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Specializing in Normal: An Overview of Midwifery in the US

Lucille Tower
Portland State University

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Specializing in Normal:
An Overview of Midwifery in the United States

by

Lucille Tower

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Thesis Adviser

Kris Gowen

Portland State University

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Table of Contents

Abstract	1
Introduction	2
Maternity Care Providers	3
Defining Models of Maternity Care	6
History	10
Before the Late 18th Century	10
Late 18th Century to Early 20th Century	11
Early 20th Century	13
Nurse-Midwifery	14
Professionalization	16
The Certified Midwife Credential and Professional Identities	20
Current Issues	22
The Future of Midwifery	27
Conclusion	30

Abstract

There was a time when nearly every infant that came into this world was caught by the hands of a midwife. The rise of obstetrics in the 1800s drove midwifery to the margins, and in the US it is only in the last century that midwifery has reemerged as an organized profession, appearing everywhere from home births to hospital labor floors. Faced with a tradeoff between autonomy and credibility, midwifery branched into several pathways, with different educational requirements and scopes of practice. The formation of national organizations like the Midwives Alliance of North America (MANA) and the American College of Nurse-Midwives (ACNM) has helped midwives build professional identity and strengthen legislative advocacy. As an ancient trade and a young profession, midwifery embodies a paradox that is visible in the regulatory debates playing out at the state and national levels. Its professional structure is shaped by, and in turn shapes, philosophies of maternity care. This paper traces the relationship between midwifery and medicine beginning in the late 1700s, provides an overview of the development of different midwifery paths in the 1900s, and examines present-day issues in order to chart a path for midwifery's continued evolution.

Introduction

The word midwife comes from the Middle English words *mid* and *wif*, meaning “with woman”.¹ Since ancient times, midwives have assisted women* through labor, birth, and the postpartum period in cultures across the globe. The rise of obstetrics in the 1800s heralded a clash of different care models and cultures, whetted by class, race, and gender dynamics in the US at the time. Midwifery was driven to the margins as medically managed childbirth became the dominant model of care. To survive, midwifery transformed, splitting into different pathways and organizing into professional bodies.

Amnesty International describes the US maternal healthcare system in the US as being in a state of crisis.² The US has a higher cesarean rate, average cost of delivery, infant mortality rate, and maternal mortality rate than comparable developed countries, and most of these figures have increased since the turn of the century (with the exception of the infant mortality rate, which has held relatively stable).²⁻⁶ Because midwives are specialists in supporting the normal birth process and minimizing unnecessary medical interventions, midwifery plays an important role in improving national maternal health.^{7,8}

The decisions made now about midwifery education, credentials, settings, identity, organizational structure, and relationship to other healthcare professions will form midwifery’s foundation for years to come. Because models of care shape, and are in turn shaped by, internal professional structures, current professional issues in midwifery have implications for the types of care that will be available to women in future. These professional issues are of interest not only to midwives but to everyone with a stake in improving national maternity care.

In this paper, I explore different models of maternity care and summarize the history of midwifery in the US in order to open the discourse to those outside the

* In this paper, feminine pronouns are used for simplicity and to illustrate scope of practice boundaries and important historical gender dynamics. However, it is recognized that neither sex nor gender are binary categories. The use of feminine pronouns in this paper is not intended to erase the lived experiences of intersex or transgender people, nor to dismiss the need for sensitive and affirmative healthcare.

midwifery community, especially aspiring midwives. Particular attention is given to the relationships between midwifery and medicine and between different midwifery paths so as to provide context for current professional issues. I frame midwifery's split into different pathways (most notably nurse- and direct-entry midwifery) in terms of a credibility/autonomy tradeoff to illustrate the way values have shaped care models and professional structures in midwifery. This construct is also used to outline the conditions that would be necessary if midwifery paths were to re-converge.

It is useful here to describe the different types of maternity care providers in the US in order to illustrate the range of credentials, educational routes, scopes of practice, and practice settings, and to introduce terms that will be used throughout the remainder of this paper.

Maternity Care Providers

Doula

Doulas are not maternity care providers, and are included here as a point of comparison. The word doula comes from the ancient Greek word meaning 'a woman who serves.' A birth doula provides continuous physical, informational, and emotional care (but not medical care) to mothers during childbirth.⁹ There are other types of doulas, as well. Postpartum doulas support mothers and infants in the weeks following birth, and many doulas specialize in providing emotional support to families through specific experiences such as infertility, high-risk pregnancy, miscarriage, abortion, adoption, or stillbirth. Recently, some doulas have expanded the profession beyond maternity to include end of life care.¹⁰ Some doulas work with a specific hospital or birth center; however, most are hired directly by expecting families. Because doulas are privately hired to provide non-medical support, there are few, if any, legal requirements for their training. The skills and experience levels of different doulas can vary greatly. However, several organizations, including Doulas of North America International (DONA International) and the Childbirth and Postpartum Professional Association (CAPPA), offer training and pathways to certification.^{9,11}

Monitrice

A monitrice provides support in a similar manner as a doula, but is also qualified to perform some clinical tasks such as monitoring vital signs and checking cervical dilation. A monitrice is not the mother's primary healthcare provider, but can help the family decide when to call the provider or leave for the birth center or hospital.¹²

Traditional Midwife

Traditional midwives are not certified or licensed and provide out-of-hospital care to expecting families. Many traditional midwives believe they are ultimately accountable to the women they serve, and thus should not be regulated by outside parties.¹³ Because of this, there are few reliable statistics about the numbers of traditional midwives in the US or the births they attend.

Licensed or Registered Midwife (LM/RM)

Licensed and registered midwives are those who are not Certified Professional Midwives but are legally licensed or registered in their state.¹³ Licensing requirements and the availability of midwifery licensing programs vary by state. In some states, it is not legal for midwives who are not nurses to practice.¹⁴

Certified Professional Midwife (CPM)

The Certified Professional Midwife is an independent midwifery practitioner who has met the standards for certification set by the North American Registry of Midwives (NARM).¹³ They are specialists in providing out-of-hospital care to women throughout the childbearing cycle. Because no national licensing system exists in the US, the regulation of CPMs varies by state.¹⁴

Certified Nurse Midwife (CNM)

Certified Nurse Midwives are dually trained in midwifery and nursing and have met the standards for certification set by the American Midwifery Certification Board. Most midwives are CNMs. The vast majority of CNMs work in hospitals, and they attend more than 7% of births in the US. CNMs provide care to women across the lifespan (not just the childbearing cycle), including primary healthcare and well-woman care such as PAP smears, STI testing/treatment, and contraception.¹⁵

Although CNM regulation varies by state, they can legally practice and hold prescriptive privileges everywhere in the US.¹⁶

Certified Midwife (CM)

