1.28 percent of all births, an increase from 0.79 percent in 2004 (Belluck, 2015). These numbers are just one example of the many ways that childbirth practices have demonstrated an increasing rejection of the medicalization of childbirth in the U.S. This increased number of births at home and in birth centers is indicative of an increased use of midwives, both CNMs in birth centers and other types of midwives for home births.

In 1975, less than 1.0 percent of births were attended by CNMs; however by 2013 the CDC reported that approximately 8.1 percent of all U.S births were attended by CNMs (Martin et al., 2007; Hamilton, Martin, Osterman, Curtin & Mathews, 2015). Midwives that are not CNMs, and therefore, do not practice in hospitals, attended approximately 0.8 percent

of all U.S births in 2013 (Hamilton, Martin, Osterman, Curtin & Mathews, 2015). This ‘renaissance’ in midwifery has manifested in a 33 percent increase in midwife-attended births in hospitals between 1996 and 2006 in the U.S (Johantgen et al., 2012, p. e76). Since CNMs are licensed to work in hospitals in all 50 states, this increase in midwife-attended births in hospitals indicates this emergence of CNMs, indicating a transition from the direct-entry (traditional) midwife to the CNM.

The advancement and expansion of the field of nurse-midwifery during the latter half of the 20<sup>th</sup> century came, in part, as a result of the women-centered movements mentioned above; however, the close proximity, as well as the dominance of the field of obstetrics in childbirth may have played a part in encouraging the emergence of nurse-midwifery. In 1971, ACOG approved nurse-midwifery for uncomplicated maternity cases (Litoff, 1986, p. 15). This approval by ACOG is an indication that ACOG acted in accordance with the demands of women during the growth of the aforementioned women-centered movements; however, it also marks that ACOG’s approval of nurse-midwifery came about on its own accord in an attempt to mold the field of midwifery in conformity to the obstetrics medical model of childbirth. These conditions that led to the emergence of the field of nurse-midwifery has led to the question: Is the certified nurse midwife a manifestation of the interests of the woman, or a representation of the imposition of the obstetrics field in midwifery? In the next chapter, I will explore the intricacies of this question, ultimately arguing that the CNM promotes and represents the pregnant woman’s interests. The CNM’s position within the obstetrics sphere of a hospital does not signify a CNM’s acceptance of the interventionist methods of obstetrics, but rather, I argue that it demonstrates its opportune position to act as an advocate for the mother within the obstetrics paradigm.

## Chapter IV: The Certified Nurse-Midwife

Doctors' interests and women's interests, as demonstrated in Chapter 2 and Chapter 3, respectively, have worked in tandem to shape the scene of childbirth today. Rothman (1991) points out the manifestation of these two contradictory interests in childbirth in the U.S today, querying, "Why the juxtaposition of the high technology of birth with a back-to-nature approach?" (Rothman, 1991 p. 32). This contradiction in the care of pregnant and parturient women is a result of a mixture of the medicalization of childbirth and the recent rejection of this medical model of childbirth by women. These complexities within the scene of childbirth practices prompt the question of whether the historical decline of midwifery has resulted in a professional midwife that upholds comparable values of the original midwifery practice or overturns these values. Due to the great predominance of certified nurse-midwifery in the practice of midwifery today, the CNM remains in the spotlight of this investigation.

### *The Role of the CNM*

A CNM is a registered nurse (RN) who has a master's degree in midwifery and certification according to the requirements of the American Midwifery Certification Board (AMCB) through a certification exam. CNMs in the U.S. are accredited and represented by the professional organization of the American College of Nurse-Midwives' (ACNM). Therefore in order to be a CNM in the U.S, one must be certified by the ACNM, in one of the 50 states. Because a CNM uses obstetrical knowledge, the CNM exists in the obstetrical medical sphere of childbirth, however, alternatively, the CNM continues to practice midwifery, a field that rejects the technocratic model of childbirth for a non-

interventionist approach. Regardless of whether obstetricians or mothers have had a greater impact in shaping the CNM of today, the question remains whether these influences have alienated CNMs from the traditional, core values of the field of midwifery in favor of the technologically focused medical model of obstetrics.

