"We Listen to Women": Exploring Midwifery in Virginia from Certified Nurse-Midwives and Certified Professional Midwives

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Abstract

The purposes of this study were to explore the work of midwives and their experiences with the medical community, and to examine their goals and hopes for the profession of midwifery in Virginia. To facilitate this purpose, the guiding research questions included: What do midwives believe the role of a midwife is? What are their experiences with the medical community? What are their hopes and goals for the future of midwifery in Virginia? Through interviews, focus groups and participating as a researcher-observer, I found that both certified nurse-midwives and certified professional midwives believe the role of midwife is one of support. Furthermore, midwives' experiences with the medical community are both restrictive and supportive, and both groups are pursuing the advancement of midwifery acceptance and practice through building relationships and advocating for midwifery. The dominance of medical authoritative knowledge of childbirth in the United States creates struggles for midwives. Consequently networking and consumer advocacy are cited as vehicles for the growth of midwifery.

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Chapter 1: Statement of Purpose

The purposes of this study are to explore the work of midwives and their experiences with the medical community, and to examine their goals and hopes for the profession of midwifery in Virginia. Midwifery was popular in the United States around the turn of the 20th century; however, over the next several decades the percentage of births attended by midwives declined from 50% in 1900 to less than 11% in 1930 (Brennan 1977; Lynch 2005; Rooks 1997; Stone 2000). While the number of births attended by physicians drastically increased, the location of birth was shifting from the home into the hospital where midwives were largely unwelcome. In the 1930s, hospitals accounted for 37% of all births, and by the 1960s the proportion of births in hospitals had reached 97% (Rooks 1997). Midwifery remained relatively quiescent during the 1930s-1950s until a revitalization of midwifery began in the 1960s continuing into the 1970s and 1980s. This was largely due to the increased workload of obstetricians resulting from the "baby boom" and their subsequent need for assistance, as well as to the consumer demand from women who opposed the medicalization of childbirth (Daviss 2001; Declerq 2001; Lynch 2005; Rooks 1997).

The profession and concept of midwifery has continued to gain legitimacy since the 1960s, and currently there are several designations of midwives, including certified professional midwives and certified nurse-midwives (Bourgeault and Fynes 1997; Rooks 1997). For the last several years Virginia has been in the process of determining professional and licensing requirements of direct-entry midwives after a statute making the practice of direct-entry midwifery practice illegal was overturned in 2003 (Craven 2005a). In March of 2005 a bill was signed into law in Virginia allowing direct-entry

midwives to be licensed as certified professional midwives (Citizens for Midwifery 2006; Midwives Alliance of North America 2006). Certified nurse-midwives can practice legally in Virginia and all other U.S. jurisdictions, though they are required to work in collaboration with a physician (American College of Nurse-Midwives 2006). There are several reasons why it is important to appreciate the different groups of practicing midwives and to understand what midwives themselves consider as midwifery.
The legalization of direct-entry midwifery in Virginia has the potential to alter the way maternity care is practiced. It has the potential to influence physician and hospital obstetrics, and it increases women's control of their reproductive rights. It also creates opportunities for nurse-midwives and direct-entry midwives to support one another in the public sphere. Midwives and midwifery proponents led and supported the grassroots activism which facilitated the acceptance of direct-entry midwives practicing autonomously in Virginia. This consumer driven movement may have implications for other direct-entry midwives or nurse-midwives seeking more autonomy in their profession.

Given that my purpose is to explore the various and evolving conceptions of midwifery in Virginia, I guided this research with the following research questions: What do midwives' believe the role of a midwife is? What are their experiences with the medical community? What are their hopes and goals for the future of midwifery in Virginia? For this study, I collected qualitative data from three focus groups of midwives practicing in Virginia—one group consisted of certified nurse-midwives and the other two groups consist of certified professional midwives, interviews with four midwives and participating as researcher-observer at the Midwives Alliance of North America annual

conference and a meeting of Commonwealth Midwives Alliance. Qualitative data was collected through semi-structured interviews of the focus groups and with individuals, and through notes from my researcher-observer participation.

Chapter 2: Development of Midwifery in the United States

> *Every culture in the history of the world has had its midwives; wherever there have been women, there have been midwives (Rothman 1982: 50).*

Prior to the movement of medicine into health care and childbirth in the United States, midwives, neighbors, friends, or relatives were largely responsible for birthing the babies of this country (Litoff 1978; Rooks 1997). Medical practice in the United States had a slow start. Throughout the late 1700s, there were no medical schools in the developing states; consequently the first doctors were not formally trained, rather they were self-taught or they learned through an apprenticeship (Litoff 1978; Rooks 1997). There were no educational standards for doctors practicing medicine, and the general health care of a family was often the responsibility of a woman in the home. Midwives were largely responsible for childbirth in the United States, and they often practiced in isolation from other midwives. Most midwives during this time did not have formal training. There were some who came to America with training earned in midwifery care in Europe, but for the most part midwives, like physicians, learned through an apprenticeship or they were self-taught (Litoff 1978; Rooks 1997). Midwives did not consider themselves to be in a profession, and midwives were often uneducated and illiterate. Midwifery was not highly regarded because birth was believed to be a natural process that required little knowledge to attend.

By the early 1800s, medical schools were established, and during the middle of the century, midwifery courses were taught at the Boston Female Medical College (Litoff 1978; Rooks 1997). Throughout the late 1800s, a growing number of formally trained midwives were immigrating from Europe to the United States, and concomitantly, physicians from Europe, who had previously worked with midwives, were also

immigrating. Consequently, there was an aroused interest in educating midwives in the United States. Several midwifery schools were opened during the latter half of the 19th century but they had little staying power. The most successful midwifery schools during this period were established by pioneering Mormons who developed educational training schools for midwives in the Salt Lake City area (Rooks 1997: 20). Medicine became professionalized as the American Medical Association was founded in 1847, and the specialty of obstetrics was recognized in 1848 (Rooks 1997). Physicians encouraged states to pass medical practice laws that controlled access to the profession. At the time, the government had minimal interest in regulating midwives which "reflected a lack of concern for their clientele: predominantly poor, immigrant, Negro and their families" (Rooks 1997: 21). At the end of the 19th century, midwives cared for women who could not afford a doctor, while physicians were attending mostly middle to upper class women.

The first three decades of the 20th century were filled with contestations concerning midwifery, culminating with a physician led campaign to abolish midwifery (Davis-Floyd and Johnson 2006; Litoff 1978; Rooks 1997). At the turn of the 20th century, midwives attended around 50% of all births in the United States. Physicians wanted to end the practice of midwifery and move childbirth into the hospital. Social and economic factors affected the status of midwifery at the turn of the century (Litoff 1978:141; Rooks 1997). Economic changes made families shift from units of production to units of consumption (Rooks 1997: 22). Families that were relatively close-knit and self-sufficient shifted as the economy restructured, causing families to become dependent on resources procured outside of the home. Families were unable to fully provide for

themselves causing women to look outside their local network for assistance during childbirth. The introduction of anesthesia during childbirth made the hospital more appealing to some women. Additionally as growing middle class was able to choose physician care, midwifery became stigmatized as almost exclusively to the lower class. All of this was occurring while physicians were solidifying their power by eliminating other health care practitioners from the medical profession.

During the early 1900s the poor status of Americans' health was realized by the government (Rooks 1997; Stone 2000). High rate of mortality among mothers and infants became a debated subject. In 1913, maternal deaths in the United States reached fifteen thousand women and half of the deaths were attributed to "childbed fever" (Rooks 1997: 25). "Childbed fever" was triggered by a postpartum infection of the mother's uterus and other reproductive organs; this infection was often transmitted through the hands of the birth attendant during delivery to the mother (Litoff 1978: 19). Doctors were quick to blame midwives who had no formal training in health care. In reality it was more probable for a physician who was caring for patients with communicable diseases to infect a laboring woman. In other words, "childbirth fever" was much more likely to occur in women who had hospital births, as doctors would see many patients without washing their hands.

Midwives struggled to defend themselves against the physician led campaign. They were women with little power against the medical establishment (Davis-Floyd and Johnson 2006). Most midwives lacked formal training, and many were immigrants who did not speak fluent English. Other midwives who were not immigrants were poor, and many of them were African Americans. Rooks explains:

> Prejudices against the intelligence and capability of women, immigrants, black people, and poor people were used to defame midwifery. As female members of the least powerful segments of society, midwives lacked the role models, access, experience, and resources needed to influence the institutions that could wield power (Rook 1997: 24).

Because midwives were also fairly isolated from one another, they were unable to unite and organize together (Bourgeault and Fynes 1997; Lynch 2005; Rooks 1997). Those who campaigned against midwives published articles in scholarly journals and popular magazines claiming the danger of having a midwife attended birth (Davis-Floyd and Johnson 2006; Rooks 1997; Stone 2000). There was not conclusive evidence to suggest that a midwife attended birth was more dangerous than a physician attended birth. Nonetheless, physicians advanced their definition of childbirth as pathological, they promised women safety during childbirth and they were successful moving birth from the home into hospitals (Declerq 2001; Rooks 1997).

The shift from mostly homebirth to hospital birth required the medical community to change the public perception of hospitals. For most people living in the United States the hospital was a place that people went to die. Initially only the wealthiest and poorest American women had been giving birth in a hospital (Litoff 1978: 28). The hospital provided care to the very poor as a charity service; however, this subjected poor women to obstetrical interventions that they did not appreciate. Thus many poor women preferred paying a meager fee to a midwife (Litoff 1978: 28).

The practice of midwifery was contested from the early 1900s to around 1935. Physicians claimed that the practice of obstetrics would never earn legitimacy if uneducated women were able to offer midwifery services (Litoff 1978; Rooks 1997). Midwives were still practicing during this time, however limited, because in many rural

areas and inner cities midwives were the only option for a birth attendant. In 1921 the federal government enacted the Sheppard-Towner Maternity and Infancy Protection Act which allocated money to states to help improve maternal and child health care services (Rooks 1997). Some states used this financial allotment to train and oversee midwives to provide care in rural areas and inner city locations, and this training helped decrease infant mortality. The American Medical Association opposed this act and Congress let it expire by 1929. Despite the medical community's opposition, a report presented by the White House Conference on Child Health and Protection concluded that "untrained midwives approach, and trained midwives surpass, the record of physicians in normal deliveries" and they attributed this to "the fact that many physicians…employ procedures which are calculated to hasten delivery, but which sometimes result harmfully to mother and child. On her part, the midwife is not permitted to and does not employ such procedures. She waits patiently and lets nature take its course" (White House Conference on Child Health and Protection 1932 in Rooks 1997). Despite evidence that midwifery was a viable and safe option during childbirth, midwifery nearly disappeared by 1935. Most births attended by midwives were done by midwives practicing in the rural southeast.

The Rise of Nurse-Midwifery

During the early 1900s, the government recognized the poor health of United States residents, and they particularly wanted to lower the maternal and infant mortality rates. Physicians were largely attached to hospital practice, and were disinterested in serving rural areas. In response to the push to improve the healthcare of all Americans,

physicians realized they could train nurse-midwives under their supervision in maternity and childbirth services (Rooks 1997; Stone 2000). Some publicly funded training programs for nurses in hospitals emerged where nurses learned to attend uncomplicated deliveries. Thus the American concept of a nurse-midwife was formed. All of the early programs were designed to meet the needs of nurse-midwives who would be serving underserved populations—people who lived in rural areas, were poor and/or were of different races or cultures than mainstream Americans.

The first successful endeavor to establish a nurse-midwifery education program and practice was founded by Mary Breckenridge (Breckenridge 1952; Litoff 1978; Rooks 1997; Rothman 1982; Stone 2000). During the first half of the 1900s, an area of southeastern Kentucky in the Appalachian Mountians had extremely high infant and maternal death rates. Breckenridge, who was trained as a midwife in England, chose this area because of the poor health of its inhabitants, and she established the Frontier Nursing Service in southeastern Kentucky (Litoff 1978: 124; Rooks 1997). Originally she sent nurses to be trained as nurse-midwives in England, and when they returned they were required to serve the area for a certain number of years. Eventually, she was able to open a nurse-midwifery school and a hospital within the Frontier Nursing Service. The health of mothers and children was significantly improved in this region. The Frontier Nursing Service was also important because it was one of the first successful training programs for nurse-midwives in the United States. Nurse-midwifery had tremendous success in southeastern Kentucky, and Breckenridge's success was an inspiration to other developing schools of midwifery (Litoff 1978: 125).

Nurse-midwives were considered public health nurses; they had an interest in family centered maternity care, and they were acutely aware of cultural and environmental effects on health. Nurse-midwives were quick to establish themselves in contrast to the non-nurse midwife (Davis-Floyd and Johnson 2006). Nurse-midwives claimed their legitimacy through education and training and positioned themselves as legitimate and non-nurse midwives as illegitimate. Most nurse-midwives experienced their midwifery work as a social mission (Litoff 1978: 98; Rooks 1997: 40). Although nurse-midwives increasingly improved the health of mothers and children, the service of nurse-midwifery was not connected to the healthcare system of the United States. Nurse-midwives were detached from mainstream America, nurse-midwives were legally restricted from private practice, and they were most often unable to work in hospitals.

During the next several decades, 1920s through the 1950s, various nurse-midwifery programs were created. Some had startling success, in 1930 the Maternity Center Association (MCA) founded the Lobenstine Clinic which opened in New York City serving poor communities that were considered medically underserved. They served women for twenty-six years with a maternal mortality rate of 0.9 per 1,000 live births compared to the national average of 10.4 per 1,000 live births. Five nurse-midwifery schools were established during this period each "designed to met the needs of special populations-people cut off from other sources of care by geography, poverty, language barriers, or cultural and rural isolation" (Rooks 1997: 39).

Nurse-midwives were detached from the mainstream healthcare and the growth of nurse-midwifery from the 1930s through the 1950s was slow. To facilitate the growth of nurse-midwifery, in the late 1950s MCA advocated for nurse-midwifery graduate school

certificates and degree programs (Rooks 1997:39). By 1958 three programs in the U.S. offered masters programs and three additional programs that offered graduate certificates in midwifery. At the university level nurse-midwives were afforded opportunities to perform research on "natural" childbirth and they were able to analyze birth in other countries. However, their opportunities for clinical practice were limited, and they were legally restricted from private practice. Prior to 1960 most midwives were practicing in maternity clinics or providing home birth care, their practice changed in the early 1960s as birth was almost exclusively occurring in hospitals—at a rate of 97 percent of all births in the U.S. taking place in the hospital. Furthermore, the baby boom increased the need for midwifery services as midwives could train medical students in normal obstetrics, and they could also take care of the overload of deliveries allowing obstetricians time to focus on and teach high-risk obstetrics. This incorporation of nurse-midwives into hospitals created opportunities for midwives though it also limited autonomy and altered the care provided by nurse-midwives. Nurse-midwives increasingly practiced in hospitals, and the implementation of Medicaid advanced the need for nurse-midwives during the 1960s and 1970s.

Nurse-midwives had organized within various localized associations, but as nurse-midwives were becoming absolved into the American Nurses' Association (ANA) and National League for Nursing (NLN) during the early 1950s, they were frustrated with the lack of recognition for their work as midwives (Rooks 1997). The ANA and NLN were not willing to create a separate niche for nurse-midwifery within the associations; they felt that nurse-midwifery did not belong within nursing and that it was a distinct entity under medicine. Consequently, the American College of Nurse-Midwifery was

formed in 1955, and thirteen years later the American College of Nurse-Midwifery joined with the Kentucky-based American Association of Nurse-Midwives and they were united as the American College of Nurse-Midwives (ACNM).

The post-World War II baby-boom left hospitals and medical schools understaffed and doctors and medical students overworked. Bringing nurse-midwives into hospitals was part of a solution to their struggle, and subsequently, nurse-midwifery graduate education became instituted into various nursing and medical schools (Rooks 1997: 43). This incorporation of nurse-midwives into hospitals created opportunities for midwives though it also limited autonomy and altered the care provided by nurse-midwives.

Throughout the 1960s and 1970s, nurse-midwives and the ACNM worked for increasing the recognition, legal rights, licensure and practice of nurse-midwives. They worked to develop standards of education and core competencies of nurse-midwives. The ACNM also created a national certification examination for nurse-midwives. They issued a definition of a certified nurse-midwife establishing that a "CNM is educated in the two disciplines of nursing and midwifery" and clarifying that "nurse-midwifery is not a specialty of nursing" (Rooks 1997: 69). In the early 1970s, the American College of Obstetricians and Gynecologists officially recognized that nurse-midwives are a part of the obstetrical team and that nurse-midwives work in collaboration with and under the supervision of obstetricians and gynecologists (Rooks 1997; Stone 2000).

The acceptance of the nurse-midwife was partly in reaction to the increasing demands of consumers for alternatives to the standards of childbirth practiced in hospitals. Prior to the 1970s, fathers were often restricted from being in a delivery room,

mothers were often medicated during childbirth, and babies were whisked away from the mother immediately after birth (Davis-Floyd 2003). Birthing paradigms, such as the Bradley Method and Lamaze, were attractive to women who were unhappy with the medicalization of childbirth and it encouraged mothers (and doctors) to approach childbirth without medication (Davis-Floyd 2003: 168-174). This challenged the medical community and ultimately with consumer pressure, the medical community made some accommodations. Hospitals began to allow fathers to be present for the birth, increasingly mothers had non-medicated options to deal with pain during labor, and gradually more they offered nurse-midwives as birth attendants. The option of a nurse-midwife attended childbirth was accommodating to some mothers while also satisfactory to the medical community, as nurse-midwives were still under their supervision.