The standards for certification as a Certified Midwife are identical to those for Certified Nurse Midwives, and both are represented by the American College of Nurse-Midwives.¹⁵ The CM is a relatively new credential developed to create an alternate pathway into in-hospital midwifery that does not require being a nurse. Although CMs are not nurses, many hold other healthcare credentials, such as physicians assistant.¹⁷ CMs are currently legally recognized in New York, New Jersey, Rhode Island, Delaware and Missouri.¹⁶

Direct-Entry Midwife

‘Direct-entry’ describes midwives who entered midwifery without first training in nursing.¹³ In the late 1900s, non-nurse midwives in the US adopted the term direct-entry (already widely used in Europe) as a replacement for the term ‘lay’ in order to convey the professional nature of their work and their view of midwifery as distinct from nursing. The details of who is considered a direct entry midwife can vary. In some contexts, ‘direct-entry’ may refer midwives who are not CNMs, midwives who are not affiliated with ACNM, midwives who are neither CPMs nor affiliated with ACNM, or midwives trained primarily through apprenticeship and self-study as opposed to an accredited program.¹⁸ In this paper, direct-entry will refer to all midwives who are not also nurses.

Labor and Delivery Nurse

Labor and delivery nurses are nurses who specialize in caring for women during labor and birth. Although they are not primary healthcare providers, labor and delivery nurses work closely with both mothers and physicians throughout the birth process.¹⁹

Family Practitioner

Family practitioners are physicians. They have training in a variety of medical fields. Those that care for patients during labor and delivery typically work in hospitals and manage low-risk cases.²⁰

Naturopathic Midwife

A naturopathic midwife is a naturopathic doctor who has gone on to specialize in maternity care.²¹

Obstetrician-Gynecologist (Ob-Gyn)

Obstetricians-gynecologists are physicians who have specialized in women's sexual and reproductive health, including pregnancy and childbirth. Like CNMs, Ob-Gyns provide care to women across the lifespan in addition to maternity care. They have extensive training in managing complications and high-risk pregnancies.²⁰ Ob-Gyns may also have subspecialties, such as gynecological oncology or maternal-fetal medicine.²²

Defining Models of Maternity Care

Given the diversity of birth settings (home, birth center, hospital, etc.), the differences in legal status of maternity providers by state, the differences in training among providers with the same credential (apprenticeship, university program, self-study, etc.), and the inevitable differences in each provider's personal experience and approach to maternity care, it would be impossible to succinctly define the care a provider offered based solely on their job title. Nonetheless, generalizations about providers' philosophies, perspectives, and approaches to birth are extremely useful in understanding the ways their roles differ and overlap.

Barbara Katz Rothman was the first to describe the midwifery and medical models in her 1979 book, *Two Models of Maternity Care: Defining and Negotiating Reality*.^{23,24} Not all conceptions of maternity care models follow this division, however. In her 1992 dissertation, *Birth as an American Rite of Passage*, anthropologist Robbie Davis-Floyd articulates three models of care: the technocratic, humanistic, and holistic models.²⁵ Each model is described using twelve tenets that, when compared, illustrate the differences between the three approaches. The technocratic model views the body as a machine, separate from the mind. It is characterized by highly standardized care and using technology to provide treatment from the 'outside in'. The holistic model views the body as an energy system interlinked with other energy systems, united with the mind and

spirit. A holistic practitioner values intuition and provides highly individualized care, guiding healing from the 'inside out'. The humanistic model is in many ways a combination of the other two. It views the body as an organism and recognizes the connection between mind and body. The humanistic model emphasizes the relationship between the patient and provider and values balance between the needs of the institution and the needs of the individual in order to promote healing, both from the outside in and the inside out. Davis-Floyd believes the humanistic model has the best chance of success as a model of change in modern childbirth.²⁵

Davis-Floyd's conception of care models is valuable in part because it is not limited to maternity care, and does not attach the models to particular groups of providers. Nonetheless, defining models of care specific to maternity and associated with particular providers is useful in that it builds unity within groups of practitioners, raises awareness about other groups, and helps the public identify healthcare providers that best fit their needs. The midwifery/medical division draws upon the histories of midwifery and medicine without unnecessarily widening the divide between different types of midwives or physicians. For these reasons, the conception of midwifery and medical models of care has persisted.

In 1996, members of the Midwives Alliance of North America (MANA), the North American Registry of Midwives (NARM), the Midwifery Education Accreditation Council (MEAC), and Citizens for Midwifery (CfM) met to write a definition of the midwifery model to allow for consistency in communications with healthcare decision-makers.²⁶ Their definition is below:

Midwives Model of Care™

The Midwives Model of Care is based on the fact that pregnancy and birth are normal life processes.

The Midwives Model of Care includes:

- Monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle
- Providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support
- Minimizing technological interventions
- Identifying and referring women who require obstetrical attention

The application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

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The Midwifery Task Force was careful to word its definition so that the emphasis was on the care provided, not on the provider.²⁶ This was to make room for the natural flexibility in models of care as generalizations—associated, but not strictly attached, to a profession. It acknowledges that some physicians may practice the midwifery model of care while some midwives may practice a medical model.

Discussion of these models of care takes place primarily among midwives and their supporters. Because midwifery is currently considered an ‘alternative’ approach to childbirth, it is natural for midwives to define the care they offer in comparison to the medical model. The medical industry, by contrast, as the dominant provider of maternity care, has little reason to define itself in comparison to midwifery. However, in some cases this has stunted discussion of the medical model and resulted in the medical model being defined only by its flaws.²⁷

Judith Rooks’s article, “The Midwifery Model of Care,” offers a more balanced view of the medical model and its natural relationship to midwifery.²⁸ Rooks describes the two models as complementary. Midwives and obstetricians share an ultimate goal: healthy mothers and babies. And yet, they approach this goal from different perspectives. Midwifery evolved out of the care women traditionally offered one another during times of vulnerability, while obstetrics evolved out of the field of medicine to address pathologies occurring in birth. Thus, there is a

difference in directionality of focus in the way midwives and obstetricians approach their shared goal. Midwives, as specialists in supporting the normal birth process, generally focus more on securing the best possible birth experience. Obstetricians, as specialists in managing complications in birth, generally focus more on preventing the worst possible outcome.²⁸

This seemingly subtle difference in providers' approaches to caring for laboring women can result in conspicuous differences in practice. Midwifery care typically involves limiting medical interventions unless a clear complication presents itself. In addition to offering physical support to the mother and watching for potential complications, midwives support the normal birth process by offering individualized emotional and social support. Obstetricians, on the other hand, have the training and experience necessary to care for high-risk patients and to manage serious complications. They are more likely to recommend interventions than midwives and sometimes use treatments as preventative measures, sacrificing the potential for a more natural birth in order to head off the potential for a complication.²⁸