CNMs assist women with low-risk pregnancies in hospitals, clinics, birth centers, and a small portion, at home. Because of the variety of settings in which CNMs practice, ACNM does not provide universal clinical practice guidelines for all of the organization's members. Instead, ACNM requires that CNMs have written clinical practice guidelines that are appropriate for their practice circumstances (Bogdan-Lovis & Sousa, 2005). CNMs are required by law to have this physician support for obstetric complications (Summers & McCartney, 2005). In addition to providing obstetrical backup if an emergency arises, these physicians also decide components of the CNM's practice protocols, leading to questions about how greatly obstetricians impact CNMs' practices.

CNMs are considered to be advanced practice registered nurses (APRNs). Because CNMs are APRNs, they must have state mandated practice agreements with physicians, which require an obstetrician's approval for a CNM's practice (Koslov, 2014). These mandates potentially affect the autonomy of the CNM because the practice agreements give obstetricians the ability to limit midwives' access to the healthcare market. The National Association of Clinical Nurse Specialists (NACNS) voices these concerns:

All APRNs collaborate, consult with, or refer to physicians. Many APRNs practice in health care teams with physicians and other types of health care providers. The issue is whether specific legal requirements for physician involvement limit the services APRNs can provide and areas where they can practice, thereby making it more difficult for consumers to access a full range of care from these providers ("Scope of Practice," n.d.).

The physician's choice to collaborate with the CNM not only holds power over the CNM's practice but also ultimately affects pregnant women's access to nurse-midwifery care in the area. Therefore, the care that the CNM delivers is the care that a physician is willing to accept. In addition, some states limit the number of APRNs a physician can advise, further restricting CNM practice and access for women. In this way, these restrictive practice agreements raise many questions about the ability of CNMs to make decisions about childbirth care based on their own values without being influenced by the values of the obstetricians. Additionally, the existence of these agreements creates the false image that CNMs are incapable of caring for low-risk pregnancies. ACNM echoes these sentiments in saying, "Collaborative agreements signed by individual physicians wrongly imply that CNMs/CMs need the supervision of those individuals in all situations" ("Collaborative agreement," 2011).

Although the CNM's practice depends on having practice agreements, physicians have not been incentivized to take on these agreements. In fact, physicians become liable for the CNMs medical decisions, and since there has been an increase in the cost of malpractice insurance premiums nationwide, taking on higher premiums to have practice agreements with a CNM places great financial burdens with potential vicarious litigation risks on physicians (Peizer, 1986). Since physicians are hesitant to take on this extra liability, this limits the practice of nurse-midwifery. This system restricts competition within the healthcare system, making costs uncompetitive and access to care limited. These restrictions are especially deleterious as they widen the disparities in health for vulnerable pregnant and parturient women. As stated by Koslov (2014):

Competition by APRNs is especially important because APRNs are expected to play a critical role in alleviating provider shortages and expanding access to

health care services for “medically underserved” populations, including rural and low-income Americans. In addition, unnecessary and rigid supervision requirements may make it more difficult to innovate new models of health care delivery – including collaborative, team-based care that is not always physician-led.

African American women are nearly four times more likely to die of pregnancy-related complications than white women (“Deadly Delivery,” 2010, p. 1). Many women do not have access to prenatal care because of the high costs. By limiting the practice of midwifery, physicians thwart preventative measures in prenatal care that could reduce maternal mortality. The U.S has a small number of obstetricians per birth, approximately 9.6 per 1,000 births, and the lowest proportion of midwives to birth, 0.4 per 1,000 births, of any other industrialized countries (“Deadly Delivery,” 2010, p. 62). By enforcing practice agreements in this manner, pregnant and parturient women in under-served areas are unable to access adequate healthcare.