Despite the modernization and medicalization of childbirth in the United States, the rate of infant mortality is relatively high when compared to other industrialized nations. The effort to reduce infant mortality and offer better prenatal care became a focus of the medical establishment in the 1980s and early 1990s (Rooks 1997). History repeated itself, and nurse-midwifery was again sought as a potential solution to the concerns. State laws and insurance practices were altered to accommodate an increased need for nurse-midwives. This increased demand for nurse-midwives created opportunities to expand the practice of nurse-midwifery (Rooks 1997). In some situations this offered nurse-midwives more autonomy. They opened free standing birth centers or created birthing centers separate from physicians in hospitals; they started private practices, and some nurse-midwives began attending home births. Nurse-midwives were increasingly appreciated in the medical community, and they were

afforded more responsibility, which allowed, and sometimes required, them to use medical technologies. This presented challenges to the nurse midwives' philosophy concerning birth (Rooks 1997). Some nurse- midwives became accustomed to using medical technologies, while others avoided these technologies.

Nurse-midwives are required to pass the certifying exam administered by the American Midwifery Certification Board (AMCB). Most CNMs have attended an accredited graduate school while other CNMs have participated in accredited certificate programs (American College of Nurse-Midwives 2006; Rooks 1997). "The majority of CNM-attended births occur in hospitals. In 2002, 97 percent of CNM-attended deliveries occurred in hospitals, 1.8 percent in freestanding birth centers and 1.1 percent in the home (American College of Nurse-Midwives 2006). Nurse-midwives are legally able to practice in every U.S. jurisdiction; however, individual states are responsible for licensing nurse-midwives and nurse-midwives are required to collaborate with a physician, consequently deciding the scope of their practice.

Further complicating this situation is the recent reports of a lack of obstetricians. Medical officials and newspapers have reported a decrease in applications of students to medical schools; and of the students attending, fewer residents are choosing obstetrics and gynecology (Hammond 2002; Wilbourne 2003). This has contributed to the rapidly increasing cost of medical liability insurance. Obstetrics and gynecology is considered a "high-risk" practice of medicine, and there are many lawsuits that arise from obstetrics practice. In the "litigation-happy" society in which we live, all OB-GYN's have been sued at least once during their practice and most likely more than that (Hammond 2002; Wilbourne 2003). It is suggested that judges and courts are sympathetic to lawsuits

against obstetricians that involve the loss of a child or a severely disabled child and often plaintiffs are awarded high damages (Landphair 2006). Consequently, liability insurance companies can justify the astronomical fees for coverage. This can be a significant deterrent for medical students considering the specialty of obstetrics and gynecology. And many practicing physicians are unable to afford the liability insurance in some states, which can cause them to close their practices. This may also decrease opportunities for nurse-midwives to practice if they cannot find physician collaboration.

Growth of Direct-Entry Midwifery

Traditional midwifery faded as physicians dominated childbirth, and non-nurse midwifery became virtually extinct during the 1930s. The record of traditional or non-nurse midwifery between the 1930s and 1960s is limited; homebirths were limited to those living in remote areas and the extremely poor. During the 1960s and 1970s, a natural childbirth movement was fueled by the feminist movement and the counterculture movement (Davis-Floyd and Johnson 2006: 38; Rooks 1997: 60). The percentage of births in a hospital reached its pinnacle of 99.4 percent in 1970; interestingly the percent of homebirths doubled from .6 percent in 1970 to 1.5 percent in 1977 (Institute of Medicine 1982 from both Davis-Floyd and Johnson 2006: 30 and Rooks 1997: 60). The increase in homebirths was mostly the result of middle class women who resisted the medicalization of birth and planned homebirths instead. Birthing mothers were responsible for the resurgence of home-based birth.

> The homebirth mother of the late 1960s and 1970s was as likely to be a childbirth educator or a conservative preacher's wife reacting against a negative hospital

> experience as a feminist seeking self-empowerment through birth or a hippie rejecting the hegemony of the medical establishment. Then, as now, she was likely to be middle class, which meant in part she was used to exercising her right to choose. Davis-Floyd 2006: 39

The women who attended these homebirths were considered "lay midwives" as they were often mothers who had experienced birth themselves, sometimes they would be friends, childbirth educators, nurses, fellow members of a religious congregation, or relatives (Davis-Floyd 2006a; Rooks 1997). They generally had no childbirth education, and they were often self-taught through hands on experience and books. Some of these lay midwives had the opportunity to form networks with other midwives, creating study groups and sharing knowledge. From these early connections several prominent groups of lay midwives emerged that facilitated lay midwifery education (Davis-Floyd 2006a; Rooks 1997). Enclaves of midwives clustered around the United States, and they had little knowledge of each other (Davis-Floyd 2006a: 40). Through informal networks and various newspaper articles, midwives learned of each other on the national level, and they began discussions of organizing. Many midwives feared that organizing had the potential to create an elitist group and they were proud of their grassroots movement. Lay midwives began publishing midwifery textbooks and Ina May Gaskin started a notable newsletter, *The Practicing Midwife* (Davis-Floyd 2006a; Rooks 1997). As midwives increasingly were aware of the extent to which midwifery had grown on the national level, they began to identify and expound as a nationwide social movement. Consequently, associations of midwives developed on the local and state level.

During the 1970s, some states revoked their permissive midwifery laws while others re-enacted old laws to allow non-nurse midwifery practice (Rooks 1997). States such as Oregon and Washington applied older laws to midwifes, and Arizona, New

Mexico and Rhode Island amended old laws or enacted new laws to license midwives through state health departments. In some other states, midwives were arrested for practicing without a license, and if a death occurred during a delivery, they were charged with murder (Rooks 1997: 64). Lay midwives felt conflicted about licensure; some wanted the protection from legal prosecution, and others thought that licensure could negatively alter their practice of midwifery. Largely unnoticed to mainstream America, a significant number of traditional midwives, mainly Latina and African American women, were practicing during the 1960s and 1970s in the southern United States.

The 1980s was a time of dialogue and change for non-nurse midwives. As debates ensued concerning the pros and cons of organizing, an organization was founded in 1982 called the Midwives Alliance of North America (Davis-Floyd 2006a; Rooks 1997). The Midwives Alliance of North America (MANA) was concerned with being as inclusive as possible. The debates did not decelerate, as MANA grew slowly during the 1980s due to internal considerations of the functions and purpose of the association. Some midwives feared the "professionalization" of midwifery; they did not like the idea of joining the "system", as midwifery had arisen outside of the "system" (Rooks 1997). The organization evolved as the women of MANA "joined together to create core competencies and standards for practice, to lobby for workable legislation, and to create educational programs and state certification processes" (Davis-Floyd 2006a).

Midwives were increasingly frustrated with the lack of respect they received, and they rebuked the expression "lay" as a characterization of their practice. They challenged "lay" as ill-fitting, arguing that this term undermined their abilities as a midwife. Many midwives felt it was ill founded, as some midwives were well educated and/or were

veterans of midwifery. The term direct-entry midwife was co-opted from a designation of a European midwifery, and direct-entry midwife was now used to connote any midwife other than a nurse-midwife practicing in the United States (Rooks 1997). Some midwives preferred (and still do) to call themselves traditional midwives or independent midwives, but direct-entry midwife is a general term used for a non-nurse midwife. The transformed terminology was paralleled by other changes as MANA members called for legitimacy and acknowledgement from larger society.

Selected states had licenses that permitted direct-entry midwives to practice. While this afforded some midwives the opportunity to practice by state defined credentials, the MANA community of midwives increasingly felt pressure to define their credentials and educational standards before others imposed external credentials and standards upon them (Rooks 1997: 248). Two other motivations that prompted MANA to create standards were a growing interest from women for a career in midwifery, and direct-entry midwives were still being arrested for practicing without a license. Many midwives felt conflicted as they were of aware of these issues, yet they were weary of setting standards and creating exclusivity. Nevertheless, MANA established two organizational bodies, one to develop standards for examining and licensing direct-entry midwives, The North American Registry of Midwives (NARM), and the other to create accredited educational programs, The Midwifery Education Accreditation Council (MEAC). MANA struggled to create standards as they appreciated and embraced diversity within their community. MANA and direct-entry midwives highly valued the process of apprenticeship, and they were adamant that the credentials for certifying a direct-entry midwife would have to embrace all options of midwifery education. MANA

esteems apprenticeship as well as other forms of midwifery education, and importantly they support an inclusive organization. MANA wanted to be sure their credentials for a certification reflected their inclusivity. Davis-Floyd explains:

> The strong desire for such a credential on the part of many MANA members was paralleled by great concern that the form of direct-entry midwifery they had been developing would become co-opted in the process of professionalization, which involved certain kinds of standardization. Concern about co-option led to the gradual step-by-step development of certification, as consensus had to be reached at each step. After the initial development of an examination and a national registry of those who had passed it, by 1994 MANA's daughter organization NARM had expanded into a full-fledged testing and certifying agency, designing, developing, and implementing the Certified Professional Midwife (CPM) credential (Davis-Floyd 2006a: 52-53).

This certification was initially used for the certification of established direct-entry midwives. In 1996, after a series of field tests NARM began certifying entry-level midwives with the CPM certification. The education originally available to direct-entry midwives was relatively informal. As direct-entry midwifery and the CPM certification has continued to gain legitimacy within some state governments, the educational opportunities available to direct-entry apprentices has grown. The MEAC was accepted in 2000 by the Department of Education as a "federally recognized accrediting body for direct-entry midwifery programs" (Davis-Floyd 2006a: 68). There are now many options for midwifery training afforded to midwifery students. Midwives in training can apprentice with a qualified midwife, attend a direct-entry midwifery school or program, or pursue a university midwifery education (Midwifery Education Accreditation Council 2006; Rooks 1997). Many direct-entry midwifery programs offer distance learning opportunities, and various midwifery training programs from other countries are recognized by NARM and MEAC. Every state is different in its acceptance and licensure

of direct-entry midwives. Various states allow direct-entry midwives to practice at home births, while other states permit direct-entry midwives to also practice in birth centers. As of 2005, twenty-one states have legal, licensed and certified direct-entry midwives (Davis-Floyd 2006a: 69).

While NARM was having discussions in the early 1990s of creating a credential for a direct-entry midwife, the American College of Nurse Midwives (ACNM) was also considering establishing a direct-entry certification under the certifying body of ACNM. Many nurse-midwives opposed the idea while others understood that some potential midwives did not want to go through a nursing track. Some factors that supported the certifying of direct-entry midwives included: nurse-midwives were increasingly frustrated feeling as though they were misrepresented as nurses when they primarily identified as midwives; they realized that a significant part of nurse training is irrelevant to the practice of nurse-midwives; and nurse-midwives often had conflicting interests with state nursing boards (Davis-Floyd 2006a: 55). The ACNM wanted to create their own direct-entry certification, feeling that the NARM certification would not support the same standards as the ACNM. As NARM certified its first CPMs in 1994, the ACNM accrediting body recognized the Certified Midwife (CM) in 1995 as a direct-entry midwife credential. They established an educational program leading to the certification of CMs, and they currently have an accredited program operating at SUNY Brooklyn that graduates approximately five students a year (Davis-Floyd 2006a: 56; Rooks 1997: 291).

The creation of the CM by the ACNM accrediting body originally created friction between MANA and ACNM. Davis-Floyd explains:

> Frye [then vice president of MANA] indicates the desire felt by many MANA members to maintain separation between the realms of nurse-midwifery and direct-entry midwifery, with the ACNM and its affiliates in charge of standard-setting and credentialing for the nurse-midwifery realm, and MANA and its affiliates in charge of standard setting and credentialing for the direct-entry realm. The conceptual neatness of this distinction was blurred when ACNM established its own direct-entry certification process. Of course, ACNM never intended to create the same kind of direct-entry midwifery practiced by MANA members, but rather is modeling its direct-entry educational programs on its existing nurse-midwifery programs (Davis-Floyd 2006a: 57).

Currently there is improved communication and understanding between the two groups. MANA has accepted the CM credential, and they have acknowledged it for what ACNM planned it to be. Both groups see it as progress for midwifery.

Situating Midwifery in Virginia

> *I wanted them [CPMs] to be legal. I worked for that legislation last year. Because people are out there doing homebirths, and I felt like we needed a minimum standard. And so that has passed now, and those folks are starting to move up to the bar…So, I'm glad that we have set a minimum, and they come out of the closet and do it and get paid for it. My next one is to get nurse-midwives going here in Virginia. I have told some other people that whether I actually practice or not is not my concern as much as that we get it going so that other people coming behind me can practice without having to go through all this (Virginia midwife, personal communication 2006).*

During the early 1900s, Virginia midwives were affected by the widespread attempt to prevent non-medical practitioners from attending childbirth. The Virginia State Legislature became involved in 1918 when they passed a law requiring supervision of midwives under the Bureau of Vital Statistics (Craven 2006; Litoff 1978; Smith 2003). This law was not only motivated by a desire to improve vital statistic records in Virginia and to assess reproductive health, this requirement was also part of enforcing "Racial Integrity Laws" in Virginia. This law made interracial marriage illegal and "supported

the sterilization of those deemed 'unfit' by the state" (Craven 2005b: 2). The requirement to fill out vital statistics on each birth, which include noting the child's sex, skin color, and race of both parents, had serious implications for midwives who were part of and/or served "Negro" populations.[1] Failure to report the vital statistics was punishable by a maximum of one year in a state penitentiary (Craven 2005b). After 1918, midwives had to obtain a permit to practice midwifery in Virginia requiring midwives to follow measures of morals, training, cleanliness and health in the "Midwife Manual" as outlined by the Department of Health (Craven 2005b). The terms of the manual were enforced by physicians and health officials whereby subjecting midwives to their considerations of "cleanliness," etc. which could result in denying or revoking a midwife's license to practice. This, together with the requirement of literacy and the requirement to report details of births, lead to a significant decrease in the midwives through the first part of the 20th century.

Virginia's license requirement, coupled with the pervasive national campaign against midwives, reduced the number of practicing midwives in Virginia. The gradual elimination of midwives and the increase of physicians attended and hospital birth was also fueled by the targeting of hospital services to middle-upper class, urban white women who could afford physician and hospital services. Hospital and physician

[1] Christa Craven explains the inclusion of Native Americans as "Negros" during this time. "Plecker—who had been instrumental in the passage of the Racial Integrity Acts—rescinded the classification of "Indian" for ancestors of native-born Virginia Indians in 1943 (Chickahominy, East Chickahominy, Mattaponi, Monacan, Nanesemond, Pamunkey, Rappahannock, and Upper Mattaponi). Plecker issued a list of surnames belonging to these "mongrel" families that initiated the reissue of birth certificates, reclassifying Indians from either "white" or "Indian" to "Negro" (Hardin 2000a). Consequently, Virginia's Indian midwives were also threatened with imprisonment for indicating "Indian" as a racial classification on birth certificates for children in their communities (Hardin 2000a:A10)" (Craven 2005b: 3).

attended births were increasingly prevalent, and midwife attended births steadily decreased from 1930-1960.

In 1962, the Virginia General Assembly transferred the responsibility of overseeing midwifery to the Virginia Department of Health. Fueled largely by the expense of hospital services, through the 1960s and 1970s, midwives, however significantly decreased in numbers, continued to serve women living in rural and impoverished areas of the state. After the introduction of Medicaid in 1965, facilitating poor women's access to hospital and physician health care, the services of traditional midwives in Virginia was severely depleted.

The General Assembly passed legislation in 1976 that restricted the practice of non-nurse midwifery to only midwives who had received permission from the Virginia Department of Health prior to January 1, 1977. Craven writes:

> Thus, in 1977, the remunerated practice of midwifery by a non-medically trained practitioner became a criminal offense in the state. In addition, this law enabled certified nurse-midwives (CNMs) to practice with certain restrictions (such as a provision for practice under the supervision of a physician), through joint regulation by the boards of medicine and nursing (Craven 2006: 318).

The number of midwives that received permission to practice prior to 1976 was around 100, decreasing to only 5 midwives in 1999. (Only one midwife was actively practicing.) Many non-nurse midwives did not know of this legislation, and they practiced relatively unhindered and/or underground for several decades (Craven 2005b; Craven 2006).

During the 1990s, responding to increased investigations of direct-entry midwives and the prosecution of several Virginia midwives, proponents of home births and direct-entry midwives organized a grassroots movement in Virginia (Craven 2005a; Craven 2006). Lawmakers reacted to the constituents by establishing a midwifery study

in Virginia, and in 1999 the Joint Commission on Health Care recommended legalizing direct-entry midwifery. Midwifery proponents proposed legislation to legalize direct-entry midwifery for the next three years, but it was repeatedly rejected "facing opposition from the Virginia Chapter of the American College of Obstetricians and Gynecologists (VA-ACOG), the Medical Society of Virginia (MSV), the VDH, the Department of Health Professionals, and the Commonwealth's chief medical examiner" (Craven 2006: 325). Finally in 2003, the state legislature passed a bill making direct entry midwifery legal in Virginia.