There are other differences between the midwifery and medical models as well. Rooks notes that prenatal visits in the medical model are often more focused on the health of the fetus while prenatal visits in the midwifery model are more focused on the emotional, social, and physical wellbeing of the mother. The midwifery and medical models also differ in the expected relationship between the pregnant woman and the healthcare provider, with midwives viewing their role as more collaborative. This difference extends to the language that is normal in each model. Within hospitals, healthcare providers typically say they delivered a patient, while out-of-hospital midwives typically say they attended a client's birth. This language makes clear both the different power dynamics of patient/provider and client/midwife relationships and also the dominant view of the mother as either normal or as likely requiring treatment.²⁸

Rooks emphasizes that both the midwifery and medical models represent valuable skills, knowledge bases, and perspectives that help families have safe and healthy births. They are complementary in nature. The medical model is designed to

better care for women with high-risk pregnancies or diagnosed diseases and to manage emergencies, while the midwifery model is better prepared to support the normal birth process. In recent years, there has been significant merging of the models. The midwifery and medical models have begun shifting from a dichotomy to a spectrum more reminiscent of Davis-Floyd's three models. Rooks suspects that if maternity care providers were charted along a spectrum from the midwifery to medical models, the result would be bimodal, with a growing number of providers in the center, practicing a combination of the two models.²⁸ Nurse-midwives in particular have a central role in this process. The hyphenation of their name represents the dual nature of their professional identity. Nurse-midwives have been key advocates for birth centers and hold great power in shaping the future relationship between midwifery and medicine.¹⁸

History

This paper will provide only an overview of midwifery's history, as the topic has already been discussed in detail in other works. Judy Barrett Litoff's, "An Historical Overview of Midwifery in the United States," and Nancy Shrom Dye's review essay, "History of Childbirth in America," provide excellent summaries.^{29,30} Dye divides the history of childbirth in the U.S. into three periods: before the late 18th century, when childbirth was a social rather than a medical event; between the late 18th century and the 1920s, when medically managed birth gradually replaced social childbirth; and the 1920s onward, when the medical model of childbirth was an established norm.³⁰

Before the Late 18th Century

Before the late 18th century, childbirth was an exclusively female event that took place in the mother's home, attended by midwives and by the mother's female friends and relatives. Midwives trained empirically through apprenticeship with more experienced midwives and generally practiced independently in their communities. The independent nature of midwifery and the lack of professional

structure at the time, combined with a general scarcity of sources on midwifery from this period, make a full analysis of the competence of midwives in early America impossible. However, recent scholars have argued that midwives were knowledgeable about the birth process and the most common complications, and that they employed a variety of effective mechanical and pharmacological methods to assist laboring mothers.³⁰ In addition to being an intense physical act, childbirth is an acutely emotional and spiritual process. The social and female-focused approach to birth offered emotional and spiritual support during this time. In *Lying-in: A History of Childbirth in America*, Wertz and Wertz describe social childbirth as a “fundamental occasion for the expression of care and love among women” (p. 6).³¹

The mystery surrounding midwifery in the colonies forces scholars to generalize, and at times this has allowed midwives to be painted as ignorant and dangerously incompetent. However, the reverse is also true. Dye and the Wertz's, among others, caution against romanticizing childbirth in early America. Although midwives were knowledgeable about childbirth, and the maternal mortality rate in the colonies was lower than in Europe, complications still arose. Many women knew someone who had died in childbirth. Puritan ministers stressed the potential for fatality, and perceptions of supernatural peril fueled fear and contributed to the association of midwives with witchcraft. While for some women, birth was a joyously anticipated occasion, primary sources indicate that others approached their births with a sense of dread.^{30,31}

As with women today, the childbirth experiences of women in early America were varied and complex. Social childbirth attended by midwives offered a personal and female-controlled approach to birth, but was not without competition.

Late 18th Century to Early 20th Century

As the 18th century came to a close, physicians, who viewed childbirth through a medical lens, began attending births in increasing numbers. The rise of obstetrics occurred gradually and amidst much debate. In addition to shifting from a social to a medical approach, obstetrics represented an extreme change in the gender dynamics of birth: as universally female midwives lost ground to exclusively male

physicians, birth shifted from a female-controlled to a male-controlled experience.^{29,30}

Feminists, social conservatives, and health reformers resisted the incursion of men into what was traditionally women's work. For centuries, it had been considered inappropriate for men to enter the lying-in chamber. Their presence raised concerns for women's modesty, and in some cases triggered vehement opposition. Others welcomed male physicians into birth work. Women were expected to serve domestic roles in 19th century American society, and the male physicians, with more formalized education than the apprenticeship-trained midwives, inspired additional confidence by fitting the image of a professional.^{29,30}

The heated debate over the merits of 'man-midwifery' played out over decades. Physicians trained using mannequins and, when attending a birth, often examined mothers without looking by reaching under a cloth drape in order to preserve the mother's modesty.²⁹ Dye draws from Jane Donegan's *Women and Men Midwives: Medicine, Morality, and Misogyny in Early America* to explore the social context of the dawn of obstetrics, noting that physicians' emphasis on the potential complications of childbirth helped defend their involvement in midwifery.^{29,32} The invention of forceps served as a symbolic difference between midwives and physicians, with critics of man-midwifery condemning the unnecessary use of 'iron instruments' with the potential to mutilate mother or child, and proponents praising the scientific innovation with the potential to aid mother or child in abnormal deliveries.²⁹ Overall, women (especially upper-class women) turned increasingly to physicians to attend their births with the promise of safer deliveries and greater pain management.^{29,30}

The number of births attended by midwives declined steadily into the late 19th century, before making a surprising, though short-lived, recovery. Between 1880 and 1920, millions of immigrants came to the US from Eastern and Southern Europe, who were accustomed to having midwives attend their births. They solicited the help of American midwives as a matter of course and helped restore momentum to what had been seen as a dying profession. By the end of the 20th century, physicians and midwives were filling different niches in the birth market,

with physicians predominantly serving upper-class women in urban areas and midwives serving women in lower-class, rural, immigrant, and black communities. All told, about 50% of births were attended by midwives.²⁹

Early 20th Century

By 1930, midwives attended only 15% of births. Dye cites Litoff's book, *American Midwives, 1860 to Present*, in examining the factors that contributed to this sharp decline. Falling birth rates helped shift perceptions of birth from normal and routine to unusual and mysterious, distancing the public from the midwifery model's assumption of normalcy. Midwifery being practiced primarily in poor areas created the appearance of lower quality care, exacerbated by midwives' exclusion from obstetrical developments. Continued urbanization put more and more mothers within a reasonable distance from hospital labor and delivery wards. Meanwhile, the medical community's public criticism of midwifery intensified.^{29,30,33}