ACNM states that, “53.3% of CNMs/CMs identify reproductive care and 33.1% identify primary care as main responsibilities in their full-time positions. Examples include annual exams, writing prescriptions, basic nutrition counseling, parenting education, patient education, and reproductive health visits (“Essential Facts about Midwives,” February 10, 2016). Although these are important duties that demonstrate the variety of ways that CNMs contribute to supporting the growing population of pregnant women, it is crucial to highlight the importance of not limiting the CNM’s role to these primary care duties. This is to say that labor and delivery care should be a core responsibility of CNMs, as they are crucial to filling a gap in access to maternity care, decreasing medical costs, and increasing birth attendant choices for the expectant mothers in the U.S.



## *Core Values*

The professions of obstetrics and nurse-midwifery in the U.S are represented, respectively by the professional organizations of the American College of Obstetrics and Gynecologists (ACOG) and The American College of Nurse-Midwives' (ACNM), respectively. Both organizations focus on the need for comprehensive coverage of birth assistance for all mothers. The ACOG states that that it values, "Access for all women to high quality safe health care" and the ACNM states that its vision is, "A midwife for every woman" ("The American College of Obstetricians and Gynecologists," July 12, 2009) ("The American College of Nurse-Midwives," April 2012). Both organizations support the "advancement" of health care for women through education, clinical practice, and research of their respective birth practices. In addition, ACNM and ACOG endorse professionalism within each field. Despite these commonalities, each organization continues to have contrasting approaches to sustaining these shared values.

A comparison of the core values set forth in the respective mission statements of each organization reveals fundamental differences in the principles upheld by their members. In "Core Values" on its official website, ACNM uses terms such as "informed consent", "respect", and "shared decision-making", while ACOG's focus is on "safety", "organizational structure", "efficiency", and "qualifications" ("The American College of Nurse-Midwives," April 2012) ("The American College of Obstetricians and Gynecologists," July 12, 2009). ACNM's values demonstrate a focus on women-centered care in which the woman's experience of birth is prioritized, while ACOG's values focus on fetus-centered care and efficiency. This leads to the question of whether efficiency necessarily leads to or

reflects safety for the fetus, which ACOG places as the main rationale for its interventionist approach to childbirth.

ACNM states that they respect the physiological processes of birth. This value is in accordance with traditional midwife values in which they, “Believe that women’s bodies are well designed for birth and try to protect, support, and avoid interfering with the normal processes of labor, delivery, and the reuniting of the mother and new born after their separation of birth” (Lay, 2000, p. 5). This notion lies in contrast to obstetrics practices in which technology pinpoints the day of delivery, if the birth or labor deviates too far from this predetermined timeframe, an induction is ordered. Obstetrics attempts to place the female body into a standardized model of birth, however, this method does not respect the physiological diversity of pregnant women. Additionally, the core values of ACOG are placed in a narrative that addresses the obstetricians, while ACNM’s values are directed at the mother. For ACOG, the doctors are the authority figures providing care, while for the ACNM, the woman is the main agent in her birth. In addition to exploring the chasm between the practices of midwifery and obstetrics, I will examine the fragmentation of the field of midwifery that manifests today.

### *Divisions in the Field of Midwifery*

Due to a variation in required educational standards and credentials in midwifery, there is a separation of midwives into multiple categories, including Certified Nurse-Midwife (CNM), Certified Professional Midwife (CPM), Certified Midwife (CM), and Direct-Entry Midwife (DEM). The differences in the categories of midwives not only reflect a differentiation in required credentials, but they also reflect a divergence in how each type of

midwife defines what it means to be a midwife. A comparison of the DEM, or traditional midwife, with the CNM, will form the core of this section.

A large distinction between the training of DEMs and CNMs is that DEMs are trained through apprenticeship. DEMs see apprenticeship training as a confirmation of the midwives commitment to, “connective and embodied experiential learning” and a, “deep trust in women and in birth” (Lay, 2000, p. 4). Many DEMs believe that professionalizing the field of midwifery is to, “recognize a knowledge system based on women’s experiential and embodied knowledge” (Lay, 2000, p. 30). However, they believe the field of obstetrics in which CNMs function does not appreciate this knowledge, and therefore, many DEMs believe the knowledge of midwifery is lost in the professionalization of CNMs.