For the last several years Virginia has been in the process of determining professional and licensing requirements of direct-entry midwives after the law was changed (Craven 2005a). In March of 2005 a bill was signed into law in Virginia allowing direct-entry midwives to be licensed as certified professional midwives (Citizens for Midwifery 2006; Midwives Alliance of North America 2006; Craven 2005a). Certified professional midwife is the legally recognized and licensed term for direct-entry midwives in Virginia. Certified nurse-midwives can practice legally in Virginia and all other U.S. jurisdictions, though they are required to work under the supervision of a physician (American College of Nurse-Midwives 2006).

Chapter 3: Theoretical Foundation

> *Doctors looked stunned, incredulous when pregnant nurses bypassed their services and chose instead a home birth with a midwife. Dr. Rider confronted Cherie, pregnant with her first child, and demanded, "How can you consider having your baby at home when you work here and see all that goes on?" Without missing a beat, Cherie answered, "That's the point. It's because I see what happens in hospitals that I'm having my baby at home" (Vincent 2002: 186).*

The dominant cultural definition of the birth event in the United States is a medical definition. Brigitte Jordan[2] explains that birth is not merely a physiological process but it is a biosocial process in which birth is both physiological and social. She explains that birth is socially constructed and each birth system's constructions may change in response to societal pressures (Jordan 1980:88). The experience and legitimacy of nurse-midwifery and direct-entry midwifery has been created in a system that is influenced by societal pressures (Jordan 1980). Medicine and the medical institution has been the dominant cultural norm in childbirth since the early 20th century. Jordan says that many aspects of the birthing process are directly influenced by dominant cultural ideals concerning birth including: the location of birth, the tools used for birthing, and the birth participants. Jordan says that birth system norms will be in flux due to societal influence, and as we have seen, midwifery in both spheres has evolved in definition, location, and legitimacy.

Jordan introduces the concept of authoritative knowledge suggesting that in any domain various systems of knowledge exist but often one can dominate (1997). She says the tendency for one knowledge system to dominate can be owing to two reasons—one

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[2] Brigitte Jordan is a pioneer in investigating obstetrics and midwifery cross-culturally, and her application of authoritative knowledge has fueled continual investigations, many of which have been created by another prominent social science researcher Robbie Davis-Floyd who has investigated obstetrics, midwifery and the technocracy of birth for last two decades.

system being more useful for a particular purpose, and one knowledge system has structural power. She suggests that it is usually both of these factors. As one system gains dominance within a domain other types of knowledge become devalued. Jordan explains that authoritative knowledge is an ongoing social process that is reflective of different communities and situations.

Authoritative knowledge is pervasive establishing what appears to be a natural order, where "all participants come to see the current social order, that is, the way things (obviously) are" (Jordan 1997: 56). Advancing this concept Jordan writes:

> By authoritative knowledge I mean, then, the knowledge that participants agree counts in a particular situation, that *they* see as consequential, on the basis of which *they* make decisions and provide justifications for courses of action. It is the knowledge that the community sees as legitimate, consequential, official, worthy of discussion and appropriate for justifying particular actions by people engaged in accomplishing the tasks at hand (Jordan 1997:58).

Jordan is concerned with how interactions within social situations create an order of superiority of what is considered knowledge and what receives legitimacy in these circumstances. The focus is not on the authority of certain individuals but the center of her discussion is how authoritative knowledge plays out—what are the indications of, or what counts as evidence of these dominant concepts within a delivery room, a hospital, a society, a home birth, etc. She acknowledges that in some situations some types of knowledge are accepted while in other circumstances that same knowledge may not be considered valid.

Looking at a hospital birth in the United States, she suggests that a birthing mothers' knowledge is not valued, and all non-medical knowledge is considered invalid. Physicians are privileged with authoritative knowledge in a hospital. Jordan explains that authoritative knowledge within the medical system is reserved for experts who can

manipulate current technologies and are able to discern the output of these tools. Birth is managed in a hospital setting with the physician holding ultimate ownership of the knowledge. Other medical staff are limited in their capacity of utilizing authoritative knowledge, and the laboring woman, the center of the event, is devoid of knowledge that counts.

Advancing discussions of authoritative knowledge in medicine and childbirth in the United States, Davis-Floyd presents the idea that the language of health care is hegemonically technical. Medical hegemony in the United States is persuasive as medicine has become a mega business within the capitalist structure. "…[T]he cultural arena of birth serves as a microcosm in which the relationships between rapid technological progress and cultural values, normative behaviors, social organization, gender relations, and the political economy can be clearly viewed" (Davis-Floyd and Sargent 1997: 6). She says that women willingly accept a technical model of childbirth, and that occurrences of epidural anesthesia, cesarean sections, fetal heart monitoring, and pitocin induced labors are becoming increasingly prevalent. Davis-Floyd highlights that Americans and specifically women, have a fear of nature in childbirth (1997; 2003). Women who believe in a technical model of birth often have little knowledge of the laboring process. She says the medical model of birth has obstetrical rituals, and she asserts that women who believe in this cultural birthing system will want to take part in the childbirth rituals of that system (Davis-Floyd 2003: 190). These technologies offer psychological comfort to laboring women calming their fears of the birthing process. The medical approach to childbirth offers many women a sense of security; they feel like the technologies available afford them better care.

Rothman explains two different approaches to pregnancy and childbirth, a midwifery model of care and a medical model of care (1982). She described the hegemonic qualities of the medical model and the underappreciated midwifery model of care. A midwifery model of care focuses on pregnancy and birth as a normal state for a woman emphasizing overall maternal health involving nutritional health, emotional and physical well-being (Rothman 1982: 156). In this paradigm, knowledge of pregnancy and birth is the responsibility of both the midwife and the pregnant mother. While a medical model distances the pregnancy from the body, creating a parasitic type relationship, a midwifery model understands the two to be interconnected, the mother affects the baby and the baby affects the mother. Midwifery care emphasizes the normalcy of pregnancy and birth. A midwifery model of care prioritizes the overall well being of a woman realizing that the physical, emotional, spiritual and social aspects of health are all equally important.

A medical model of pregnancy and childbirth understands the body to be inherently imperfect (Rothman 1982). A medical model focuses on pathology assuming nature will mess up, allowing technology and science to step in and correct the dysfunction. She furthers that medicine historically is based on a male body creating an automatically disease laden body for a female. For example the description of the "symptoms" of menstruation, menopause and pregnancy suggest a disease like state. The reproductive aspects of the female body are seen as stresses on the body's systems because they are not part of the standard male body. Consequently, a medical model of care is based upon controlling for the imperfections of pregnancy and birth, assuming something can go wrong at any moment.

Davis-Floyd expounded upon Rothman's descriptions creating the technocratic model of birth and the holistic model of birth. Davis-Floyd's technocratic model of birth acknowledges the increased emphasis on technologies and machines to monitor and manage pregnancy and birth and the authority bestowed upon those who know how to use and interpret them (Davis-Floyd and Davis 1997; Davis-Floyd 2003). "Other basic tenets include the metaphorization of the female body as a defective machine and the working premise that birth will be "better" when this defective birthing machine is hooked up to other, more perfect diagnostic machines"(Davis-Floyd and Davis 1997:316). Davis-Floyd describes the holistic model of birth whereby birth is understood to be a normal process of the female body. The pregnant and birthing woman is supported by a network of care-givers (partner, birth attendant, family, and friends) nurturing and reaffirming her mental and physical strength and the normalcy of birth.

> …Birth rituals should affirm and reaffirm the unity and integrity of the family and the individuals who comprise it, instead of sending patriarchal messages about the primacy of science, technology and institutions. Each of these has a place, but that place is to be of service to-rather than to exploit-nature, individuals, families and most especially the birthing woman (Davis-Floyd 2003: 156).

Davis-Floyd acknowledges the dominant cultural paradigm of obstetrics in the United States based in medicine and technology, and asserts that midwives struggle to work in a culture that values the medical approach to childbirth (Davis-Floyd and Davis 1997). They face societal pressure to perform birth in accordance with medical standards while they have a model of care that does not parallel a medical model of obstetrical care. Davis-Floyd discusses the use of intuition as authoritative knowledge in midwifery care. Midwives rely on their intuition to guide some of their work; their trust in intuition acknowledges the connectedness midwives feel to their birthing mothers. Davis-Floyd

explains that the process of authoritative knowledge within a midwifery framework plays out differently than the medical model. She says that midwives receive information from mothers and other support persons, and they incorporate that knowledge into the situation. There is not a prescribed way that birth happens or a way to handle it, and midwives are constantly redefining the labor process. The process of authoritative knowledge in this situation occurs horizontally rather than vertically. Davis-Floyd expounds:

> In short, these midwives are willing to expand protocol parameters to reflect the realities of individual labors rather than reshape labor to fit protocol parameters. They see a labor that is unlike other labors, not as a dysfunction to be mechanistically normalized according to the standardized technomedical system of authoritative knowledge, but as a meaningful expression of the birthing woman's uniqueness, to be understood on its own terms (Davis-Floyd and Davis1997: 335).

While midwives involve intuition in the process of authoritative knowledge during a birth, they are constantly reminded that their process of authoritative knowledge stands in contrast to societal standards of authoritative knowledge. Davis-Floyd has a working hypothesis suggesting that midwives trained in didactic care will not trust or rely in their intuition.

Devaluation of Skill and Commodified Caring

Women's work and skills have been under valued and under appreciated. Midwifery has endeavored to gain legitimacy as a practice, and midwives have struggled to earn recognition as a profession. Medical hegemony has placed midwifery practice in a subordinate role. Wajcman discusses the gendered nature of skill definition, and that skill has been traditionally defined to give power to male work (1991: 43). Skill definitions are rarely based on the amount of training or ability required for them; definitions of skill have more to do with ideological and social constructions than with

technical competencies. "…[S]kills are not technically but socially determined and that the skills women use in their jobs are not fully recognized and evaluated" (Wajcman 1991: 43). Hegemonic ideology is constantly recreated within skill definitions.

Himmelweit looks at the devaluation of caring labor in the labor market investigating whether caring labor is altered as it becomes commodified (1999). She suggests that caring work was traditionally performed by females without a fee. As this type of work becomes absorbed into the labor market, she argues that paid caring does not exhibit significant differences from unpaid caring. "Because carers tend to be motivated by a genuine concern for their clients' well-being, caring becomes to some extent its own reward, and to that extent carers' wages can be set lower than those with objectively comparable skills" (Folbre and Weisskopf 1998 in Himmelweit 1999). Workers are motivated by the intrinsic rewards from caring work thus care work cannot be fully commodified in the labor market.

Within the medical model of childbirth in the United States, the knowledge that is counted during a pregnancy and birth is medical knowledge. Medical knowledge is deeply embedded in technologies as maternity care is increasingly a technocratic procedure, and the skills used to interpret and utilize these technologies are highly valued. Medical hegemony devalues the skills and motivations of midwives, leading midwives and proponents of midwifery to defend and develop alternate models of care.

Chapter 4: Literature Review of Midwifery

Nurse-midwives and direct-entry midwives have struggled to adhere to their model of care while practicing within a medical community and culture that medicalizes childbirth. The movement of mainstream health care in the United States to a managed care system may encourage an increased need for nurse-midwives; in addition midwives and proponents of midwives have used ideologies to facilitate the growth of midwifery practice. Opponents of midwifery have employed dominant authoritative knowledge to devalue midwifery.

Nurse-midwives, historically, have had to use the medical institution and medical discourse in their profession. Traditionally, direct-entry midwives were not required to use medical discourse, and the direct-entry midwife movement originally opposed the medicalization of childbirth. Foley and Faircloth found that nurse-midwives and direct-entry lay midwives in Florida both use medical discourse in their practices. They explain, "...[T]here is not a clear-cut difference between the narrative practice of certified nurse-midwives and licensed (lay) midwives...[B]oth groups of midwives draw upon a discourse of medicine and collaboration and use it in different ways depending on the context and purpose-at-hand"(2003:182). Hunter discusses the prominence of medical discourse in hospital based nurse-midwifery. She writes, "A medicalised[sic] approach to childbirth appeared to dominate hospital midwifery practice, despite many midwives' apparent criticisms of this…[O]bservation of hospital midwives indicated that practice was controlled by obstetric protocols and policies…"(Hunter 2004:267).

Some midwives feel that the traditional midwifery model is being overtaken by the dominant medical model of childbirth (Foley and Faircloth 2003). Foley and Faircloth

mention that direct-entry midwives have noticed that the "legitimization" of midwifery (the states' acknowledgment of midwifery as a legal practice) has facilitated sacrifices to the midwifery model (2003). Foley and Faircloth have found that some lay midwives and nurse-midwives define themselves as in opposition to the medical community. "...[T]wo direct-entry midwives and a nurse-midwife distance themselves from the medical establishment, creating a sense of legitimacy in contrast to what they consider a less legitimate enterprise-'mainstream medicine'"(2003:172). Many midwives are disappointed about the increased integration toward a medical model. Faircloth and Foley quoted a nurse-midwife "... I was disappointed in how much medicine interferes with midwifery. I've learned that this profession requires a constant battle to survive and remain autonomous. The natural practice of midwifery is difficult to practice in a policy-ridden private practice and hospital setting" (2003: 173). Additionally, nurse-midwives have had to defer to the medical establishment for legitimacy and lay midwives have had to rely on physicians as back-up.

The level of autonomy that nurse-midwives and direct-entry midwives experience has varied over time and from one jurisdiction to another. Overall midwives seem to desire more autonomy within the medical establishment. Foley and Faircloth found that many nurse-midwives do feel that they are in a team relationship with physicians (2003). Direct-entry midwives seem to feel more independent of the medical community than nurse-midwives, but we see that they still have to rely on physicians and the medical establishment. Foley and Faircloth discuss that direct-entry midwives need to have a medical contact as back-up in case of an emergency, and interestingly, the direct-entry midwives that need to utilize the medical establishment see their knowledge of medicine

and medical discourse as capital in their interactions with physicians and medical staff (2003:177). Faircloth and Foley recognize that midwives are in a constant state of flux between the medical establishment and midwifery. Hunter describes nurse-midwives in England who practice in a hospital feel limited in their autonomy. She reports that they feel much of their time is spent carrying out doctors' orders rather than caring for birthing mothers (Hunter 2004:268).

Wooten and Crane discovered that nurse-midwives practicing in the facility called "Big Hospital" were able to maintain a humanistic ideology and practice autonomously in the midst of medical surroundings (2004). The nurse-midwives work independently of the physicians, and the midwives are able to consult the physicians when they deemed it appropriate. They do not discuss their profession in terms of the medical model but instead in contrast to it. The nurse-midwives reported having to conform to some pressures from the hospital, but they see their role as midwife legitimized through the care they give their "patients" and the women's health movement.

Annandale found in her research that nurse-midwives found it difficult to fully practice their birth philosophy (1988). "The need to standardize birth to deal with obstetrical pressure and to counter the possibility of a woman's self transfer produced practices inconsistent with their values as midwives. They found that they had, in some cases, socialized women into a model of childbirth that they could not deliver" (Annandale 1988:107). Nurse-midwives have struggled to maintain their work ideologies in a workplace that is dominated by a medical and masculine model of birth; consequently, sometimes they adopt some of the philosophies and beliefs that their medical environment embraces.

Direct-entry midwives are often hesitant to rely on medical models of care in their practice of midwifery while nurse-midwives are most often required to work in medical institutions and with physicians. Hunter looked at nurse-midwives and direct-entry midwives in England that were in training programs together (2004). In her research she found that nurse-midwives defined themselves in opposition to direct-entry midwives and that the nurse-midwives aligned themselves with the medical establishment. Nurse-midwives defined most of their work in terms of the medical institution and they reported spending more time working with colleagues than with birthing mothers. Despite nurse-midwives' conflicting thoughts about their work, Hunter suggests that nurse-midwives practiced midwifery in a "with institution" ideology. In contrast, lay midwives' work was defined as a "natural process," and they developed relationships with the birthing mothers. Hunter described lay midwives as a having a "with women" ideology. Interestingly, nurse-midwives practicing in "Big Hospital" suggested that they apply a feminist approach to their work, and they see their profession as a "public servant" wanting to contribute to society (Wooten and Crane 2004:856).

Weitz and Sullivan interviewed twenty-seven licensed (direct-entry) midwives practicing in Arizona, exploring the interactions between physicians and licensed midwives. The definitions of childbirth that physicians embraced were in contrast to the midwives' definitions of childbirth, creating consequences for midwives and their clients. The midwives reported not feeling influenced by the doctors' assessments of their care because they were confident with their patient-centered model of care. Midwives also recognized that they threatened physicians—they challenged not only their ability to draw clients but they challenged the core of a physician's approach to childbirth.