Studies at the beginning of the 20th century found that the US had alarmingly high maternal and infant mortality rates, higher than most European countries at the time.²⁹ Despite nationwide studies in the 1930s by the White House Conference on Child Health and Protection, the national Committee on the Costs of Medical Care, and the New York Academy of Medicine that all found that women had better birth outcomes under the care of midwives, the high mortality rates further increased physician's criticism of midwives and ignited a campaign to curtail, and in some cases eliminate, midwifery practice.^{29,30,33}

The evidence that this blame was misplaced did little to brace midwives against the campaign against them. Because midwives often worked in isolation and had few professional structures (especially compared to the vast, hierarchical structure of the medical community), there were few avenues in place for midwives to advocate on their own behalf. Government and public health officials defended midwifery to limited effect. Frances Kobrin's article, "The American Midwife Controversy: A Crisis of Professionalization," examines the differing perspectives of physicians and public health officials on midwifery in this period. This division of the midwifery debate between physicians and public health officials is telling-

midwives, without the professional structures necessary to hold a united front in the realm of public policy, were themselves a background voice in the debate over their profession.^{30,34}

A slew of midwifery regulations passed at the state level resulted in midwives' status differing greatly in different places in the US. For the most part, this haphazard arrangement further isolated and marginalized midwives. However, in a few places, it allowed for the development of localized and municipally supported midwifery organizations. New York City established the Bellevue School of midwives in 1911, and saw the infant mortality rate of the city drop by half.²⁹ Other states and cities also established training and supervisory programs, with some models empowering and disempowering midwives more than others.

Nurse-Midwifery

It was in this context that the idea of nurse-midwifery first emerged in the US. In her 2010 article, "Nurse-midwifery Self-identification and Autonomy," Helen Varney Burst describes the joining of nursing and midwifery as "a natural marriage of women's professions" (p. 406).³⁵ Mary Breckinridge, who had encountered nurse-midwives while volunteering in France in the aftermath of World War I, made it her life's work to establish the Frontier Nursing Service (FNS) in 1925. She first trained in nursing, then, because no program existed for educating nurses in midwifery, traveled to England to become certified as a midwife. She encouraged other nurses to also learn midwifery in England, and together, they developed the Frontier Nursing Service. The FNS nurse-midwives enjoyed formidable independence in their work in rural Kentucky and saw excellent birth outcomes, with maternal mortality rates nearly a tenth the national average.³⁶

Other nurse-midwifery organizations that followed did not allow this same level of independence. In the Maternity Center Association (MCA), developed in New York City, nurse-midwives operated under the close supervision of local doctors. This was a reflection of the more urban setting and institutional healthcare system. The Maternity Center Association nurse-midwives achieved similar results as the nurse-midwives in the Frontier Nursing Service. In the 1940s, and throughout the

mid 20th century, nurse-midwifery continued to expand. Grantly Dick-Read's 1944 book, *Childbirth Without Fear*, spurred interest in natural childbirth and increased demand for nurse-midwives.^{29,30,36} The momentum of the natural childbirth movement, a shortage of obstetricians in the post-WWII baby boom, and increased access to health insurance all fueled nurse-midwifery's expansion.³⁶

Although an in-depth analysis of the effect of health insurance on maternity care (including recent developments such as the Affordable Healthcare Act) is beyond the scope of this paper, it is important here to note that efforts to improve access to maternity care have significantly changed the populations served by different maternity care providers. In the 1800s, it was primarily upper-class, white, urban women who called on physicians to attend their births, while lower-class, rural, immigrant, and colored communities relied on traditional midwives.³⁰ Today, programs aimed to improve access to maternity care for low-income women often exclude direct-entry midwives as care providers because of their inconsistent legal status.¹⁴ The result is that many (but not all) direct-entry midwives must rely on clients paying for care out-of-pocket. In the same way that physician-attended birth was once an alternative form of care accessible to women of higher socioeconomic status, today, women of lower socioeconomic status face barriers to accessing out-of-hospital midwifery care.³⁷

Nurse-midwifery contributed to a complex dynamic in the landscape of maternity care in the US. Midwifery and obstetrics had existed, up to now, as a relative binary. While midwifery was community-based, independent, and individualized, medicine was institutionalized, industrialized, and standardized. Nurse-midwives took elements from both models to turn the binary into a continuum. Several sources have referred to a tradeoff between autonomy and credibility in maternity care.^{38-40,18} Credibility here refers not to competence but to the trust afforded by outside entities. This trust requires both trans-disciplinary transparency and predictability, which depend on standardization. Autonomy refers to a provider's ability to individualize care using whatever resources are available to them (including intuition) without being confined by outside protocols. In Helen Varney Burst's, "The History of Nurse-Midwifery/midwifery Education," Burst

describes nurse-midwives as sacrificing autonomy for credibility.³⁸ Though this statement ignores that most nurse-midwives were not midwives later trained in nursing, but nurses later trained as midwives, it is a useful illustration of both the unique benefits and drawbacks of nurse-midwifery.

Nurse-midwifery embodies the merging of the midwifery and medical models Rooks identified, so much so that the dual identity of nurse-midwives is evident in the hyphenation of their name. In many ways, nurse-midwifery aims to take the best of both worlds: mixing the standardization and organized structure of medical care with the community-based, individualized care of midwifery. Nurse-midwifery was lauded by people from both sides of the maternity care divide for this new approach. Nurse-midwives successfully advocated for changes within the hospital setting including allowing partners and family in the delivery room, having a single room for labor, delivery, and recovery, supporting early breastfeeding, and allowing mothers to be unrestrained during labor.⁴¹ However, as is typical for groups that emerge as a middle ground between two historically separate categories, nurse-midwifery faced resentment from both sides as well. Many doctors fought to keep nurse-midwives categorized as assistants, rather than as providers in their own right.³⁸ Out-of-hospital midwives resented nurse-midwives for compromising the midwifery model in exchange for approval from the medical community and for dividing midwifery at a time when they needed unity more than ever.^{29,36,18} Not all of this resentment was unwarranted, as many nurse-midwives joined the unfounded and sometimes explicitly racist campaign against traditional midwives (most of whom were of Eastern European or African-American descent) and agreed that replacing traditional midwives was an appropriate goal.³⁶ Thus, nurse-midwives were not passive observers to the complex dynamics of maternity care in the US, but multifaceted actors who embodied these complex dynamics while pioneering a new, merged model of care with excellent results.