Some DEMs believe this professional training and their perceived subordination to obstetrics results in CNMs being more likely to approach birth with interventions. To support this claim, opponents of CNMs highlight the fact that fewer than 2 percent of CNMs attend home births—attending births mostly in hospitals (“Frequently Asked Questions about Midwives and Midwifery,” n.d.). Although most do not attend homebirths themselves, CNMs are most often proponents of the concept of homebirth. Vedam, Aaker & Stoll (2010) call attention to this disparity in CNMs’ beliefs and practices, stating, “Despite the fact that CNMs were generally favorable towards planned home birth, most CNMs were unwilling to translate these attitudes into action.” This point returns to the argument presented by Morris (2013) in Chapter 2, in which she claims that the continued medicalization of childbirth is due to organizational constraints that exist to avoid malpractice claims. In most states, CNMs do not attend homebirths, not because they do not support births at home, but rather because they cannot because their insurance will not cover homebirths.

Another factor that has contributed to the division between CNMs and DEMs is a separation across accreditation programs and professional organization. For example, Midwives' Alliance of North America (MANA) was founded in 1982 to "build cooperation among midwives and to promote midwifery as a standard of health care for women and their families" (Lay, 2000, p. 6). MANA was created as a professional organization for all midwives of the U.S because at the time, ACNM was limited to representing CNMs. The formation of MANA was in response to the lack of organization and cohesion for all other midwives. However, in 1994, ACNM expanded its scope in "professionalizing" the sphere of midwifery to direct-entry midwives when ACNM's Accreditation Commission for Midwifery Education (ACME), began accrediting direct-entry midwifery education programs in addition to nurse-midwifery programs ("Accreditation Commission for Midwifery Education." n.d.; Lay, 2000, p. 9). This attempt to regulate DEMs has been met with both acceptance and rejection from DEMs, as such accreditation brings visibility to DEMs, as well as more practice opportunities, however, some fear the repercussions of regulation that may result in a degradation of midwifery values.

### *Collaborative Models*

In 2011, the ACNM and the ACOG published a Joint Statement of Practice Relations Between Obstetrician-Gynecologists and Certified Nurse-Midwives/Certified Midwives. It states that, "To provide highest quality and seamless care, ob-gyns and CNMs/CMs should have access to a system of care that fosters collaboration among licensed, independent providers" ("Joint Statement of Practice Relations," 2011). One form of collaboration between CNMs and obstetricians is the interactions across state regulated agreements as

discussed above, however, another collaborative arrangement is through collaboration models have also been formed in joint practices in hospitals. These models demonstrate a microcosmic display of the position of the CNM within the medical sphere.

A critical component of many collaboration models is that they exist in teaching hospitals, resulting in early exposure to midwifery values for medical students and obstetric residents. One example of this model is the Obstetric Team program at Baystate Medical Center in Springfield, Massachusetts developed in 2003 (Collins-Fulea, 2009). The team consists of two full-time CNMs, a first-year obstetrics resident, a first-year emergency medicine resident, and a third-year medical student. The CNMs teach the residents and medical students about low-risk labor, teaching hands on skills but also classroom seminars.

The Obstetrics Team is an example of a fully integrated collaborative model in which the CNM acts as a member of the resident team without practicing privately with her own patients (Feinland & Sankey, 2008). However, the fully integrated model is not the only form of collaboration in teaching hospitals. There are also parallel models, in which CNMs function in a private practice setting in the same institution as a residency program. There is little interaction or crossover of responsibilities; however, it is the beginning of residents developing some skills of consultation with midwives by observing relationships between CNMs and obstetricians (Collins-Fulea, 2009). Another type of model is the coexistence model in which CNMs have their own private practice but use senior obstetrics residents as first-line consultants. They also cover shifts for residents in intrapartum care when residents are not available. Lastly, there are blended models in which CNMs have a private practice but also act as an attending faculty for residents. These varying models of collaboration

demonstrate different ways of putting midwives and obstetricians in communication. Each model has its benefits and its drawbacks (Collins-Fulea, 2009).