Midwives and their clients experienced verbal abuse from doctors. Weitz and Sullivan noted that the power struggles midwives in Arizona encounter have shifted from the courtroom to the doctor's office. If a transport to a hospital was needed, they commented that the mother and midwife were frequently verbally abused, that the midwife would often be unable to stay with her client and that the mother may be ill treated by the attending physician. "While the medical profession in Arizona could not prevent the licensure of lay midwives, it nonetheless retained substantial control over the licensure process and over the lives of lay midwives and their clients…This continuing conflict occasionally resulted in physical risks to mothers, as well as emotional stress for midwives and clients" (Weitz and Sullivan 1986: 172). Midwives felt concern for the welfare of their clients and they felt helpless in their lack of power within the hospital. They conclude that physicians will not accept direct-entry midwifery until an overhaul of the medical ideology of childbirth occurs.

Hartley argues that managed care has increased the number of nurse-midwives practicing, indicating a decline in physician dominance in health care (1999). Hartley suggests that the desire for alternative health care and the recent corporatization of health care have brought about the concept of managed care (1999: 87). Managed care has called for a restructuring of the established organizational structure of health care, and it has shifted the emphasis away from costly specialists to generalist providers. "Given the prominence accorded to economic rationality in managed care organizations, such organizations may increasingly substitute low cost personnel, such as nurse-midwives, physician assistants, and the nurse practitioners for physicians" (Hartley 1999: 88). Hartley argues that using generalists, like nurse-midwives, has an economic advantage in

modern health care, and as an additional outcome of managed care, we may see a shift in the occupational power within health care organization. While Hartley stresses the significant influence of managed care on traditional occupational power in the medical organization, she adds that consumer demand for birth that is less technological has also increased the presence and relative power of nurse-midwives in the medical organization (1999: 98). As the demand for nurse-midwifery grows, it is likely that the supply will grow. As that supply grows, it is probable that those providing the supply will garner more power and prestige in the workplace. Hartley writes, "These findings have longitudinal implications, suggesting that the expansion of managed care will continue to alter the jurisdictional boundaries in the system of professional health care, eroding the dominance of physicians while creating new openings for nurse-midwives" (1999:98).

Rushing explores ideologies that midwives have used to garner occupational legitimacy and recognition in North America. She found that the midwifery option has been empowered by ideologies of science and feminism. These ideologies were important to both nurse-midwives and direct-entry midwives, but she suggests direct-entry midwives have benefited the most from scientific and feminist ideologies. Proponents of midwives and midwives have used scientific data on childbirth and pregnancy to support the safety and value of "natural" childbirth. Furthermore, feminism is closely tied to the women's health movement that promotes women taking responsibility for their health and being informed consumers. This has encouraged women to be vocal advocates for their reproductive health. "Midwives, activists, and clients interviewed for this project also used the language of spiritual and family values in their discussions about the importance of midwifery. However, I suggest that science and feminism have been more

important in their *public* presentations and negotiations regarding the establishment of midwifery in the health care system" (Rushing 1993: 61).

Craven documents the use of authoritative knowledge within the legislature of Virginia explaining medical officials' use of medical discourse to undermine homebirth (2005a). In Virginia the attack on homebirth was directed at proponents of midwifery. During a legislative session a physician expressed, "Birth is, by nature, a medical event. /In contrast, homebirth is/ a slippery slope, like driving a car without brakes" (Craven 2005a: 199). Medical officials condemned mothers to be "pathological" and they argue that homebirth mothers are not "competent to make the choice for a home birth because they do not participate in good American mothering practices" (Craven 2005a: 208). The physicians' and government officials' application of authoritative knowledge in the courtroom assumed control over women's choices, attempted to regulated childbirth and maintained the medical community's hold on definitions of childbirth.

Chapter 5: Methodology

> *Some of the most compelling issues addressed by feminists deal with research into women's everyday lives and their particularities, and thus with gaining access into their lives. Hence feminists are attempting to use and develop research methods geared toward facilitating forms of communication with women and among women (Madriz 2003: 374).*

Methodology

I use a feminist interpretive approach to my research. My methodology presumes that the complexities of life are not understood from an objective position, and this descriptive study seeks to understand social life through the experiences of those involved. A feminist approach seeks to uplift the voices of the participants; it emphasizes a considerate and empathetic connection between the participants and the researcher (Neuman 2003; Sprague 2005). I embrace an epistemological perspective that seeks understanding of social life through the voices of those involved. Furthermore, this research perspective is process- and participant- oriented, creating the opportunity for the participants to comment on my transcriptions and data analysis.

Feminist methods and methodology facilitate, to varying degrees, incorporating the participants throughout the process. Traditional methods of research have been critiqued for the researcher dominating the entire research process, and the participants' voices have often remained silent throughout the research process (Madriz 2003: 368). I tried to decrease my power in the research process and to share the process of my research with my participants. Preliminary interviews were originally conducted to encourage the voices of midwives in the development of my research questions.

As I have considered my research participants in this project, I also have to acknowledge my investment in this research. I respect the idea that women have control

over their reproductive rights, and I am consistently reminded of the lack of power women have of their bodies. Women of diverse socioeconomic status have been subjected to subordination by hegemonic ideals, and in 21st century America it offends me to realize that women do not have control over their bodies and midwives are restricted professionally and legally from their work. As I have made connections in the midwifery community, I am in awe of the dynamic and inclusive attitudes of its members. They are ardently fighting, and I am energized by their passion.

Methods

I engaged in several precursory semi-structured interviews with midwives in Virginia. These preliminary interviews allowed me to explore my research questions with midwives and to further develop my thesis questions with the information they shared. I also attended part of the Midwives Alliance of North America (MANA) annual conference and a quarterly meeting of the Commonwealth Midwives Alliance (CMA), a consumer and midwife supported organization in Virginia that facilitates communication and unity among midwives in Virginia while advocating, in various manners, for midwifery.

The initial interviews were a beneficial first step into exploring midwifery in Virginia; the one-on-one conversations encouraged midwives to share more in-depth stories with vivid descriptions and details. A semi-structured format for the interviews allowed me to ask the same questions to each informant while also having opportunities for them to bring up pertinent issues. Their reactions to my questions and their unprompted discussions were helpful in further formulating my questions. My participation as researcher-observer in the conference and the meeting was also

significant to my research. It created opportunities for me to appreciate and advance my knowledge of midwifery and midwives. Bernard writes that even brief stints of participant observation in an area where the researcher has some knowledge can "…help you intellectualize what you already know" (1995: 140). Each of these experiences contributed to my general knowledge of midwifery in the context of Virginia and the United States; they enhanced my research and contributed to my analysis.

I chose focus groups as a method for collecting data because they facilitate discussions amongst midwives, offering a unique method to capture the informants' accounts (Bernard 1995; Kamberelis and Dimitriadis 2005; Madriz 2003; Neuman 2003). The researcher has the opportunity to observe the interactions and discussions among the focus group participants, and this setting allows the group participants to share individual thoughts and experiences while it also supports group reflection.

Midwifery is a topic of debate and discussion in the United States, and there have been many debates in the state legislature, discussions within the medical community and conversations amongst midwives concerning midwifery in Virginia. I see the focus group discussions as an effective method of data collection that can parallel these larger discussions. Group discussion can generate a synergistic effect within a focus group, creating opportunities for participants to react to one another and to compare/contrast experiences (Berg 1995; Carey 1994; Gaskell 2000). Focus groups can be an opportunity for underrepresented groups to experience social support and have a collective voice. Madriz explains "…[F]ocus groups can be an important element in the advancement of an agenda of social justice for women, because they can serve to expose and validate women's everyday experiences of subjugation and their individual and collective survival

and resistance strategies" (2003: 364). Additional advantages of focus groups include the potential to decrease the power differential between the informant and the researcher, and the peer group setting may lessen the risk of the informant trying to please the researcher (Madriz 2003).

As with any research method, focus groups do have some limitations. Focus groups often occur in artificial settings and focus groups have the potential to be dominated by a participant. Madriz suggests that focus group sessions can occur in familiar settings; participants' homes, offices, churches, and classrooms can be locations for focus group interviews that encourage a higher degree of comfort for the participants. She says that using the participants' space for focus group interviews contributes to a reduction in the researcher's power (2003). Madriz suggests that if someone dominates a focus group, it gives the researcher the opportunity to observe the development of hierarchy within the group. She continues that if this occurs, these are the group's "*own* power relations," and this circumstance may offer valuable information to the researcher (2003: 372).

Gathering the Sample, Collecting Data and Interview Questions

During the fall of 2006 I interviewed three midwives, one certified professional midwife and two certified nurse-midwives, and I attended part of the MANA conference in Baltimore, Maryland. These interviews and observations assisted me in further developing my research questions. During January of 2007, I conducted three focus groups, one group consisting of certified nurse-midwives and the other two groups were certified professional midwives. I individually interviewed one certified nurse-midwife,

and I also attended a meeting of Commonwealth Midwives Alliance.

The focus groups did not come together as neatly as I proposed. However, they happened in a way that was accommodating and agreeable to the midwives involved, and I felt satisfied with the quantity and quality of the data I gathered from the variety of methods. My experience arranging interviews and focus groups of midwives was truly a learning opportunity. I explicitly wrote in my methodology that I wanted to relinquish some of the power I have as a researcher. I wanted to relinquish power but I suppose I thought that would be more on my terms; I was quite wrong.

From the beginning I felt comfortable with this project being qualitative. I felt it was appropriate to the research questions, and I wanted to increase my knowledge base and practice of qualitative work. But what I was not prepared for was the feeling of an impending deadline (hoping to defend my thesis in April) and the feat of gathering midwives (people with real lives, families, schedules and imminent births to begin any given moment). It took a few agonizing moments to get over the fact that I was not in full control of this project reminding myself of my methodology and my desire to share in this process with the informants. But then I quickly settled into a deeper understanding of sharing power with participants. My neat vision of two focus groups with six to eight midwives was not necessarily a feasible option for them. Furthermore, if I wanted to collect data with them I would have to be more accommodating and responsive to their lives. Midwives have hectic schedules, as their next action may be altered by a frantic phone call or page that beckons them—as I often heard them explain "birth happens!"

The sample was collected through contacts in formal organizations, informal connections, and snowball sampling. After narrowing my thesis topic to midwifery, I wanted to conduct initial interviews to better formulate my research question. I was able to very quickly locate some potential interview participants. Speaking with friends and family members about my thesis topic, one relative and one friend said they knew some midwives, and they agreed to contact them. From their connections I was able to arrange three interviews—two interviews with CNMs, Teresa and Hannah, in Southwestern Virginia; and one interview with a CPM, Ann, in the Northern Central region. Two of the interviewees suggested names of midwives that I might like to contact.

The CPM whom I interviewed mentioned several names of women who would be attending the MANA conference, suggesting that it might be a good opportunity to talk with them. I met and spoke briefly with three CPMs at the MANA conference planning to contact them for the focus groups at a later time. I contacted Laura first, as she was an older midwife who was very well connected in the CPM community. In late November, we began to discuss arranging a focus group. She immediately wanted to help me organize the meetings; she suggested that setting up focus groups in conjunction with their meetings may increase attendance. She mentioned that midwives love to get together but they rarely do because of their demanding schedules. She was enthusiastic about the project saying she would make some contacts, gauge others' interests in participating and make arrangements to create time for two focus groups. We communicated through email over the next month about times that might be opportunities, eventually settling on two dates in January. Both focus groups occurred

right before other meetings the midwives had planned. The first happened in early January at a coffee shop, and the other happened prior to a CMA meeting at Ann's home.

I intended to arrange the CNM focus group by contacting various midwives, names I had heard through other midwives, to gauge their interest in participating and to select a central location to meet. However, the first CNM I contacted by phone mentioned emailing the secretary of the Virginia chapter of ACNM requesting an email be sent to all CNMs in Virginia. I decided that was a terrific idea. I created a document detailing who I was, the nature of my research inquiry and my interest for participants for a focus group. The secretary promptly sent it out, and I heard from twelve CNMs who were interested, depending upon location and time. The residences of the interested CNMs were fairly scattered, some clustered in the southeastern part of the state, some central and the others in the northwestern and northeastern parts of the state. It seemed appropriate to organize one in the southeastern part of the state and another in a northern and central location. The southeastern group came together easily with a location and five prospective attendees. I struggled to arrange the meeting with the other midwives. Most did not want to drive farther than thirty minutes, and the time frame of January or early February did not work for some others. I eventually interviewed a CNM individually from Northwestern Virginia and had two others willing to participate in individual interviews but time schedules did not work out.

The focus group of CNMs in southeastern Virginia was scheduled to be at the home of a CNM but she had something come up unexpectedly. Thankfully, another CNM offered her home to meet. I had five confirmations for the meeting but only two

showed up—the others were called away at the last minute. For the individual interview, we agreed to meet at the CNM's house.

The first focus group of CPMs, with four midwives in attendance, was approximately two hours long while the second CPM focus group, having three CPMs and several apprentices present, was nearly an hour. The focus group with the CNMs, five midwives scheduled to participate but only two made it, was two hours, and the individual interview with a CNM was an hour and a half. The locations of the meetings were decided by the midwives, as I was traveling to unfamiliar locations, and I wanted them to choose an environment where they felt comfortable. A fun and illuminating note is that no matter cold or warm weather, whether we were in a midwife's home or her favorite coffee shop, all of the focus groups and interviews happened over cups of either coffee or tea.

Interview Questions

The research design was flexible to accommodate the needs and constraints of the midwives, and the research incorporated a variety of research methods. The interview questions varied accordingly, as some questions were better suited to individual interviews or specific focus groups considering time constraints, group dynamics and personal privacy. Furthermore, the individual interviews and the focus groups were both semi-structured to allow for some continuity between interviews while also creating opportunities for participants to bring up pertinent issues.

The interview schedule is below also noting the connections between the interview questions in relation to the research questions.

Research Questions in Relation to Interview Questions

Research Question	Interview Question
1. What do midwives believe the role of a midwife is?	Q1: Based on your personal thoughts, what is the role of a midwife during pregnancy and birth? Q7, Q8
2. What are midwives' experiences with the medical community?	Q2: Will you describe your interactions/experiences, as a midwife, with the medical community? Q5, Q6
3. What are their hopes and goals for the future of midwifery in Virginia?	Q3: What are your hopes for midwifery in Virginia? Q4, Q5, Q6, Q8

Due to the semi-structured nature of the interviews, which often flowed like a conversation, the questions manifested themselves in some variation of words to express the interview questions.

The three questions that were asked for all of the interviews and focus groups include:

Q1: Based on your personal thoughts, what is the role of a midwife during pregnancy and birth?

Q2: Will you describe your interactions, as a midwife, with the medical community?

Q3: What are your hopes, goals and/or ambitions for midwifery in Virginia?

Other questions that were asked to some of the participants came from a preliminary list of potential interview questions and some questions were also conceived as the project moved along. Some of these questions were addressed or came out of discussions with some participants but not others. This was not a strategic plan; it was

just part of the evolution of the project. Nevertheless, they contribute to the research questions and they include:

Q4: What are your goals in the practice of midwifery?

Q5: How has the recent legalization of direct-entry (CPM) midwives in Virginia impacted your practice of midwifery?

Q6: How do you see CPMs and CNMs interacting in Virginia? Are there possibilities for collaboration?

Q7: Why did you become a midwife?

Q8: Will you describe your clientele in terms of socioeconomic status and diversity?

Analysis of Data

The qualitative analysis loosely follows the idea of logic in practice. The examination of the data did not have a strict linear path but the path was shaped through the research process. The process of data analysis began as I contemplated my interviews and read through my field notes, as well as when I was listening to and writing down information from my interviews. This continued as the audio recorded interviews were transcribed. I employed the technique of content analysis to analyze the data. Content analysis is a useful tool for uncovering patterns and themes in data (Bauer 2000; Neuman 2003). Content analysis involves identifying themes "…with the researcher focusing on the way the theme is treated or presented and the frequency of its occurrence" (Spencer, Ritchie and O'Connor 2003:200). I employed a series of coding measures to uncover themes from the data; as I progressed through the coding, I remained connected to the data and consistently referred to its content to ensure the appropriateness of my findings. Measures were taken to increase the visibility of the data analysis process. Making the research process more public increases the opportunities for readers to question the

findings and increases a reader's understanding of how the researcher developed their analysis (Anfara, Brown and Mangione 2002). Utilizing tables, I present three iterations of data whereby large quantities of data were transformed into themes. "[T]he data generated by qualitative researchers is 'voluminous,' and this process of sitting down and making sense of it can be 'overwhelming'…The purpose of the [t]able …is to present the reader with the larger, consolidated picture that emerged from the 'process of bringing order, structure, and interpretation to the mass of collected data'" (Patton 1999 and Marshall and Rossman 1999 from Anfara, Brown, Mangione 2002: 31-32).

The analysis also documents the midwives' perspectives with extensive quotes. This offers the opportunity to illuminate their thoughts. Feminist methodology critiques more conventional data analysis methods as not acknowledging individual differences among group members. In addition to presenting themes, I looked for conflicting answers among group members and, when applicable, detail will be given to the range of answers from the midwives. Recognizing differences among group members is important for quality analysis; social context is influenced by individual variation and individual variations are influenced by social context (Sprague 2005:92). Variations between the groups were noted when appropriate, and variations within groups were also documented.