Professionalization

By 1940, it became apparent that nurse-midwifery would benefit from a national organization, in order to better expand the profession and protect its standard of

practice. The multiple and varied efforts to create such an organization are detailed in Katie Dawley's article, "Doubling Back over Roads Once Traveled: Creating a National Organization for Nurse-Midwifery."⁴² The Frontier Nursing Service created the Kentucky State Association of Midwives, which later became the American Association of Nurse-Midwives. In 1944, Hattie Hemschemeyer, nurse-midwife and education program director at the Maternity Center Association, called a meeting to address the issue of national organization. The nurse-midwives in attendance dismissed the idea of supporting the American Association of Nurse-Midwives because of its unofficial but established exclusion of colored midwives. Creating an independent, non-exclusive organization was likewise dismissed, because the required investment of time, money, and energy made it infeasible. The nurse-midwives agreed on a third alternative: to form an autonomous and integrated nurse-midwifery section within the National Organization of Public Health Nurses (NOPHN).⁴²

This arrangement worked well until 1952, when the NOPHN was merged with several other nursing organizations, forming the restructured American Nurses Association and the National League for Nursing. Sister Theophane Shoemaker convened a committee of leading nurse-midwives to address the future of organization in nurse-midwifery. They were faced again with three options: to form an organization within nursing, to expand the American Association of Nurse-Midwives, or to create a new and independent organization. The committee decided that, until such a time as the new nursing organizations had a place for specialty groups, they should pursue the other two possibilities. Sister Theophane and Hemschemeyer corresponded repeatedly with Mary Breckinridge about the possibility of expanding the American Association of Nurse-Midwives. However, Breckinridge was deeply concerned that expanding too quickly would draw opposition from physicians that the community was not yet prepared to weather and objected to the committee's priorities, arguing instead for a focus on developing additional nurse-midwifery education programs. The committee thus agreed to create a new, independent organization, which led to the creation of the American College of Nurse-Midwifery in 1955. In 1969, the American College of Nurse-

Midwifery merged with the American Association of Nurse-Midwifery to form the American College of Nurse-Midwives (ACNM).⁴² Nurse-midwives, aided by the structure of a unified national organization, continued to strengthen their community and profession.

It was not long before pressure to professionalize was extended to direct-entry midwives. Direct-entry midwifery and out-of-hospital birth had seen a resurgence through the 1960s and '70s, buoyed by the feminist movement and renewed interest in holistic healthcare.⁴³ At a 1981 meeting with 'lay' midwives and nurse-midwives who had started out practicing 'lay' midwifery, Sister Angela Murdaugh, president of ACNM, urged direct-entry midwives to organize. The Midwives Alliance of North America (MANA) was created in 1982. This was not uniformly supported by nurse-midwives, many of whom saw nurse-midwifery as the future of midwifery and did not wish to see the profession divided. However, many direct-entry midwives rejected the medicalization of midwifery through nursing and did not believe that holistic, out-of-hospital birth could be adequately protected through ACNM. MANA, unlike the ACNM, was created as an inclusive organization in order to promote unity and honor the diversity and autonomy of midwives.^{18,43}

The MANA midwives were in agreement that to preserve a place where all midwives, regardless of educational route or style of practice, could gather, membership could not be limited to those possessing a specific credential. However, direct-entry midwives stood to gain by developing a credential that would formally validate the knowledge and skills of midwives who chose to pursue it.⁴³ By certifying that the midwife who held it had demonstrated mastery of a standardized knowledge and skill-base, this credential would increase the trans-disciplinary transparency (and by extension the credibility) of direct-entry midwifery. However, there was great concern that standardization would co-opt the diversity that characterized direct-entry midwifery and undermine their model of care. Thus the continuation of direct-entry midwifery was both threatened by and dependent on creating a direct-entry midwifery credential.¹⁸

In response to these opposing needs and concerns, the MANA midwives developed the Certified Professional Midwife credential gradually, with great care put into crafting the requirements in a way that would ensure quality service while affirming the midwifery model of care.¹⁸ MANA created the Interim Registry Board, which later became the North American Registry of Midwives (NARM), to direct this process. NARM conducted an in-depth survey of experienced midwives, the *1995 NARM Job Analysis*, to determine what knowledge, skills, and experiences midwives considered appropriate entry-level requirements.¹⁸ The responses showed a high level of consensus and were used to develop the requirements for certification as a CPM. This process was reviewed and endorsed by experts in competency-based assessment from the Ohio State University Vocational Instructional Library.⁴³ Because the CPM requirements are competency-based, they validate the skills, experience, and knowledge of new CPMs without limiting acceptable educational routes (university affiliated, apprenticeship, etc.) This competency-based approach embodies the compromise between credibility and autonomy the direct-entry midwives needed in order to ensure quality work without limiting the diversity of perspectives in the profession.

Although direct-entry midwifery successfully created a credential and national certification system, in the US, there is no national licensing system for out-of-hospital midwives. Instead, licensing and regulation of direct-entry midwives varies from state to state. Because MANA remains inclusive of all self-identified midwives, it could not meet the need for CPM-specific professional representation. Thus, the National Association of Certified Professional Midwives (NACPM) was created in 2000. NACPM has put together essential documents defining the scope and standards of practice for CPMs that have already been adopted for the licensing of CPMs in several states.⁴⁴ NACPM has made clear from its conception that it exists to fulfill a role MANA cannot, but is not intended to compete with MANA—its meetings are usually incorporated into MANA's annual conferences.⁴¹

As they have grown, MANA and ACNM have developed affiliate organizations to oversee certification of new midwives and accreditation of educational programs. Figure 1 (below), taken from Robbie Davis-Floyd's article, "ACNM and MANA:

Divergent Histories and Convergent Trends,” illustrates the relationships between these programs. The ACNM Certification Council (ACC) and the North American Registry of Midwives both oversee certification of new midwives for their respective organizations, while the Department of Accreditation (DOA) and Midwifery Education Accreditation Council (MEAC) oversee accreditation of midwifery schools. The National Association of Certified Professional Midwives (NACPM), as previously discussed, works in close collaboration with MANA to represent midwives with the CPM credential.⁴¹

Figure 1. Taken from Robbie Davis-Floyd’s article, “ACNM and MANA: Divergent Histories and Convergent Trends” in *Mainstreaming Midwives: The Politics of Change*, this figure illustrates the relationships between ACNM and MANA and their affiliate organizations.⁴¹

The Certified Midwife Credential and Professional Identities

Because ACNM represented the interests of CNMs, MANA, though inclusive of all midwives, arose as its counterpart to represent the interests of direct-entry and out-of-hospital midwifery. This dynamic was interrupted by ACNM’s creation of a new credential in 1995: the certified midwife (CM). CMs must pass the same exam as CNMs but are not required to be nurses. This allows students to focus their education on knowledge and skills that are directly relevant to midwifery. It also allows other healthcare professionals, such as physician assistants, to become midwives without having to repeat a large portion of their education.¹⁸