Under these collaborative models, as obstetric residents are learning about childbirth, they are exposed to evidence supporting the midwifery model of care. By learning with this model, it is possible that these residents will be more accepting and willing to support the use of midwives or to enter into collaborative practice models after residency. Collins-Fulea (2009) highlights the benefits of obstetrics residents working alongside CNMs in writing:

Midwives are more likely to have skills that support physiological processes in healthy women and allow these processes to occur without interference. Physicians who work with midwives would likely have increased exposure to the midwifery skills or the midwifery model of care that support physiologic childbirth; thus midwives should be a critical component in the education of physicians who will be involved with childbearing women.

At Boston Medical Center the collaborative maternity teams are made up of CNMs, obstetricians, and family physicians. “Family physicians could bring to the team expertise in managing medical conditions; midwives, expertise in managing normal labor and birth; and obstetricians, expertise in high-risk conditions and surgical management” (Pecci et al., 2012). This gave patients options for prenatal care but also assured coverage if their care provider was not available. Pecci et. al (2012) shows that the collaborative model at Boston Medical Center increased patient satisfaction and resident deliveries by 25 percent, resulting in residents having more experience with birth.

One of the issues with these models is that some were developed “solely to address gaps in service” since residents’ work hours have been greatly shortened along with there being a shortage in physicians (Feinland & Sankey, 2008). This may indicate that although the programs have been beneficial in including the model of midwifery, the intentionality of the programs do not demonstrate a purposeful shift in obstetrics education, which may result

in long-term rejection of the midwifery model. Although this concern about the intentionality of the programs has been voiced in the literature on collaborative models, as demonstrated in earlier chapters, changes in midwifery have not always been necessarily “intentional,” but rather have come about because of social expectations for institutional change. Although a shift from the medical model into the midwifery model is imperative, the reemergence of midwifery during the 21<sup>st</sup> century demonstrates that social expectations, especially of women, will pressure and push this shift if desired.

Additionally, Collins-Fulea (2009) questions whether a midwife’s involvement in high-risk situations would result in a midwife shifting from the midwifery model to the obstetrics model that medicalizes childbirth. This view simplifies the values of midwifery, which are not against medical interventions, but rather emphasize the birth experience of the woman that is most ideal in her own view. This is to say that the midwifery model opposes unnecessary medical interventions that create physical and financial burdens on the mother, not medical interventions in themselves. A midwife would not support delivering a baby in a high-risk pregnancy without access to advanced medical interventions. Despite these questions, collaborative models have been shown to make communication easier between obstetricians and CNMs, making transfer of care seamless in cases of obstetrical emergencies. In addition, these models help to remove the barriers of the system that rely on specialist care for low-risk populations, making CNMs responsible for low-risk patients while not excluding obstetricians. Therefore, these models augment the presence of the midwife in childbirth in accordance with the interests of women.

These models demonstrate that although there are structures that prevent the free practice of CNMs, the CNM maintains an opportune position to influence the practice of

childbirth in hospitals. Although CNMs' practices are dictated by the regulations of hospitals and insurance companies, this is not a problem singular to CNMs, but an issue with the U.S healthcare system.

Despite the structural restrictions placed on their practice, CNMs have introduced midwifery's ethical and ideological frameworks through their opportune position within the medical sphere's paradigm. The CNM represents the interests of the mother to remain close to interventionist methods through their practice in hospitals, however the CNM does not inherently accept the interventionist methods of obstetrics, but instead acts as an advocate for the mother, promoting her experience. Although working in a hospital sacrifices some of the values of midwifery, such as attending homebirths, this remains to be an issue of the system in which all medical professionals exist. By not entering the medical sphere of birth because of such limitations on traditional midwifery values, CNMs would deny many women the benefits of midwifery care within a hospital in the U.S.



## Conclusion

*“Whereas the physical process of childbirth has changed very little, childbirth practices have changed tremendously” (Allotey, 2011, p. 132).*

Midwives were the only birth-attendants in the U.S for most of history, but at the start of the 20<sup>th</sup> century, midwives attended approximately fifty percent of U.S births. By 1930, midwives attended less than one percent of births. The principal reason for this drastic decrease in the use of midwives was the permeation of obstetrics into the mainstream of childbirth in the U.S. This has resulted in a transformation of childbirth practices in the U.S from the social midwifery model to the medical obstetrics model. The obstetrics model has led to high rates of medical interventions, such as expensive birthing technologies in U.S births. Despite these high costs for maternity care, infant and maternal mortality rates remain high in the U.S. This scene of childbirth has resulted in the reemergence of the field of midwifery in the form of the CNM.