Trustworthiness

To facilitate quality scholarship and boost the potential of qualitative inquiry, certain measures and techniques of trustworthiness are an essential part of the research design (Anfara, Brown and Mangione et al. 2002). Credibility was addressed through persistent observation. This research project was established with the vision that the

informants are the center of the project, meaning that their issues, concerns and thoughts are central to the focus of the research. From that position, I have employed persistent observation by seeking sources of information, literature or data mentioned by the interview participants. This technique has encouraged the project to develop in ways that I had not imagined, enhancing its structure and content. Additionally, I performed member checks with the informants giving them the opportunity to read and comment on my transcriptions and/or analysis. I asked the midwives if they would be interested in reading and commenting on the history section and/or the analysis section. One nurse-midwife and three certified professional midwives read through the history of midwifery section giving me their comments. One CPM suggested I send the history of direct-entry midwifery to the former Vice President of MANA to receive her comments. The Vice President said it was great other than one typo. One CNM had some comments on the history of nurse-midwifery. With her comments, I rechecked my sources and made some alterations to the section. One certified professional midwife and three nurse-midwives commented on my analysis section. All of the midwives responded positively to the analysis. One nurse-midwife reminded me to change the names of some locations.

Interview quotations and thick descriptions are used to promote transferability. Using informants' quotations allows the reader to interpret the data themselves, thus increasing the potential for the transferability of the data and analysis. Additionally, making the data analysis process more visible to the reader, through presenting the iterations of analysis in tables, boosts the possibility of transferability. To support the measure of dependability I had a somewhat flexible research plan, and I have documented the choices and assumptions of the research plan. Furthermore, data

collection, the recording and transcribing of interviews, was complemented by incorporating field notes with personal comments about the interview, explanations about the interview setting and descriptions of the interactions. I addressed confirmabilty through the external auditing of my three committee members.

I attempted data triangulation using my field notes; primary data from my interviews and participation in a midwifery conference and meeting; and secondary information which I have gathered from midwifery texts. Lastly, I employed various methods to collect data and increase my awareness of midwifery. While the focus groups contributed significantly as method of data collection, the knowledge I garnered from my preliminary interviews and my attendance at a midwifery conference and meeting can not be disregarded, and they contribute to method triangulation.

Ethical Considerations

The researcher took precautions to protect the midwives' identities. The medical and political debate concerning midwifery has positioned it as a contested issue and practice in the United States. Midwifery is the occupation of my participants, and I will take necessary steps not to jeopardize their livelihood. Bailey proposes that the three major ethical concerns of qualitative researchers in the field are informed consent, deception and confidentiality (1996). I received permission from the Institutional Review Board for the work on my thesis. I received verbal and written consent from all of my interview participants and focus group participants; furthermore, during my attendance at the CMA meeting all in attendance were aware of my presence and had the opportunity to object to my presence. I have been honest with my participants; they are aware of my work as a graduate student and my topic of interest. I protected the identities of my

clients through the use of pseudonyms and I changed or left out the names of locations of their residences and practices. This research is specific to Virginia, so I cannot conceal the larger location but I was able to alter the specificities of their locations.

Chapter 6: Findings

Before I present the findings of my research, I would like to share a little about the midwives involved in this research and discuss who comprises their clientele. Due to time limitations during data collection, I was unable to fully develop details of their demographic backgrounds. However, this knowledge should offer some insights into who these midwives are and who they serve. Below I present a brief demographic outline of the midwives I interviewed; however, first I thought it would be engaging to understand why some women chose the path of midwifery.

Katie explains her desires to be a midwife.

> As a young child I was really fascinated with the whole thought of childbirth and nursing, probably partly because my mom was having babies in the early 70's and 80's. She was kind of really into natural childbirth at the time when her peers were still allowing themselves to have twilight sleep and they were being restrained in the bed… I remember playing as a little girl with my cousins and friends and whenever they were playing having babies I was the one that delivered the babies. So I guess I just kind of grew… For one thing it really seemed more healthy to think of having your baby in an environment that honored your dignity and your privacy and you weren't being treated as if you had a disease and needed a surgical process…I think sometimes a lot of mothers have had fearful stories and many girls dreaded childbirth but for me I think of how much was passed down to me from my mom and her sister that birth was wonderful and it deserved to be celebrated.

Sarisha describes what led her to midwifery.

> When I was pregnant with my first child, I can distinctly remembering asking about classes and this dear sweet wonderful old gentleman, his name was Dr. Smith, patted me on the shoulder and said "Oh Sarisha don't worry I will take care of you and everything is going to be okay. You don't have to worry about having a baby, you have me." I have a pelvis you can drive a truck through, and I had about two hours of real labor when I finally started having contractions that were real, I said "Oh this is it, this is what I have been waiting for, this is it". They weren't bad, I had pretty easy labors and then the nurse came in and said, "Do you want to go to sleep for the birth of your baby?" I said "I don't know"… My daughter is 37 years old and very adorable. She said "Sweetie you were up all night and you just need to go to sleep when this baby is born. I said, "Do you think I need to? I had had no pain medications at all. She said "I think you will

> feel better if you do. I will feel better if you do." So, I went to sleep, they had to use forceps to pull my baby out through my big pelvis. That made me angry enough that I have been fighting for the rights of women to have the kind of birth that they can have, and to know that there is more to birth than just someone patting you on the back and saying, "there, there dear I will take care of everything."

The midwives I spoke with struggled with the idea of childbirth as a medical process while others were enraged that women do not have control over their birth, each expressing a desire to help women regain power in childbirth. They are passionate in their mission and most of them were empowered by their privileges to actively do something about it. All of the midwives I spoke with were White women with varying socioeconomic status. All of the nurse-midwives have nursing degrees and graduate level training for nurse-midwifery. Some of the certified professional midwives had a nursing degree, others had graduate degrees in unrelated fields while some I did not learn of their education. From my understanding of their life stories, I speculate their ages range from thirty to sixty-five. Some of the apprentices I encountered at the meetings were younger, in their twenties. At the MANA conference, there was more diversity in terms of race. Again, I do not have specifics—just what I heard and saw—but Latina midwives from Mexico and Central America were in attendance; as well as African American and White midwives.

Midwives described a wide range of clientele. Michelle explains who she works with.

> My clients are mostly white upper middle class but I have also been serving moms who are immigrants, others who once they are in the country long enough will qualify for Medicaid. And I think that with the work I am focusing on right now it is mostly going to be immigrant, uninsured and financially underprivileged women.

The midwives I spoke with described serving a varied population. Both groups discussed attending people who were "educated," people who acknowledged the medicalization of childbirth and had the resources to obtain alternate care. Also, some midwives explained serving women in the lower classes. Nurse-midwives have historically "served the underserved," which still appeared to be true amongst most of the midwives in this study. Nurse-midwives are able to accept Medicaid, increasing the number of their clientele from the lower classes. Certified professional midwives said their ability to serve lower class women was somewhat limited, as they were not yet able to accept Medicaid. However, I heard quite a few CPMs talk about serving lower class families in rural areas. Something to note is that most women who hire CPMs need the resources to pay out-of-pocket for their services. This may prohibit women from having access to CPM care; however, I heard one midwife discuss compensation in other terms—"I have some nice paintings." Each CPM's fees vary. They practice autonomously; therefore they can tailor their fees to different circumstances.

Several CPMs and CNMs described serving people of diverse ethnicities and races. One nurse-midwife discussed that some immigrants are used to women attendants for pregnancy and childbirth—thus they seek out midwives to care for them. I specifically heard about midwives serving Latina, Muslim, Russian and Asian women. The midwives in the study are from various locations around the state serving women from rural, suburban and urban parts of Virginia. Nurse-midwives discussed caring for pregnant teenagers, whereas I did not hear that from CPMs.

The Role(s) of Midwives

> *Well, I don't have a role, I have many roles and it's kind of dynamic because it changes. The role I might have with a pregnant fourteen year old having her first baby is very different from the role I might have with a thirty-two year old having her third baby.*
>
> *Sandy, CNM*

> *One word is support and it can mean many different things. It is unique to each experience, each woman, each family.*
>
> *Laura, CPM*

As I listened to both certified professional midwives and certified nurse-midwives explain their thoughts about the role of a midwife, they had very similar notions of midwifery work. Many midwives explained that midwife means "with woman" and they appreciated that concept. They all expressed the dynamic nature of their work to incorporate various roles. Each midwife had a unique way of expressing their role(s) but there was an undeniable consistency among the respondents' considerations of their roles as midwives. I originally conceived three categories from the data broadly defined as "educator," "being with woman," and "guardian." As I considered these categories and consistently referred back to my transcripts, I realized that the three broad categories were all part of a support role that midwives perform (see table 1 in Appendix A).

All of the midwives were confident and clear in their responses to questions regarding their practice of midwifery. I was aware of a sense of pleasure they exuded as they discussed the role of a midwife, and I considered that this was seemingly connected to their reasons for being a midwife. Various midwives expressed that they were "called" to midwifery, had a "burning desire" to serve women or wanted to empower women through birth. Consequently discussing the role of a midwife was close to their hearts. During the focus group sessions, as one midwife would discuss the roles of a midwife,

the others would take pleasure in building off the first one's answer and they enjoyed reaffirming each other.

Ann: I will [explain the roles of a midwife] first because I see it pretty clearly that our role is to guide women and to guard them. And we guide them with patience and education and time and story telling. And we guard them with truth and our knowing of the birth process. I always felt like I knew I had really done my job when someone did not necessarily need me to be there but they wanted me to be there…

Genie: Yeah. Another aspect would be informing and teaching them about the process and ways they can improve the outcome through their daily living.

Sophia: Making them healthier people.

Genie: Empowering them.

Ann: That is the guide.

Sophia: If I could have chosen words that would be it. The profound moment of watchful attendance and letting them become that person through birth and guiding them. Not guiding them I mean guarding them holding a space for them.

Ann: Holding that safe space.

The Role of Support

Midwives' discussions of the role of a midwife during pregnancy and birth always involved a supportive role. Support was regarded as the most important role a midwife can have when providing care. The actual means by which support occurs can vary according to who was doing the supporting and who was being supported. Three consistent threads of support were explained by the midwives. Again, they expressed this by discussing their support through education, by being with women and through guardianship of the pregnancy and birth process.

Educator

All of the midwives discussed supporting clients through education. The role of educator varied greatly for a midwife depending on her client and her style of practice. Some clients approached midwives with an abundant amount of information of pregnancy and birth while others had limited knowledge of these processes and the choices available to them. Midwives tailored the content and process of educating uniquely to each client. They all expressed the importance of providing knowledge to women as a vehicle for empowerment.

Midwives reported sharing their wisdoms and understanding of the pregnancy and birth process with mothers and informing them of pregnancy and birth related research. Midwives stressed the importance of educating clients about pregnancy and birth and equipping them with knowledge of what is safe and normal. Ann says:

> … And [the role of a midwife is] to continue to define normality for her and it's really one of just primary support for her. Um, support, information, you know help her find information or give her information, you really just continue to define what is normal and to help her dissipate her fears by knowing what is safe and what is normal… Well, a lot of what a midwife does is helping you, say that you have some fears based on things that have already happened to you. You know, time is one of the tools that we use, because we are not going to know when you have fear based on some traumatic event if we don't spend time with you to find out. And, those fears of that event can lead to more tension and pain. So we really work on the fear element. Um, either trying to help you heal from the past or replacing fear of the unknown with the known. And that's where the whole concept of replacing the unknown with information comes from.

Furthermore, midwives expressed their supporting women by bringing their knowledge and experience to the situation.

Meredith: …It is recognizing self-directed care but also bringing our training and experience as an added benefit. That is why they have asked us to be there not just because we are somebody nice to have.

Katherine: They could do it by themselves if it did not involve that documentation of normalcy that we do.

As midwives would share their personal knowledge, they would also encourage women to cultivate knowledge on their own through reading and support from other mothers. Midwives support what they call "self-directed" care through empowering and informing women with knowledge so they can be more participatory in their care. Teresa says "Our role is to support women in taking care of themselves and sometimes that might be teaching…" While midwives bring their knowledge to the situation, the knowledge that their clients bring is equally valuable. These explanations support Davis-Floyd's holistic model of birth where the knowledge of both the mother and the midwife are valued with the mother being central to the process (Davis-Floyd 2003:156).

They encouraged education not only on the process and progress of pregnancy and birth, but they encouraged overall healthier living. Some pregnant clients approached midwives wanting education but lacking the resources to acquire it, or lacking the assertiveness to seek it. Some midwives expressed the responsibility they felt to encourage nutritional education. Teresa shares:

> I got people that weigh 250 pounds that were never given nutritional counseling, never given help. I started teaching childbirth classes and I would ask how many of you were told about smoking, told to quit smoking. You know about half of the people would raise their hands and say yeah we were told to quit smoking. Okay, how many of you were told how to quit smoking? And I would get no hands. The more I realized they are asking the questions but if somebody says yes I do smoke then they say well quit and that is where it stops. You know it is very difficult to quit smoking without somebody helping you figure out. There is no education, no motivation. Sometimes just explaining how smoking affects your baby and your body is enough motivation to get them to start thinking about changing and then you can work with them over time. Each time they come in you can see how they are doing with it. And give them the knowledge. It is very important.

Being with Women

Supporting women through education creates a space and a dialogue for midwives to "be with women." It opens avenues for dialogue, and it allows a mutual respect for each person involved. As clients share their fears and anxieties about the process midwives can reassure and encourage them. Teresa says "A lot of times women know what is right they just need encouragement to keep on that what they are doing is the right thing." Many midwives valued the availability of time in their practice allowing opportunities to be with women by listening, affirming and encouraging them through the process.

Laura: …By and large the tool we use more than anything is listening. I mean physically when you break it all down, that is what you really spend your time doing.

Katherine: Yeah. That is why I thought we would be better regulated under the board of counseling rather than medicine, personally. (laughs) Definitely do more counseling than medicine.

Laura: All that other fancy stuff has its place and time but I think we are all pretty decent listeners. We have to be or we can get a woman in big trouble.

Through listening midwives increased their awareness of a client's physical and emotional health. Sandy explains "I need to have an awareness of their manner, their demeanor, whether they look happy or sad or depressed or you know they interact with their partner. I need to sort of be on the lookout for things that might have something to do with danger in their lives or something like that." Listening to a woman is important to the practice of midwifery, it opens the relationship creating advanced connections between the client and the midwife (Davis-Floyd and Davis 1997). Davis-Floyd and Davis explain these connections are valuable as they increase a midwife's use of intuition

in the practice of midwifery (1997). In a midwife and client situation, these connections can reaffirm intuition as a part of authoritative knowledge in childbirth.

Another aspect of being with women is respecting who they are. Midwives affirmed and honored their clients through valuing their traditions, cultures and desires for the birthing process. Sandy conveys:

> I think one of the things about midwifery is that we honor the women that we work with and one of the ways that we could honor these Hispanic ladies is to learn their language. One of the ways that we honor and respect the Old Orders (Mennonite population) is accommodating their cultural conditions that make it hard for them to get to us. It's easier for us to get to them. We can do that. One of the ways we honor the Muslim women and their cultural modesty is to protect them in the hospital environment. I make sure when I have those women in there, I make very sure that stray people don't come in the room, you know that if I'm going to have say I'm concerned about a baby then I'm gonna have the respiratory therapy come to be at the birth which doesn't happen often but if it's a must then we ask to have a woman come so there's not a male stranger in the room. I try to keep a sheet over the legs a little bit more carefully with them than I would with somebody who is less inhibited than Muslim women are. You know just little things. You know that as midwives we don't take care of people, we work with women and um, we need to honor and respect them in all aspects of their lives. Their culture that surrounds them is part of that, and so that is something that we need to encourage.

Midwives provide a constant supply of encouragement to women during labor and birth. Many midwives' clients have intentions of how they want their birth to evolve, barring no emergencies; however, as Meredith and Dawn suggest that in the throws of birth a woman may doubt her strength.

Meredith: What can happen is that women know what they want, they are educated. They have chosen their provider, their obstetrician, but they have said I want this and I want this and this is the birth I want. That when they are actually in labor it gets very easy to convince a woman that she needs a procedure because they are vulnerable in that sense that they are in the midst of it and it becomes difficult to become an advocate and ideally a midwife who can be certified as an obstetrician or a nurse-midwife or anyone is someone is going to continue to honor what their intentions are… In that moment when someone says I can't do this anymore and the difference between oh yes you can, you're doing it and you're doing great. Versus I don't think you can either, lets get an epidural going. And that is what happens.

Dawn: And they say oh good. And what they really want in the vast majority of cases is to say you're doing okay you can do this and they are very grateful afterwards because it is that vulnerable place and they need that extra support.

Midwives offer encouragement and reassurance to a woman during birth that reaffirms the woman's strength and ability to give birth according to her prescribed desires. Connected to the concept of self-directed care, as discussed earlier, is the concept of "informed choice" which not only involves the mothers' knowledge of pregnancy and birth process but equips them with an awareness of available tests, technologies and "procedures" that are available. Midwives said their responsibility was to inform the clients of what services are available and the evidence that supports or refutes the potential benefits of procedures. But ultimately it is the client's choice of what to do or not to do. Informed choice advances the client's ability to be participatory in the decisions for their care. Meredith explains:

> We have to first critique it ourselves but then we also then have to inform our clients—now there is a test that has been made available. Certainly [it] is available to you here is what we understand about it. This is how it might impact your care based on the results of it. For the most part try and maintain a neutral position and I think every practice is different as far as the midwife's comfort level.