The CM credential has significant implications for the self-identity of midwives affiliated with ACNM. Midwifery paired with nursing as a means of being accepted into hospital settings, trading a measure of autonomy for credibility within the medical system. However, this dual identity creates problems in regulation and policy.³⁵ CNMs are legally considered advanced practice nurses (APRNs), which effectively classifies midwifery as a subset of nursing. ACNM, on the other hand, defines a CNM as “an individual educated in the two disciplines of nursing and

midwifery,” which illustrates clearly its view that nursing and midwifery are separate, though related, professions.³⁵ The result is a contradictory regulation system where ACNM oversees the education and certification of CNMs on the national level while various nursing boards, differing from state to state, oversee licensure and regulation. Ultimately this means that CNMs are often not represented on boards making decisions that directly impact their practice, including their ability to practice within their full scope as primary care providers. The CM credential, then, represents a concrete step by ACNM toward securing its autonomy as the professional organization and regulatory body for in-hospital midwifery.^{35,18}

The CM credential has brought attention to variation in nurse-midwives’ self-identification. While many CNMs consider their nursing training/experience a valuable part of their midwifery identity, others self-identify as midwives, not nurses, and view nursing as a costly and roundabout way to enter midwifery practice.^{18,35,36} In 1998, ACNM considered changing their name to the American College of Midwifery, though the vote did not pass.⁴¹ However, other significant name changes have occurred that distance ACNM-style midwifery from nursing, including the title of ACNM’s journal’s change from the *Journal of Nurse-Midwifery* to the *Journal of Midwifery and Women’s Health* and the title of Helen Varney Burst’s midwifery textbook from *Varney’s Nurse-Midwifery* to *Varney’s Midwifery*.⁴¹ The controversial nature of ACNM’s proposed name change illustrates a significant lexical gap in the self-identification of CM/CNMs, as there is currently no label that effectively distinguishes between ACNM-affiliated midwives and other midwives (except for the terms ‘ACNM-affiliated’ and ‘ACC-accredited’, which function for legal purposes but have little meaning to the average consumer). In-hospital midwifery effectively excludes CPMs, licensed, and traditional midwives but fails to include the small percentage of CM/CNMs who work outside of hospitals. Listing both CMs and CNMs accurately defines the intended group but undermines ACNM’s efforts to brand the CM and CNM as equivalent credentials. As CMs grow in numbers, it is likely that the issue of ACNM’s name will be revisited. One option would be for ACNM to unite its membership under one credential by changing the CNM credential to the CM-RN, which would more clearly embody ACNM’s definition of a

nurse-midwife as “an individual trained in the two disciplines of nursing and midwifery.” If this change were to take place, ACNM would have the option of renaming itself the American College of Certified Midwives. I prefer the American College of Certified Midwives to the American College of Midwifery because it more accurately reflects ACNM’s membership by excluding (but not erasing) other types of midwives.

The CM credential raises issues of identity not just between nurses and nurse-midwives, but also between nurse-midwives and direct-entry midwives. Separating from nursing would mean that the strictly university-affiliated and primarily in-hospital form of midwifery practiced by the ACNM-affiliated midwives was now technically direct-entry- a term the MANA midwives had been using to brand their form of individualized, out-of-hospital midwifery for over a century. It also raised justified fears that ACNM’s move into direct-entry midwifery represented its intent to replace MANA and the CPM credential that the MANA midwives had worked so hard to secure.

The tensions between ACNM and MANA exist within a stark power differential. While MANA does not have the influence in mainstream culture to be a threat to ACNM, ACNM’s credibility within the healthcare system affords it significantly greater power over midwifery’s future. The ACNM midwives are themselves divided over the appropriate relationship between ACNM and MANA. While many ACNM midwives are part of both organizations and envision their complementary coexistence, others think midwifery would be strengthened by having a single organizing body and view ACNM as the more competent/legitimate of the two.¹⁸

Current Issues

As an ancient practice and young profession, midwifery is at a crossroads. The decisions made now about midwifery education, credentials, settings, identity, organizational structure, and relationship to other healthcare professions will shape midwifery’s future in profound ways we cannot fully fathom. Midwifery today is

defined by both passion and tension: the relentless passion all midwives share for providing quality, client/patient-centered reproductive healthcare, and the acute tension between different groups as they seek to establish the models and practices they feel best accomplish this goal, according to their own experiences and values.

Midwives must continue to advocate for the policies and practices they believe in. And yet, this debate cannot preclude solidarity with midwives of different groups, or internal conflict will compound external resistance from the medical community and extinguish valuable parts of midwifery's tradition. In this high-stakes climate, it is paramount for midwives to listen across divides of credential, practice setting, and professional body to identify and preserve the best that each group has to offer.

One group in particular is uniquely positioned to promote discussions across midwifery divides: aspiring midwives. Because aspiring midwives are passionate about the midwifery model of care but not yet committed to a particular midwifery path, their perspective brings a curiosity about different forms of midwifery that supports ongoing discussion of what each different path has to offer. Their process of choosing the midwifery path that is right for them can mirror the national debate over an appropriate course for midwifery's future, on a smaller and much more personal scale. While the debates taking place within and between professional midwifery groups have an unquestionable impact on midwifery's development, the discussions that are accessible to those outside the professional discourse (especially students) are also significant. The paths aspiring midwives choose, and the opinions they form of other midwifery paths in the process, will shape the tone of professional discussions in years to come.

The accessibility of information on different midwifery paths is complicated by the tensions between them. As an aspiring midwife myself, I can attest to the challenges involved in researching the benefits and limitations of different midwifery paths without already being connected with the midwifery community. Robbie Davis-Floyd sought to bridge this disconnect and open the discourse to students. Her 1998 article, "The Ups, Downs, and Interlinkages of Nurse- and Direct-Entry Midwifery: Status, Practice, and Education," which has been cited throughout

this paper, was written explicitly for aspiring midwives.¹⁸ As a renowned anthropologist and supporter of midwifery, but not a midwife herself, Davis-Floyd offers a refreshingly frank and thorough summary of the history, professionalization, and current status of different midwifery paths, including insight into the differences in day-to-day life of midwives with different credentials.