The question I explored in this thesis is: Does the position of the certified nurse-midwife in the medical sphere compromise its status as a midwife and the values traditionally associated with midwifery? This question is embedded within the historical narrative of the childbirth in the U.S because the field of childbirth, including the position of the CNM, has been greatly shaped by the historical controversy between midwives and obstetricians as well as the role of women through the promotion of women-centered movements during the 20<sup>th</sup> century. Due to combination of these influences, the field of nurse-midwifery, and along with it the CNM, were born.

Throughout this thesis, I touch on the economic forces that shape childbirth practices in the U.S. Although I do not go into great detail on these financial pressures, these economic systems remain at the center of healthcare in the U.S, including the care of pregnant and

laboring women. In this paper, I do not argue for or against home births; however, I acknowledge that economic barriers from denial of insurance reimbursements impede women from maintaining full agency in their birthing decisions and experience. For example, many insurance companies are more willing to reimburse obstetricians over midwives, due to liability concerns. Amnesty International reported one personal narrative that highlights this notion: “My daughter chose to have a midwife deliver her baby at home, for a cost of US\$2,500. In the hospital system it would have cost US\$12,000, but because it was at home, insurance wouldn’t pay for it” (“Deadly Delivery,” 2011, p. 60). Since CNMs are limited to the hospital setting due to malpractice insurance restrictions, home birth reimbursements are not a concern for CNMs.

However, CNMs are not fully covered or recognized across all insurance systems. For example, Medicaid reimbursement for CNM care is mandatory in all fifty states, however, in 27 states, there is no requirement that private insurance reimburse nurse-midwife services at all (“Essential Facts about Midwives,” February 10, 2016; “Deadly Delivery, 2010, p. 81). Although the lack of a requirement does not mean that private insurance companies deny access to CNM to all women in that state, but the lack of recognition in insurance policies not only creates an image of the CNM as less of a professional figure than the obstetricians, but also it makes the option of midwifery care to a woman less visible, and seemingly more complicated.

This concept leads into another topic that pervades this paper without explicit mention, which is the ways in which a woman’s ability to participate in her childbirth is thwarted by a lack of clarity and information as to the options for maternity care. This paper alludes to the innumerable groups of women who have advocated for childbirth that is free of

the amnesia of Twilight Sleep, the binds of hospital births in the 20<sup>th</sup> century, and the obligatory repeat c-sections of the 21<sup>st</sup> century; however, this picture fails to mention the masses of women who may not have the privilege or the passion to advocate for themselves during birth, which is the average American woman. The CNM provides access to care under the model of midwifery within the hospital, an environment in which a vast majority of U.S women will give birth by default. Therefore, the CNM increases the visibility of midwifery to these women in hospitals, where they are most likely to give birth.

The CNM may not present an immediate solution to the high maternal mortality rates and the high usage of obstetrics technology and procedures, however, the values of nurse-midwifery put a spotlight on these issues in childbirth within the facilities in which obstetrics is practiced. In addition, they provide cost-effective approaches to low-risk births to lower the medical costs of childbirth in the U.S and increase access to appropriate maternity care for all women. Although the CNM has compromised some of the original values of midwifery, its evolved role encompasses the desires of U.S women to give birth in a hospital setting with obstetrical technology nearby. In this way, the gradual change in childbirth in the U.S has embodied women's demand and physicians' interests, while also incorporating both advancing medical knowledge and traditional cultural values. Therefore, the CNM's position in a hospital gives a woman the choice of what kind of pregnancy she wants—one of the fundamental values of midwifery.

Female patients and professionals have had their autonomy stripped from them in the name of technology, and I believe the CNM holds an opportune position in the healthcare field to serve as a vehicle for reclaiming and asserting female agency in childbirth in the U.S.

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