Sandy also explained that informed choice is also important in the event that the "birth plan" does not happen as the client envisioned; informed choice enables the mother to make decisions based on knowledge of the situation.

Guardian

Many midwives acted as guardians of the birthing process. They explained the importance of creating a safe place for birth to happen. For the midwives who practiced inside of the hospital creating a safe place for birth often involved muting the effects of

hospital policies that tend to generalize the laboring and birthing process—setting guidelines for how long a labor should be, etc. Jointly they worked to establish autonomy for the clients in the hospital and to protect the clients' best interests. This is often challenging to accomplish, and sometimes they are unable to protect their clients and the normalcy of birth in the hospital. Meredith and Katherine, both CPMs, and Dawn, a CNM studying to be a CPM, discuss some of the struggles to guarding that space for a woman in the hospital.

Meredith: …But I do think it is harder in a birth center or hospital to maintain that you have to work harder to maintain that sense of it being her space and supporting her because there is a pull towards it being the ownership is who owns the space. So, I think that midwives have to really work hard.

Katherine: It is more a matter of creating it at that point as opposed to just allowing or not having to create it from scratch.

Corey: Who would do that work?

Dawn: The certified nurse-midwife in the hospital.

Corey: That would be your responsibility to do that?

Dawn: Oh it is. To work within guidelines that a hospital can live with, but also to be strong enough to stick to those guidelines and to say that essentially the buck stops at the door. Within the protocol of the hospital nurses can come in and out, and there are certain things that need to take place but the parents and also the midwife is the guardian of normal birth, whenever possible. There is a lot more tension in some cases in the hospital, it is getting that way. It wasn't always that way.

Midwives that practiced outside of the hospital described holding a safe space for birth as facilitating the opportunity for the normalcy of birth to unfold. They explained that maintaining the normalcy of birth involved allowing for uniqueness and individuality. Genie explains:

> Another thing I think is that we allow for individual differences. We don't force their pregnancy and their birth to be a certain way. The normal range is so wide. One of the medical issues I have is that they expect it to be certain length of time. You know they want to put it into this box and it is not a box for everyone. We are able to maintain their individuality and keep them within that safe zone.

The course of guarding birth may be different in a hospital or outside of a hospital; nevertheless, all the midwives spoke of the importance of guarding as a primary role of a midwife. This is consistent with Davis-Floyd and Davis's assertion. "They see a labor that is unlike other labors, not as a dysfunction to be mechanistically normalized according to the standardized technomedical system of authoritative knowledge, but as a meaningful expression of the birthing woman's uniqueness, to be understood on its own terms" (1997: 335).

Both midwives that practice in the hospital and midwives that practice outside of the hospital expressed the importance of protecting and advocating for a woman's intentions during pregnancy and birth. They respect the normalcy of birth and each woman's access to the birth they desire because they believe in the unique opportunities that arise through birth. Some midwives expressed the positive outcome of the empowerment of women through the birth process. Teresa elucidates:

> I had a 15 year old one time who came in and she was very shy, very shy. She would hardly ask you for a glass of water. I had to offer her everything. She wanted to get through labor without anything, and we helped her and she did. She made it through labor without anything, had her baby. I came back the next day, and she was a different person. She was asking for things for her baby. She could ask for what she needed and felt good about herself because she had done it. She had gotten through labor by herself. So, it has the ability to change how women see themselves and guys [physicians] don't get that. People that have never seen it, don't get that. It is incredible and women need that. To be able to raise kids, they need to be assertive and to have enough confidence in themselves to be able to raise their kids. I never knew that until I saw some women go through it.

Nurse-midwives have been exposed to the medical model of childbirth through their nurse training, and some of the certified professional midwives have worked as nurses, consequently exposing them first hand to a medical approach to childbirth. Therefore, some CNMs and some CPMs have witnessed births approached from a medical model and births approached from a midwifery model. This, compounded with an understanding of the research that supports the safety of un-medicated childbirth and realizing that many of the medical interventions are harmful to both mother and baby, prompts midwives to protect and guard the opportunity and space for a "natural" birth to happen. Dawn shares:

> There was a study published in *OB-GYN. Obstetrics and Gynecology*, it is not the (inaudible) journal but it was a study that came out of one of the Western states and it looked at 5,000 births. So, the numbers were good. It showed that the fetal mortality rate for elected cesarean sections has doubled from .6 or 6 per thousand to 1.2 or 12 per thousand with all other factors being equal. There is something going on with elective cesareans that babies don't do well. We know it is a complicated process and we know that babies get triggers from birth.

The supportive role of a midwife interweaves the threads of education, being with women and guardian. Each component enables another. In one of the focus groups several midwives shared the vision of walking alongside a woman during her pregnancy and birth explaining that the midwife was not on the path with the woman but was rather on the shoulder (of the path) propping her up every now and then.

Sophia: You see the whole imagery is that-you are on the path with them but you are in the non-path…

Genie: The shoulder. Make sure they do not fall over.

It was clear that midwives, despite their designation of certified professional midwife or certified nurse-midwife, felt their role was of support. They were committed

to being with women through birth, guiding them through birth and educating them about pregnancy and birth. As presented in the literature, Hunter expressed that nurse-midwives had a "with institution" ideology and direct-entry midwives had a "with women" ideology suggesting that each group aligned priorities of their role along alternate means (2004). However, my research supports that both nurse-midwives and certified professional midwives had a strong commitment and connection to women through pregnancy and birth. Both groups described an allegiance to women and the birthing process, and they valued the mothers' knowledge during pregnancy and birth. Despite being trained in different systems and educated about midwifery through alternate tracks, they were similar expressing the role of midwife.

My findings support Davis-Floyd's assertion that authoritative knowledge for midwives and clients usually forms on a horizontal plane—where each player brings valuable knowledge to the situation (1997). Their explanations are also congruent with a holistic model of birth where the woman is centered in the process; her presence and knowledge are essential (Davis-Floyd 2003). The role of support involves intense listening and caring for the well-being of expecting mothers connecting them to their clients; in this manner, midwives often rely on their intuitive understanding to guide women through the birthing process. Davis-Floyd explains that midwives incorporate intuition as knowledge through pregnancy and birth. Intuition, while valued by midwives, has no value in a medical or technocratic model of care. Davis-Floyd states that authoritative knowledge plays out differently in midwifery care compared to obstetrical care, and the acceptance of intuition as knowledge through birth may in part separate the two spheres of midwifery and medicine (1997). For example a physician

may decide a breach baby needs to be delivered by c-section, for liability and insurance mandates, whereas a midwife may be more willing to trust birth and follow the mothers cues to see how her labor progresses. These variances in knowledge systems limit the degree to which the medical community can support midwifery.

Experiences with the Medical Community

The conversations I had with midwives concerning their experiences with the medical community involved varying degrees of frustration often broken with individual stories of satisfying encounters or situations. I discussed CPMs and CNMs separately as their experiences were often different because of their relative position to the medical community.

Certified Professional Midwives' Experiences with the Medical Community

> *A few women who are coming from medical practices, and they just wanted a more natural birth. So, they call a home birth [midwife] and one of them, recently, she was my first RH-negative client, I had to do all this work to figure out how to assess her and how to get RhoGAM because we are not allowed to carry that…[W]omen are coming expecting things that they always had from medical providers that we hadn't even had the ability to access before.*
>
> *Katherine, CPM*

During analysis of the transcripts it became clear that the CPMs' experiences varied, depending upon the doctor, the hospital, and the situation. I present three themes from the data including the frustrations and restrictions they experienced with some doctors and the larger medical community, doctors who were supportive and empowerment CPMs felt in their interactions with their licensure (see table 2 in Appendix A).

Frustrations and Restrictions with Physicians and Medical Community

Midwives described frustrating encounters with the larger medical community—medical societies, the AMA and Virginia Chapter of ACOG, State Health Department and hospitals—often meeting hesitant and distrusting representatives. Some CPMs were politically involved positioning them to represent direct-entry midwifery as a profession concurrently subjecting them to judgments from medical societies and representatives of the medical community. Meredith discusses her attempt to encourage the medical community to understand the importance of licensing direct-entry midwives.

> When we were lobbying that was sort of pointed out to medical skeptics, was look we can help this situation. The train wreck stories that would often get told of someone showing up in ER from a home birth. We were saying, yeah let's license them. Because if you license them they can come, they can be held accountable, and they can act as liason to that freaked out family. That you think is a lawsuit waiting to happen well now there is a licensed provider there who is going to not only assume responsibility but potentially eliminate a sense of negative animosity toward the doctor. It has taken them a long time to think about it in that way.

All of the CPMs, regardless of their level of participation in the legislative process, were acutely aware of the negative attitudes toward midwives and midwifery that medical societies have projected. They felt frustrated personally and professionally that something they believed in whole-heartedly was being condemned by the medical community. There was a definite sense of dissatisfaction surrounding this topic.

Genie: The Board of Medicine.

Michelle: Tell her how supportive they are. (laughs)

Sophia: They hate us.

Genie: They would like us to disappear of the face of the earth. I think they actively do things to prevent us from being successful. They keep tripping us. And they are so

protective of their own profession and the AMA is definitely a union. They are out to protect and promote themselves and anything that does not fit their model has to go because we are a threat. They are even willing to sacrifice their client's best interest for their own. That is in general. If you take each doctor individually, you will find that some are really supportive.

Sophia: Or kind of supportive.

Genie: Or prefer to be able to promote us. So, I have worked with doctors who have been great, and others who have been horrible.

Before Ann received her license to practice, prior to the legalization of direct-entry midwifery, she was concerned to take a transport to the hospital that the hospital may report her, and ultimately she was investigated by the State Health Department.

> Transport was always really dicey because you knew whenever you took a woman to the hospital you could get popped before you left the parking lot. It was really, really scary every time you had to transport someone…I was a guest speaker at a natural living conference and was investigated because someone that was there worked for the State Health Department. I'm just you know telling them how wonderful midwifery is and then two days later I get a knock on the door, "Are you Ann Smith?" Yeah, I was investigated two times before I was arrested, and never because anything was wrong…

Stories like Ann's coupled with judgments directed at midwives from the medical community that both complicated the process to legalize direct-entry midwifery and have demonized midwives created a general sense, among the midwives I spoke with, of negative association between the medical community and CPMs. Ann was weary of encountering the medical community prior to licensure; however, now CPMs in Virginia do not have to be concerned with arrest from practicing midwifery.

Some states require professional connections between CPMs and physicians; however, currently in Virginia, the occasions for CPMs and medical professionals to interact are somewhat limited. CPMs described several reasons why they would interact

with an individual physician, including: if a midwife transported a woman to a hospital due to complications during a pregnancy or birth; if a client needed medicine that a midwife did not have access to, a midwife may approach a physician to prescribe medicine for the client; or if a potential problem arose during the pregnancy that required a referral to a physician.

In an emergency situation, a midwife may transport her client to a hospital, encountering unpredictable interactions with physicians during hospital transfers. Davis-Floyd articulates that the emergency transport offers a unique opportunity for biomedical knowledge and midwifery knowledge to come together (Johnson and Davis-Floyd 2006a: 470). Transports force an encounter that can further divide or solidify the two knowledge systems. Some midwives explained having negative experiences. Dawn and another CPM were transferring a client to the hospital but were ill received by the physician on-call. The doctor on-call explained to the nurses that he wanted the midwives to leave before he arrived to care for the client.

Dawn: The nurses were fine and we stayed with them until he was in route.
He had called ahead and wanted us to step out.

Laura: Did he want you to step out before he came?

Meredith: He didn't want to see them.

Dawn: Yes, he didn't want to see us. He wanted us out before he came.

In this situation, the physician did not appreciate the presence or knowledge of the midwives. He wanted a clear physical separation between himself and the midwives; they do not have a place in his knowledge of birth within a hospital, and ultimately their presence challenges his authority on birth. This suggests that the doctor, recognizing a

potential challenge to his authority as expert, did not share his space with the midwives in order to protect his authority of birth as uncontested knowledge. The authoritative knowledge in this situation solely rested with the doctor, affecting the midwives' value and presence as part of the client's care. Davis-Floyd describes these types of interactions as "fractured articulations" where incomplete information is shared between the biomedical and midwifery knowledge systems (Johnson and Davis-Floyd 2006a: 470). Dawn arrived at the hospital with her client and conversed with the nursing staff; however, her transfer of knowledge and her client's situation was limited as the physician was unwilling to communicate with her.

Their descriptions of the restrictive experiences are laden with a depreciation of the practice of midwifery. In the past, medical associations have had to legitimize the practice of obstetrics as a medical specialty, simultaneously negating the safety and practice of midwifery. The CPMs I spoke with explained a similar occurrence: medical associations and physicians protect their profession, their specialty and ultimately their knowledge, while devaluing the knowledge and skills of midwives. As discussed above, when Dawn transported a woman, she went with her client to continue filling her role as support person. Although her client needed to go to the hospital after the birth, Dawn did not feel her role of midwife had ended. However, the doctor neither appreciated her presence nor valued the skills that Dawn and her client esteemed.

A key discussion expressed by Jordan is the manifestation of authoritative knowledge in a situation—what counts as knowledge (1997). She explains that doctors are privileged with authoritative knowledge within the hospital. Dawn's experience is congruent with Jordan's assertion; the physician was the owner of knowledge, the expert,

in this situation and outside knowledge systems were unacknowledged. Addressing further the situational circumstances of authoritative knowledge, despite the state legislature's acknowledgement of midwifery practices as viable, doctors and medical communities make their decisions about what is valued as knowledge and what is not.

Supportive Physicians and Empowerment Through Licensure

While some midwives have had upsetting experiences transferring a client to the hospital, others have had positive interactions. They explained situations where they were able to stay at the hospital and maintain their role of support for their client. Being able to be an assertive licensed provider has given them some power, and some physicians have responded by supporting their presence and their insights to the client's situation.

Meredith: So, when you have that interaction with that OB, friendly or non friendly, you are the midwife. Even though this is now their client you can say this is why we came. This is what we were hoping for. They like that, actually. Because otherwise they feel like it is that they are coming in and it is a puzzle that they are supposed to figure out.

Katherine: Thin ice.

Meredith: Like they really seem to like when we, even on the phone call, say here is what is happening and here is why we are coming. This is what we think we need.

Katherine: I even ask permission. Can I come in? And nobody has ever said no.

Meredith: We say our plan is to continue on. We would like to come with them and stay with them.

Another certified professional midwife, Michelle, shared that a doctor who had previously helped her, subsequently offered her help again if she needed to transfer a client.

> The other night I volunteered at the free clinic in Freeport, and I caught a friendly OB. Who I knew to be friendly because she took a transfer of mine a year ago, and she backs up Dr. Brown at times who is very homebirth friendly, can't always say it because the hospital and insurance get on him but otherwise he is very favorable towards us. I told the doctor what I was up to serving immigrant populations. She said if you ever need a friendly face for a transport, you just call me.

While midwives have received mixed reactions from doctors, the licensure of CPMs allows them to be open about their practice, creating opportunities for them to share knowledge and be participatory in a client's care after a transport to a hospital. As Meredith mentioned above the doctors seem to appreciate the midwives ability to fill them in on the client's situation and what they perceive may be wrong. Davis-Floyd explains this type of interaction between medical staff and midwife as "smooth articulations;" in this manner, biomedical knowledge and midwifery knowledge are both accommodated during a hospital transport (Johnson and Davis-Floyd 2006a: 470). Also discussed earlier by Meredith is that these exchanges may free the physicians from feeling all the burden of responsibility for the client's care. This is clearly situational as was emphasized to me by the CPMs. Nevertheless, these lines of communication that were previously unacceptable now have the capacity to create a situation with some shared power—a midwife can have a valued role during a transport to the hospital.

The legalization of direct-entry midwifery and the licensure of CPMs have opened avenues for conversations with medical professionals and hospitals that were previously inaccessible. A current interest for CPMs is to create a dialogue concerning transports to hospitals; midwives want to increasingly establish transport guidelines with hospitals and EMS. Katherine was successful in beginning a dialogue with the local hospital about creating a protocol for client transfers.

> The closest I have come is to try to get RhoGAM[3] for my clients. An interesting serendipitous issue was that on the advisory board that I am on, I was appointed by the governor on this advisory board, with two other midwives and a client consumer member and there also needed to be an obstetrician or a medical, it could be a CNM I think. So, it just so happened that the obstetrician that was appointed by the governor is in Riverside. So there is only one hospital, and I meet this man at the advisory board meetings. I just bugged him until he agreed. I wanted to establish some guidelines for transports basically. He set up a meeting for me with the hospital staff and anybody who would be involved in that. That was just a unique situation, you know. That other midwives haven't been able to have. So, it didn't create a relationship but it created a body of people in our community that were aware of the issues that I would bring to them. And say to them, what are we going to do about RhoGAM. They are like I'm not doing it; I'm not doing it but they helped me come up with idea of how to get what we needed.

As Katherine points out her situation is unique, and it may have helped her to be on a committee with someone who worked at the hospital. Nevertheless, Katherine was able to converse with the local hospital and staff in a productive way.