Davis-Floyd ends her 1998 article with a description of her vision for midwifery, which emphasizes the potential for complementary coexistence of CPMs and CM/CNMs. In her vision, both midwifery cultures honor the other and the differences between them while presenting a united legislative front, finding unity through diversity. She points out that dual midwifery systems, where both CNMs and CPMs are licensed to practice, have already been implemented successfully in several states. In the future she describes, communication and mutual support between ACNM-style and MANA-style midwifery strengthen over time. More and more midwives choose to certify as both CPMs and CM/CNMs, and the two models may eventually converge- but in a way that preserves and combines the strengths of each midwifery model instead of allowing one model to be subsumed by the other.¹⁸

In 1997, a group of midwives who were part of both ACNM and MANA formed the informal Bridge Club with the goal of increasing understanding and mutual support between the two organizations. In the last endnote of her 1998 paper, Davis-Floyd writes joyfully that as she was reviewing the final draft for publication, she received word that a motion introduced at the 1998 ACNM Board meeting by the Bridge Club had passed and would establish a formal liaison group composed of both ACNM and MANA representatives.¹⁸

Lynette Ament's 2007 book, *Professional Issues in Midwifery*, offers an interesting update.⁴⁵ At their first meeting, the liaison group drafted a statement that endorsed all current midwifery credentials, including the CPM. The ACNM Board of Directors rejected the statement and revoked ACNM's participation in the group, later reinstating it (though without funding) in response to an outcry from ACNM midwives.⁴⁵

It may seem that the controversy surrounding midwifery care, and MANA-style direct-entry midwifery especially, could be resolved simply by looking to the

evidence. Is it safe? What do the studies say? In the course of preparing this thesis, I attended the Nurse-Midwifery Grand Rounds at Oregon Health & Sciences University (OHSU) on January 20th, 2015. Judith Rooks, CNM, former president of ACNM, and author of *Midwifery and Childbirth in America*, was presenting on the subject of homebirth. Many nurse-midwives and nurse-midwifery students from OHSU were in attendance, as were a number of direct-entry midwives and a group of direct-entry midwifery students from Birthingway College of Midwifery. Judith Rooks supports direct-entry midwifery and homebirth but argued that substantial changes are needed to ensure safe, quality services.

The debate that ensued illustrates many of the challenges facing policy makers as they strive to make decisions that are evidence-based. As the attendees referenced different studies on birth outcomes in the US to support their various positions, and in turn debated the merits of these studies, it became clear that none of the studies were comprehensive enough to resolve the issue to the group's satisfaction. The studies differed in what constituted intrapartum and perinatal death; whether reporting was mandatory and enforced, mandatory but not enforced, or voluntary; whether they distinguished between different types of direct-entry midwives and the ways that regulation of direct-entry practice differs by state; whether they included known stillbirths and deaths due to congenital abnormalities; whether they included only low-risk clients; and whether they discriminated between planned out-of-hospital births that were transferred to in-hospital care before labor began (due to risk screening) and during labor (due to unforeseen complications). Still other attendees pointed out that the studies focused only on birth outcomes (i.e. medical complications and maternal or fetal deaths) but did not account for the family's birth experience by reporting use of interventions or indicators of mental/emotional health, such as incidence of postpartum mood disorders.

This is not to say that the studies that have been conducted on maternity care models and birth outcomes in the US should be discounted. Though imperfect, these studies are the most objective and reliable means available to assess the safety of maternity care programs, and are thus of critical importance. Analysis of specific

studies is beyond the scope of this paper. I include my experience at the Nurse-Midwifery Grand Rounds to illustrate the challenges that come with carrying out effective studies in a composite maternity care system. When clear evidence is required for standardizing midwifery structure and regulation on a national scale, but evidence collection is impeded by the current lack of unified structure, it creates a causal loop in which lack of standardization both is caused by, and contributes to, problematic regulations. This dilemma is not unique to midwifery, but rather is a natural step in the development of young professions.

It is important here to remember that although midwifery has a rich history as an ancient practice, as an organized profession in the US, it is exceptionally young. ACNM was not created until 1955.⁴² MANA is younger still, established only in 1982.⁴³ The turning point in midwifery is clear: after declining steadily since the late 18th century, the percentage of births attended by midwives in the US hit an all-time low at less than 1% in 1975 before rebounding, and has been growing ever since.⁴⁴ The percentage doubled between 1990 and 2003 and now stands at more than 8%.⁴⁶

The timeline of midwifery's resurgence as an organized profession can be measured in decades. In light of this, the tensions within midwifery cannot be taken as a sign of midwifery's unraveling. Rather, they are an unsurprising consequence of a high-stakes period of rapid change. Midwives salvaged their profession from the brink of extinction by adapting it for modern times while refusing to sacrifice elements that define the midwife model of care. Conflict is a symptom of this ongoing transformation, as midwives of all paths work to shape and strengthen the profession according to their own beliefs, experiences, and values. The extent to which this conflict serves as a constructive force in midwifery's professionalization will depend on whether it can be approached through open-mindedness and mutual respect.

The Future of Midwifery

What will midwifery's continued transformation look like? Judith Rooks' editorial, "Unity in Midwifery? Realities and Alternatives," outlines three possibilities: co-optation, convergence, and parallel paths (see Figure 2, below).⁴⁷ In the first path, co-optation, direct-entry midwifery is absorbed into nurse-midwifery. Rooks emphasizes that this path is not a desirable outcome, as the unique and valuable characteristics of home-birth based direct-entry midwifery would be lost. In the second path, nurse-midwifery and direct-entry midwifery converge in a way that preserves the most valuable characteristics of each. Rooks describes this possibility as contingent on two major changes: ACNM-style midwifery becoming independent from nursing, and MANA-style direct-entry midwifery accepting the necessity of formal education as a mandatory requirement. In other words, ACNM must sacrifice some credibility in favor of greater autonomy, while MANA must surrender some autonomy for greater credibility, in order for the two midwifery models to be compatible for convergence. The third possibility Rooks identifies, parallel paths, involves MANA and ACNM co-existing indefinitely, with three possible modes: minimal interaction, hostility and competition, and collaboration and mutual support.⁴⁷

Figure 2. Possible futures for midwifery, from Judith Rooks' 1998 editorial, "Unity in Midwifery? Realities and Alternatives."⁴⁷

Rooks writes that coexisting parallel paths for nurse- and direct-entry midwifery is the most probable possibility.⁴⁷ Although this may be the case for the near future, and indeed for quite some time, I disagree that a dual system of midwifery is likely to continue indefinitely. Instead, I predict a gradual convergence of the two midwifery models over the next century. Significant progress has been made toward deconstructing the two barriers to convergence that Rooks identifies (though of course much more remains to be done). The CM credential represents an important step by ACNM toward securing its autonomy from nursing. Building an alternative structure for the licensure and regulation of in-hospital midwives is an intimidating task, but one that is feasible and that would give ACNM midwives significantly more control over their profession. Meanwhile, the growth of NACPM, increasing numbers of CPMs, and increasing recognition for the CPM credential represent a trend in the direct-entry midwifery community toward standing behind competency-based certification as a minimum standard for practice. Davis-Floyd's 1998 article, "ACNM and MANA: Divergent Histories and Convergent Trends,"

identifies further evidence toward convergence and compares the midwifery system in the US with Canada's more unified system.⁴¹ During the 1990s and early 2000s, educational programs for direct-entry and nurse-midwives became more similar, with many direct-entry programs adding didactic elements and nurse-midwifery programs incorporating modified apprenticeships through clinical preceptorship.^x Davis-Floyd also observes that the MANA and ACNM conferences she attends have grown more similar over time, with MANA increasing its professional focus and ACNM adding holistic components such as storytelling, dance, and song.⁴¹