CPMs in Virginia, currently, do not have legal access to any prescription medicines and this can be complicated if a midwife's client needs medication. I heard several tactics for handling the situation. One approach is for the client to consult with her family doctor or gynecologist to prescribe her the needed medication, and another option is for the client to visit a health clinic because legally the clinic cannot refuse someone care. Also a midwife may consult with a physician(s) seeking prescriptive support to care for the client. Midwives have found physicians that are willing to support their clients. Dawn said "The baby's pediatrician or family practice doc will provide some of the things the parents want for the baby" and after going through a variety of

[3] RhoGAM, a Rh Immune Globulin product, is used to treat pregnant mothers who have Rh negative blood. Mothers with Rh negative blood, who go untreated during pregnancy, will often lose their baby in-utero or after birth to Hemolytic disease. Prior to the discovery and availability of RhoGAM approximately 10,000 babies in the United States died each year from Hemolytic disease. Since the introduction of RhoGAM to the market in 1968, over 20 million injections have been given worldwide (accessed at www. rhogam.com).

channels, as mentioned above, Katherine was able to track down RhoGAM for her clients. The legalization of CPMs has allowed midwives to consult with a physician about medications for a client.

Several midwives had established relationships with doctors prior to working as a midwife, increasing the doctors' respect for and willingness to help the midwives. Midwives explained how working as a nurse gave them rapport with the doctors. Genie explains:

> I had the experience of working in my community in the hospital before I became a midwife. So, I had relationships with the doctors from working with them for years in the hospitals so they knew me as a person, as a nurse, and so then when I became a midwife they knew me. They felt comfortable enough answering my questions having to consult with them, taking my clients and stuff.

Johnson and Davis-Floyd acknowledge that exposure to midwives and midwifery can increase physician support of midwifery (2006b: 528). Katherine may have benefited from being on a committee with an obstetrician who has knowledge of midwifery; moreover, this connection subsequently created a hospital and emergency services staff who had positive exposure to midwifery. Genie earned rapport with physicians. They first respected her as a nurse; accordingly when she became a midwife they transferred their respect to her work as a midwife. Both of these situations advance the physicians exposure to midwifery. In so doing, they may be more willing to support midwives during future encounters.

Through the legalization of direct-entry midwifery and the licensure of CPMs, midwives have been empowered to publicly represent themselves as midwives. This has created opportunities for midwives to approach physicians directly. The larger medical community or individual hospitals may influence the work of physicians but each

physician has a choice whether to support a midwife and her client. There is not a requirement that CPMs have a relationship(s) with physicians, medical associations or hospitals, but midwives are thankful when they encounter a doctor that supports them. They are cautious in their reactions when a doctor does not.

Meredith: I don't think it has been a magic change. I think it really is individualized. And like I said here it already was okay at this *one* hospital *for us*. There are other midwives ten years ago that had terrible experiences at that same hospital. So the big fundamental difference is that there was change in the guard of attending physicians at that particular hospital. Ones that were really anti-homebirth to the point of mistreating or disrespecting midwives and mothers left and that changed. [emphasis added]

Laura: They are elsewhere.

Meredith: Yeah, exactly… So, when you can you legislate something that will impose (inaudible)…I always think about it like bullies on the playground. We go back to the legislator, like the parents, and say make them be nice but the legislature turns it back and they can find another way. You know. So, we have to be really careful how often we go back and say they're not being nice to us.

Laura: You can get up in their face now and say, privately, behave.

Meredith: Exactly.

Laura: You're just being naughty and mean, behave. Whereas before, you didn't dare.

Meredith: No, you just stayed quiet.

Katherine: Our clients are so savvy now too they will say those things that we can't say. I wanted to say to on a broad basis the theoretical issues are still scary for the medical community. But my experience has been when you are one on one it is really different. When you have a mother and a baby that have some concerns and you have a doctor that is going to have to interact and deal with the situation it is so different, and then what they think at the Virginia Medical Society level or even the Virginia ACOG chapter.

Meredith: I don't think any of us have approached a doctor about forming a formal relationship we don't have to but I don't know of anybody that has taken that leap. I sometime will.

CPMs practice without a required relationship with a physician; however their connections and/or interactions with a physician can affect their ability to practice

midwifery. Whether they are supported in seeking medicine or during a transfer can encourage or limit their work as a midwife. Licensure has empowered CPMs to actively seek assistance from the medical community and to represent themselves as competent professionals.

The licensure of the CPM has created a space for CPMs to interject themselves and their knowledge system into the medical community. The fact that some physicians are accommodating their knowledge is notable. While Meredith is participating in the care of a client within the walls of a hospital, the prevailing authoritative knowledge is disrupted as she becomes a knowledgeable voice in that interaction. This signals a stretch in the prevailing authoritative knowledge creating a space for alternative knowledge to be regarded. This is limited as it is dependent on the physician and the situation, and individual support of a CPM is not nearly as threatening as supporting CPMs in a broader context. Nevertheless, these "smooth articulations" support the knowledge of the midwife simultaneously offering hospital staff, residents and doctors exposure to midwifery, hopefully encouraging future support of midwives.

A key theme in the literature is the power of the medical community to define pregnancy and childbirth holding dominant authoritative knowledge. Jordan and Davis-Floyd explain the rigidity of the medical community to disallow other knowledge systems a viable place within its structure (Jordan 1997; Davis-Floyd and Davis 1997). Contrastingly, some CPMs recently have been able to contribute to the prevailing authoritative knowledge within the medical structure. Additionally, Weitz and Sullivan suggested that doctors would not accept midwifery until there was an overhaul of medical ideology concerning childbirth (1988). However, through my research we see that some

physicians, hospitals and medical communities are making room for and respecting midwifery knowledge; not only does this suggest the injection of alternate knowledge from midwives into the prevailing authoritative knowledge, but it also signals that members from within the dominant system are challenging established notions of childbirth. Hopefully, this will facilitate the reconstruction of the meaning of birth from the bottom up (Johnson and Davis-Floyd 2006a: 495).

Certified Nurse-Midwives' Experiences with the Medical Community

> *There is not always a lot of logic operating in medical systems; a lot of turf protecting and all egos, not a lot of logic.*
>
> *Sandy, CNM*

Certified nurse-midwives had varying experiences with the medical community. Although midwives practiced in different capacities creating unique experiences for each of them, I conceived three categories of discussion from the data. All of the CNMs that explained positive experiences also explained negative experiences. The three themes include—lack of support from physicians and restrictive policies of medical societies, hospitals and health insurance companies; working collaboratively with or unhindered by physicians; and navigating midwifery and medicine (see table 3 in Appendix A).

Certified nurse-midwives in Virginia are required to practice in collaboration with a physician meaning at the very minimum they have a professional relationship with a doctor outlining their practice guidelines. CNMs in Virginia practice in a variety of capacities—some practice in a hospital, others work at a birth center and/or they attend homebirths. Three of the nurse-midwives I spoke with currently practiced in a hospital, one was a home birth CNM, one was a former hospital practicing CNM who was training

to be a CPM while the other had briefly worked as a CNM in the hospital but was currently unable to find employment in her area. While their individual circumstances and practices were different, there were perceptible similarities in their experiences with the medical community. The ability for a nurse-midwife to practice is dependent upon a cooperative physician and/or hospital; interestingly each person I spoke with had a unique arrangement.

Restrictions from the Medical Community

CNMs seeking to practice midwifery are at the mercy of physicians, hospitals and health insurance companies. These entities often restrict or refuse the opportunities of CNMs to practice. One of the barriers to practice for nurse-midwives can be liability or malpractice insurance. Teresa thought she would be a home birth CNM after earning a graduate degree in nurse-midwifery two years ago, but malpractice insurance for CNMs practicing homebirth became unavailable the year she graduated. "The month that I graduated was the month that home birth malpractice insurance dried up and you could not get it anymore. You can't purchase it. It is very rare. It was available. You could get it up to that point apparently." Katie, a homebirth CNM, practices without malpractice insurance; she feels comfortable with this because she has a low volume of clients only accepting low risk patients. However, the lack of insurance options limits her practice and it restricts the opportunities for other CNMs to practice homebirth.

Working to open a birth center, Teresa is contacting insurance companies to further understand the details and options of insurance for a birth center. However, she

says the insurance companies will not discuss insurance options with her unless she is employed by a physician. She explains:

> Some states allow midwives to work totally independently; others require a supervising physician like we have in Virginia. Most insurances that I have called they won't even talk to me unless I have a supervising physician and that he is on the insurance plan. Unless I am in an employee relationship they won't even talk with me in Virginia.

The issue of insurance has also restricted Teresa from practicing in her local hospitals. The hospitals in her area will not hire nurse-midwives, and she has not been able to find a physician group where all the partners support nurse-midwifery.

Corey: You mentioned that [ABC Health System] said they would not hire nurse-midwives—is that for insurance reasons? Hospital policies?

Teresa: Let me put it this way, other hospitals have nurse-midwives. Some are directly employed by the physicians, others are employed by the hospitals, and they don't have any trouble getting insurance. (laughs) They are telling me that it is because of their insurance, but I know insurance is available, and I know that it is not anymore cost for a nurse-midwife than for a physician. In fact it should be less. I think that is just something I am being told. I really don't believe that. I know other hospitals that have them and some of them are much smaller hospitals and physician groups than what [ABC Health System] has. I think it is a matter that they believe it is competition…

Katie echoes Teresa's experiences. "This is what I hear from the doctors that [ABC Health System] has said that their malpractice insurance will not cover doctors working with midwives and that has been a barrier to midwives having hospital practices and relationships with physicians who would welcome them into their practice." While Teresa doubts the validity of the insurance excuse, the explanation is nonetheless keeping nurse-midwives out of the hospitals. Hospitals and doctors may avoid low-intervention care provided by midwives as they bring little economic benefit to hospitals and doctors (Johnson and Davis-Floyd 2006b: 528).

Another insurance impediment to midwifery is reimbursement for services. Sandy, a hospital practicing CNM, explained that the physician owned insurance company, XYZ Insurance, does not fully support nurse-midwifery, restricting nurse-midwives' opportunities to full reimbursement for their services. She expands:

> …[I]nsurance companies like [XYZ Insurance] is a physician owned company and they have always been very negative against midwives. Some years back, 10 or 12 years back, we got a law passed it sort of happened before they noticed it that mandated insurance reimbursement, they had to reimburse nurse-midwives. But it didn't say at what rate, and so they will reimburse us at much lower rates than doctors. You know when I help at the birth of a baby I don't birth 80% of the baby. I birth the whole baby and so you know I should not get 80% of the reimbursement.

Insurance companies limit nurse-midwives' opportunities and can limit their recompense for services rendered. This is similar to Johnson and Davis-Floyd reporting that Medicare reimburses nurse-midwives only sixty-five percent of the physician's fee reimbursement (2006b: 529). Also influential in the practice of nurse-midwives are hospitals, and hospital policies which are often written by physicians. Some hospitals require nurse-midwives to be employees of physicians; concomitantly, hospitals can write policies that discourage physicians from wanting to employ nurse-midwives. Sandy explained each hospital is responsible for writing their policies, sometimes creating difficulties for nurse-midwives.

> You know we also had passed a law previous to that, that said hospitals could not deny nurse-midwives privileges just because they were nurse-midwives; so hospitals would get around that and would say okay a doctor can hire a nurse-midwife and she can have privileges at our hospital. But, in order to move from provisional to full staff she has to have 150 supervised births. Well that means that the doctor has got to be there for the first 150 births. It's not worth his time so he's not going to do it.

Sarisha said her practice has been threatened by the hospitals' re-evaluation of the need for nurse-midwives. She works at a university hospital, and the hospital is contemplating eliminating the midwifery practice to allow the residents more opportunities to deliver babies. Because midwives do not often have autonomy to practice, they are at the mercy of hospital policies and hospital desires. Sandy says:

> As an organization sometimes medical societies or medical staff will work hard at making things difficult—you know, restricting hospital privileges, difference in reimbursement… doctors and hospitals can do that, they can make, they can have criteria that is obstructive to midwives and most nurse-midwives (inaudible). You could say, "Why don't you take them to court and all that stuff?" I can't afford that.

This is a recurrent experience for nurse-midwives. Historically, they were restricted from practicing in hospitals as physicians protected their territory, thus limiting the expansion of nurse-midwifery. Back then, physicians were more visibly restricting nurse-midwifery. Now, as some nurse-midwives shared with me, the excuses for disallowing midwives into practices or hospitals are tied up in liability insurance and insurance reimbursement. Nurse-midwives are thus again restricted from practicing by the medical community (health insurance companies included). Medicine has moved swiftly in the last several years claiming to practice "evidence-based" medicine, meaning that treatments and therapies prescribed are based on evidence that supports their effectiveness (Johnson and Davis-Floyd 2006a: 501; Rooks 1997; Simonds 2007b: 170). However, this concept has frequently not been applied to the low-intervention practices of nurse-midwifery.

Rushing expressed that midwives have used scientific ideologies to earn respect; she advanced that direct-entry midwives have been more successful using science

ideologies than nurse-midwives (1993). This is consistent with the findings of this research highlighting nurse-midwives' struggles to use scientific evidence to facilitate the acceptance of nurse-midwifery. The evidence strongly supports the efficacy of nurse-midwife attended births and the cost of nurse-midwifery care is considerably less than obstetrician care. The ACNM has made progress to gain more autonomy from physicians. Nurse-midwives formerly negotiated the move of nurse-midwifery into hospitals (Daviss 2006: 417), and they just had "supervision with physicians" replaced with "collaboration with physicians" (American College of Nurse-Midwives 2006). As Sandy told me, "…[I]t's taken us twenty years to get rid of supervision. That's you know twenty years."

While hospitals and insurance companies can make practicing nurse-midwifery challenging, doctors also affect the practice of nurse-midwifery. The requirement to have a collaborative practice with a physician impedes nurse-midwives from practicing if they cannot procure a professional relationship with a physician. Some nurse-midwives explained struggles to find physicians who are willing to work with them. Teresa shares:

> I had sent out a physicians survey and none of the groups had every doctor in it that was willing to work with nurse-midwives. There might be one in a group of three that said they would consider it and the others would say absolutely not. It was like that with all groups. I never found one where they were all totally against it or there was only one or two in it. And you would have to have the whole group to back you because whoever is on call is who you are going to end up with.

Katie has had limited success finding obstetricians willing to support her home birth practice. Living in Georgia and Tennessee, physicians were more willing to support her; she says maybe that was the result of smaller physician groups and their physicians did

not have a big hospital conglomerate like ABC Health System to deal with. In Virginia, she has struggled to find a physician willing to collaborate with her.

> …[O]ne of my ladies recently, I felt she needed to have a relationship with a physician and probably needed to see him more than once. At first he said "Oh sure, I don't agree with home birth but I can't argue with the evidence." She can see me if he has the time and then he told her 6 or 7 weeks later, "Oh no, I talked to my risk manager and she says no." That was really disheartening for my client as well as me…we want to be able to work with them if we can.

A part of physician resistance to supporting nurse-midwives may be a lack of education physicians have concerning nurse-midwifery; they may know very little about midwifery leading to assumptions concerning midwifery (Johnson and Davis-Floyd 2006b: 527). Sandy confirmed that physicians are often inexperienced with nurse-midwifery, and they continually have been slow to investigate the possibilities of collaborating with nurse-midwives.

> They are not going to understand you know if a nurse-midwife says you know, "I'm gonna have my own little practice here, I don't really need you to supervise me would you work collaboratively with me; can I call you for advice, can I refer patients to you?" I think a lot of doctors are pretty ignorant and they are going to say, "I'm not going to do that it's going to raise my malpractice."

All of the CNMs I spoke with felt the lack of support from physicians principally resulted from a concern of competition. Ingrid said, "…medicine is pathology, and what I tend to not understand and of course I am biased because I am a midwife, is why we are still the competition and why not just embrace us, let us take care of the normal healthy women and work in companionship with each other. Let all women know." Katie does not feel optimistic about changes in medical attitudes toward midwifery. "I don't see doctors getting more and more willing to work with midwives, and I see them feeling more and more threatened." Sandy explained that midwifery care is appealing to women;

consequently doctors can lose business to nurse-midwives. At Sandy's hospital 25% of all births are attended by the midwives in her practice. While the obstetricians she collaborates with appreciate midwifery, the other physicians in her city do not. She explains it is easy for physicians to feel threatened by nurse-midwives. "So, all of those people are not going to the other doctors, so that's a fair amount of diverted income. That can be very frustrating to them." Relying on support from physicians who are uneducated concerning nurse-midwifery, who are restricted by their hospital to support nurse-midwifery, and who are concerned with profit margins all reduce the opportunities for midwives to practice.

As discussed by authoritative knowledge scholars and explained above, physicians and medical communities have devalued midwives in theory and in practice (Jordan 1997; Davis-Floyd 2003). Having control over hospital policies and insurance companies already allows physicians significant dominance. Furthermore, if doctors feel increasing competition from midwives in the future, they may further tighten the reins on their hold as childbirth authority.

Supportive Doctors

Some midwives have experienced respectful and beneficial working relationships with physicians. Katie has looked unsuccessfully for an obstetrician to collaborate with in Virginia; however, Katie works in collaboration and has practice guidelines with a family practitioner. Unfortunately the family practitioner is limited in the way she can help. If Katie has an emergency, the family practitioner does not have hospital privileges, or if one of Katie's clients develops a problem during a pregnancy, the family practitioner is limited in her ability to provide care as she does not specialize in

obstetrics. Katie's collaboration with a family practitioner allows her to legally practice, but she is limited in her access to resources for her clients.