I also predict the eventual convergence of ACNM and MANA's brands of midwifery based on personal experience, having felt and witnessed the struggle many aspiring midwives face in choosing whether to pursue training as a CPM or CM/CNM. Although I have only had the opportunity to speak with a small sample of aspiring midwives, the vast majority of them recognized unique and valuable traits in both direct-entry and nurse-midwifery and felt that both would be appropriate and fulfilling career paths for them. If this interest and passion for both brands of midwifery is representative, I think it likely that high demand could develop for educational programs that allowed CPMs to certify as CMs, and vice versa, without having to repeat large portions of their education. The bridging of midwifery educational programs could precede wider professional convergence.

Direct-entry midwives and CM/CNMs have more commonalities than they do differences, most notably a passion for providing quality, woman-centered reproductive healthcare and supporting policies to protect and increase the accessibility of that care in the long term. Raising awareness of midwifery and the normalcy of birth is a crucial, ongoing part of this goal, which is being undertaken by different midwifery groups in their own ways. ACNM has launched a campaign, Our Moment of Truth, to raise awareness about CM/CNMs and the services they provide.⁴⁸ MANA is producing a video series, I Am A Midwife, showcasing different midwives and information about midwifery care.⁴⁹

In addition to national campaigns, public perception of midwifery is shaped by local efforts, and by the collective impact of innumerable personal interactions every day. These efforts are not limited to midwives themselves. In my hometown of

Portland, Oregon, an obstetrician spearheaded a program to improve the relationship between his hospital and the local birth center in order to improve care for patients who transferred from the birth center to the hospital to give birth.⁵⁰ Citizens for Midwifery is a grassroots, consumer-based organization that advocates for midwifery and the Midwives Model of Care.⁵¹ By continuing the dialogue about midwifery and evidence-based maternity care—between direct-entry midwives, CM/CNMs, policy-makers, nurses, physicians, and consumers, and on the personal, local, and national scale—the US may move closer to a system that offers accessible, optimal maternity care services according to each family’s needs.

Conclusion

Maternity care in the US is lagging behind other developed countries, with higher cesarean rates, costs of delivery, infant mortality rates, and maternal mortality rates than many of its counterparts around the world.²⁻⁶ A variety of professionals currently attend births in the US and all have a stake in finding solutions to the current maternal health crisis.^{2,12,13,15,19-21} Because the midwifery model of care is founded on supporting the normal birth process, midwives have a key role to play in improving national maternity care.^{28,7,8}

The dynamic history of midwifery in the US illustrates how care models both shape and are shaped by professional structures. Midwifery originated out of the care women traditionally offered one another in times of vulnerability, while obstetrics rose out of organized medicine to address pathologies of birth. These structural differences shaped variations between the midwifery and medical models of care. Compared to obstetricians, most midwives attend lower-risk births and employ fewer medical interventions.^{24,28} Today, the midwifery and medical models are not as disparate as they once were but continue to encompass different approaches to birth and lead to measurable differences in practice.²⁸

The relationship between care models and professional structures is visible within midwifery, as well. As midwifery was marginalized, it transformed, splitting into different midwifery paths and, later, organizing into professional bodies. The

credibility/autonomy tradeoff is a useful construct for understanding the reasons for midwifery's divergence into direct-entry and nurse-midwifery and the ensuing structural differences between these two paths. As the hierarchical, standardized medical system became the dominant authority in maternity care, midwifery as it had been up to that time (autonomous, individualized, and community-based) was forced out of the mainstream. Midwifery's marginalization was driven in part by race, gender, and class dynamics, as predominantly white, formally educated, male doctors advocated against predominantly colored, apprenticeship-trained, female midwives.

As the campaign against midwifery heightened, midwives were faced with a choice between sacrificing a measure of autonomy for a measure of credibility within the medical system, and sacrificing said credibility in order to continue as an independent, inclusive practice. In effect, both options were taken. Midwifery joined with nursing, adopting formal, standardized education programs and an exclusive framework, and gained external credibility including legal status in all 50 states, access to new developments in reproductive healthcare, and the ability to practice in hospitals and clinics. Meanwhile, direct-entry midwifery continued as a diverse, autonomous, and inclusive profession, but remained marginalized.

The divergence of midwifery's professional structures led to a similar divergence in care models. Midwifery's reorganization into two overlapping but largely separate communities, with different credentials, educational norms, usual practice settings, etc., has culminated in what Davis-Floyd described as "disparate midwifery cultures" (p. 20).¹⁸ Although both branches of midwifery continue to view birth as a normal process, the day-to-day realities of how midwives support this process can vary significantly. These differences extend to the language midwives use, their values relating to birth and midwifery care, and their beliefs regarding the appropriate course for midwifery's future. The historical basis for midwifery's split into different branches provides important context for the tension between ACNM and MANA, as well as for current controversial issues such as the new certified midwife (CM) credential.

Several possibilities for the future professional structure of midwifery exist.⁴⁷ ACNM-style midwifery and MANA-style direct-entry midwifery may continue to coexist, either with minimal interaction, hostility, or mutual support. MANA-style midwifery may be subsumed by ACNM-style midwifery. It is also possible that the two branches may eventually merge. Lessened sex-, class-, and racism, together with midwifery's professionalization, may soften the credibility/autonomy tradeoff and open an option for compromise that was not possible two centuries ago. It may be too early to predict whether midwifery will follow this course. However, the credibility/autonomy tradeoff provides a useful framework for understanding the conditions Rooks outlines as necessary for ACNM and MANA-style midwifery to become compatible once more: ACNM-style midwifery must become independent from nursing (a sacrifice of credibility in favor of autonomy) and MANA-style midwifery must adopt standardized requirements (a sacrifice of autonomy in favor of credibility).

Midwifery in the US is both an ancient practice and young profession. Its transformation into an organized profession is ongoing, and we have yet to see what professional arrangement, requirements, and credentials will persist in the long term. However, midwifery's history makes clear the importance of weighing professional issues carefully, keeping in mind both short-term feasibility and long-term implications. Professional structures both shape, and are shaped by, models of care; and thus current professional issues in midwifery will come to shape the types of maternity care women access in future.

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