When Teresa was doing clinical work for her graduate degree, she worked in a birth center where physicians and nurse-midwives worked together. She described an environment where the power was shared equally; they each recognized the strengths of the other, and they were able to cooperatively provide care to patients.

> …[T]he midwives had one hall and there was a nurses' station in the middle, lab equipment and that kind of stuff. Then on the other hall was the physician. They each had their own patients that they saw. But if the physician had a lady that needed more help with things that were the midwives' usual education or whatever, he or she would ask the midwife to come over and talk to the woman. And if the midwife had a question or wanted the doctor to see somebody or hear a heart murmur or whatever then she would go over ask the doctor to come listen, or come tell me what you think about this leg or whatever. You utilize both strengths and that's the way they work.

Sandy practices in a collaborative relationship with a physician that is also based on equality; she is part of a practice that has nurse-midwives and physicians. Sandy and another midwife are partners with one of the physicians, whereby Sandy, the other CNM and physician jointly own the building where their practice is located. Due to limits of corporation ownership, Sandy cannot legally be part of the business ownership (because individuals of two distinct occupations cannot be owners of a corporation) but in every other aspect Sandy says they truly are a cooperative practice. The midwives in the practice control their finances, they decide how many clients they would like to see and they have their own call rotation. Furthermore, if Sandy feels like she needs to consult with the physician, she and the physician then collaborate on the care of the client. They respect each other's opinions and they support one another. Sandy explained that the

doctor she collaborates with was trained in medical school with nurse-midwives, which significantly impacted his willingness to work with nurse-midwives.

Ingrid practices with physicians in a private hospital wherein she is able to attend births without a physician present, and she has access to their help if it is needed. Working at a university hospital, Sarisha is always surrounded by doctors and residents. However, she explained some doctors feel indifferent to her practice of midwifery while others question it.

> We bring who we are, and some of the attendings don't care what I do. You're fine, you're fine, that's fine Sarisha, I trust you, that is fine and some of them are like what are you doing, why are you doing that? (laughs) It depends a lot who you are working with. At (specific hospital) we have 5 physicians in the unit all the time during labor. There is 1st, 2nd, 3rd and 4th year and an attending who are close by. There is always a physician close by. But because they are doing what they are doing, a lot of the time they are not focusing on what we are doing. They will let me do what I want to do.

Wooten and Crane found that nurse-midwives were able to practice unhindered and supported by a hospital; similarly, some nurse-midwives in this research project practiced autonomously. As described by Rothman, the midwifery model of care and the medical model of care (or as Davis-Floyd labels them, the technocratic model of birth and the holistic model of birth) are strikingly different. Physicians and/or hospitals are not obligated to support nurse-midwives, and insurance companies and hospital policies often discourage such support. The acceptance of nurse-midwifery by some physicians addresses Jordan's assertion that authoritative knowledge can be fickle; knowledge may be valid in some situations and it may not be in others (1997).

Navigating Midwifery and Medicine

Nurse-midwives also discussed their struggles to define themselves or their practice of midwifery within the hospital and the larger medical community. Sandy describes the challenges to the medical community negotiating the nurse-midwife entity. "I'm constantly being put into situations where people don't understand who I am and what I do because I don't fit in anybody's niche. Hospital by-laws have to be changed because we are not doctors, not medical doctors, were not D.O.'s, we're just different from everybody so it's always a problem. I'm always having to explain." Hospitals wrestle with how to fit nurse-midwives into the system while nurse-midwives can struggle to fit their practice of midwifery into the medical setting. All of the midwives expressed difficulties they faced practicing midwifery in the hospital. As mentioned in an earlier section, those that practice in the hospital sometimes do work to balance the needs of their clients and the demands of the hospital. Ingrid explains:

> I think working in the medical culture limits us a little bit. I feel like with patients I am constantly dancing, bowing to her needs, then what her pregnancy may be presenting, and then what the physicians are comfortable with. I had a patient whose baby was breach who needed a C-section and this is a patient who is a therapist who believed very strongly in primal health stuff, believed in the value of labor and getting things ready for life. So, what her question was, "Why can't I labor and if the baby doesn't turn you do a C-section? Why do I have to schedule a C-section?" The real answer was because the physician really wanted to do a section during daylight hours not at 3 o'clock in the morning. It was this whole dance in that and then she really wanted a birth, needing a C-section. How do we do that? How do we create this? She had the anesthesia, she didn't want her arms tied down, she wanted to see the baby, she wants skin to skin and she wants the lights out in the OR. Of course everybody rolled their eyes, and she wants to have her Christmas lights and she wants her IPOD playing, and she wants it absolutely quiet and nobody talking, you know all of this stuff and then just balancing that with what is needed medically. I just feel like I am always doing a dance.

The midwives I spoke with all explained struggles to fit their practice into a medical environment; however, some of the nurse-midwives described that the challenge may not be present for all nurse-midwives. They discussed how some nurse-midwives practice in a very medical way, suggesting that each midwife understands her responsibilities of midwifery differently. Thus the medical environment may also impact midwives differently. Sarisha and Ingrid discussed different types of practices:

Sarisha: …You have that end of the spectrum and you have people that are very, very they see birth as totally innocuous and something very safe and it is different. And then the other end of the spectrum you have nurse-midwives who learned in schools that really focused on the medical model, and so they learned midwifery from a medical model. They practiced as though, we call them mini doctors or junior residents or want-to-be doctors or something like that…

Ingrid: Medwives.

Sarisha: So they really are at the other end of the spectrum. They may as well be physicians. They are mid-level providers that may as well be physicians. The rest of us are kind of sprinkled around the rest of the spectrum and we are sprinkled through the middle…

Obstetricians and hospital staff sometimes do not respect or appreciate the practice of midwifery. Midwives often involve alternate techniques or follow different timelines that challenge the medical definition of "normal" birth. Some nurse-midwives explained situations where doctors questioned their practices and challenged the validity of their approach to caring for a laboring woman. Nurse-midwives have a constant challenge to practice midwifery, to attend their clients with guidance, support and presence, and to hold off the pressures of authoritative knowledge in the hospital (Wagner 2006: 111).

Nurse-midwives' practice are dependent upon supportive doctors or restrictive policies; in addition, they navigate midwifery in a medical environment. The

relationships between nurse-midwives and physicians (and the larger medical community) expose some inner-workings of medicine as authority in childbirth and the alternative knowledge of midwifery working within the medicine system. As highlighted by Jordan, authoritative knowledge is situational (1997). Some doctors incorporate midwifery knowledge into their understanding of birth while others distrust midwifery. From my research it seems that one of the larger struggles is the authoritative knowledge of the insurance companies, and perhaps doctors using insurance as a vehicle to fend off competition from midwives. Before some doctors have a chance to consider or incorporate nurse-midwifery, insurance companies cry liability risk. The authoritative power held by insurance companies' considerations of childbirth can trump a doctor's intentions. The above shows how nurse-midwives' struggles to practice apply to Jordan and Davis-Floyds explanations of authoritative knowledge.

Goals and Hopes for the Future of Midwifery

Midwives are excited about the future of midwifery in Virginia. They are encouraged by the potential for growth of midwifery and the spreading of positive changes in birth. The findings discuss certified professional midwives and certified nurse-midwives separately.

Certified Professional Midwives Goals

Sitting in Ann's living room surrounded by fourteen women, some sitting cross-legged on the floor while others sit two to a chair, I realized this is where many of the ambitions of midwifery in Virginia are brought to discussion and placed into action. They may come to fruition in another locale but amidst the children running through the house, the potluck lunch buffet cluttering Ann's kitchen counter (lovingly assembled by each woman in attendance) and the mid-afternoon sun streaming in through a wall full of glass doors, this is where it happens. The delegating of responsibilities, the ideas placed

on the table, the issue discussed, the voting-"we operate by consensus, I don't think we have consensus," and the awesome consideration of others-"do we have any Jewish sisters that this date might interfere for?" takes place on Saturday afternoon in the rolling hills of Virginia over cups of hot tea and fresh pressed coffee and a lunch as colorful as a rainbow.

Two themes surfaced from the CPMs as goals and hopes for midwifery in Virginia (see table 4 in Appendix A). Those involved in practicing and facilitating the growth of direct-entry midwifery in Virginia are concerned with the maintenance and expansion of midwifery and they are committed to building relationships in their communities. Most of the midwives laughed or smiled when I asked them about their desires for the future of midwifery in Virginia. I heard things like "I am trying not to have too many goals," "don't tell anybody but we just rode that train," and "I just still feel like I am holding on with my fingernails." Several of the midwives I spoke with were part of the core group that pushed the legalization and licensure bills through the legislature. These comments were surrounded by laughs as they quickly jumped into discussing their next steps. However, it was clear that they hoped these goals would not be nearly as arduous as their previous work.

Maintenance and Expansion

Many CPMs spoke of maintaining what has already been accomplished legally as part of their objective for the future. Ann contends:

> … I think that we are all kind of perched to defend what we have worked so hard to create. And we have to remember that we got to this place, and we have to hold it. You know we can't just take a big breath and say okay we've done it now. I mean we still have a lot of work just to maintain that, and I think it is a major part of what we are all doing as well.

CPMs, through the Commonwealth Midwives Alliance (CMA), have a paid lobbyist in Richmond who is responsible for helping to "maintain a positive presence" for CPMs in the state legislature. CMA also sponsors an annual midwifery breakfast for the delegates in Richmond whereby some representatives of the CMA—midwives, home-birthing mothers and babies—attend to "let them know how well licensure is going." This is important for future legislation as legislators change. Having a consistent presence is crucial. The CMA does have work they would like to do with their bill[4] but there is a hesitancy in opening it up as it may result in adding restrictions.

Many midwives discussed wanting to expand their practice to include Medicaid clients and some mentioned wanting to increasingly serve immigrant populations. They felt that being able to serve Medicaid clients could open up their practice, and they are still networking to figure out how to make that possible. They are also interested in the development of informal networks of support for midwifery apprentices around the state. The number of apprentices in the state is growing and some of the veteran midwives expressed the importance of resources, such as birth circles and study groups, and support for the midwives-in-training.

Meredith: The heart of this whole movement has been grassroots, and I think it still is. Now, as each midwife, we are [particular region] Virginia midwives, getting together and building relationships. Each of us in our own practices building relationships with physicians and sharing that information and hopefully seeing that continue to grow.

Laura: A lot of little cluster groups around this state are forming too. Birth circle groups, midwifery study groups, church groups, all kinds of different groups to discuss birth options, midwifery directions and it is great.

Corey: And that is growing.

Laura: Yeah, everywhere. That is growing around the state.

[4] CPMs would like to have legal access to eight controlled substances that they are currently unable to legally possess.

Midwives were particularly excited about the increasing number of apprentices training in Virginia. Several of the midwives I spoke with had a number of women serving as their apprentices. As one midwife pointed out, the rising number of apprentices really accounts for the flourishing of midwifery in Virginia.

Genie: Right now, you've got Michelle and me who are actively practicing midwives. Ann is a midwife but she is not practicing. The rest are students. So, I think that we have major expansion going on here.

Michelle: Yeah.

Genie: And in the next five years we are going to have a hundred midwives in Virginia and if each one of us does our little part to promote it to our communities we are going to be serving a lot more women.

The growth of CPM apprentices in Virginia speaks to the consumer demand for home birth and the benefits of the CPM licensure. In Virginia both consumers and midwives wanted home birth options and advocated for the legalization of direct-entry midwifery; in this way the market for direct-entry was created and the CPM licensure filled the need (Davis-Floyd 2006b: 181-185). Davis-Floyd explains that two years after the legal licensure of CPMs in Vermont the rates of home birth doubled there. The home birth rate in the country hovers around one percent, regarded to be not because of disinterest but because of inaccessibility. However, in locations like Seattle, where CPMs are reimbursed through insurance, the home birth rate is eight percent. The CPMs in Virginia are excited about the increasing number of apprentices and licensed midwives. All of the midwives-in-training at the CMA meeting were serving as apprentices to CPMs. Simonds suggests that as more college educated women chose direct-entry midwifery as a career that apprenticeship training will fall out of favor. "…[T]he educational route could eventually entirely replace the apprenticeship route"

(Simonds 2007a: 145). Interestingly, all of the midwives-in-training (ten women) at the CMA meeting were serving as apprentices to CPMs. Apprenticeship is at the core of direct-entry midwifery and direct-entry midwives value the connection they have with other midwives. Also, apprenticeship may be more appealing to people who cannot relocate to attend a formal school or who need the time flexibility that apprenticeship offers. From my interactions, I suggest that apprenticeship is alive and well in Virginia and, in fact, is currently central to the expansion of CPMs in Virginia.

The excitement about the expansion of CPMs was so enthusiastic that it ended one of the focus group meetings. A discussion of the future goals of midwifery was abruptly ended as old and new friends entered the room exchanging hugs, and within moments the crowd exploded with cheers. "Yeahhhhhh! Claudia! She is our newest licensed midwife. Yeah number 22!" The dream continues to build as each new CPM is licensed.

Building Relationships

Some midwives also discussed their hopes for an increased connection with certified nurse-midwives. In other states ACNM chapters have come out against the licensure of CPMs; however, the Virginia Chapter of the ACNM did not oppose the CPM legislation which CPMs perceive to be an optimistic step.

Dawn: …For me I would like to see midwives in Virginia be a group that unites the CNM and the CPM. That is really…

Meredith: We are considered absolute forerunners nationally in terms of CNM and CPM relationships.

Dawn: I did not know that.

Meredith: They think on the national level, they think Virginia because of the fact that the CNM didn't oppose the CPM legislation… They moved they started in a neutral position and then they came out and supported and then they kind of moved back to neutral but there was always, if they couldn't officially support there was behind the scenes support.

The CMA does not have any legislation this year but they will be actively supporting the legislation that the Virginia ACNM chapter is trying to pass. Just recently the CMA decided to become "friends" [5] of the VA ACNM. They felt this would be another step toward them, and it would show their statewide support. They are hoping that this will create more opportunities to send referrals to one another. Furthermore, the CMA and the ACNM are coming together to support positive change on birth. Meredith shares:

> There are two events where the ACNM and the CMA are joining forces publicly working for the common cause of promoting positive change in birth and that is what we have found is finding language that we can all agree on. I remember going to a CNM meeting, I can't remember if it was before or after the bill passed, and tried to sort of say let's find the words we can agree on. We don't really need to focus when people ask what is the difference. It doesn't help us. We can sit there and do that but it sounds like a judgment. The sameness is that we all try to meet the needs of the women we serve. So, the difference is that we may serve a different population but the sameness is more at the heart of what we talk about. We talk about what a midwife is. We listen to women.

While CPMs acknowledge a difference between the two groups, they seemed focused on the likeness between their work and they are interested in setting aside dissimilarities for the common good of serving women and babies. Ann expresses:

> How I see them is that in my vision they are sisters and that they are harmonious and they hold hands and walk into the sunset and catching babies left and right…my vision is that they really work together. I know that the CNMs just had a huge bill that allowed them to hopefully be able to practice in Virginia without physician backup. And that bill could have never been passed if the CPMs hadn't

[5] Becoming a "friend" of the VA ACNM involves support through a membership fee, and through membership, it encourages members to "stay abreast of issues affecting nurse-midwifery in Virginia." The VA ACNM also requests thoughts and feelings of its members regarding the chapter's goals and projects.

> had their bill. So, they were able to kind of use the path that we had scored for them in order to change some things that they didn't like.

There are differences between CPMs and CNMs and their practices may be more similar in some instances and starkly different in others, but at the core of their practice is serving and supporting women and babies through pregnancy and birth. To gain more autonomy and credibility in midwifery childbirth practices in a medically dominated culture, coming together to support "positive change in birth" is a desirable option. Joining hands is experienced as a powerful opportunity by CPMs. This notion of similarity contrasts Hunter's finding that nurse-midwives and direct-entry midwives had different allegiances creating disconnect between the groups (2004). Some CPMs and CNMs in Virginia have come together focusing on their similarities and working for a common goal.

Organizationally, Davis-Floyd believes the animosity between the two groups, ACNM and MANA is beginning to decline (2006a). However, in contrast, Simonds and Rothman explain that direct-entry midwives are cautious about CNMs. "The direct-entry midwives…have reason to fear that the CNM will be destructive of the larger goal: co-optation is scary…Move a few CNMs into the local hospital, or let the local OB hire a couple of CNMs in her practice, and of course the direct-entry midwives lose clients and community support, and become seen as the lunatic fringe" (Simonds and Rothman 2007: 290-291). Meredith does not express the competition that Simonds and Rothman refer to; rather, she explains that they are serving different populations. Coming together they want to focus on what is really at the depth of the matter.

CPMs are two years out from the legal licensure, and they are now focused on making relationships in their personal communities. Some CPMs described the newness

of being able to vocalize their profession as a refreshing sense of freedom. Developing the CPM credential, and simultaneously the professionalization of direct-entry midwifery, was a double-edge sword for MANA and MEAC (Davis-Floyd 2006a). They were concerned that the professionalization of direct-entry midwifery could have consequences on the essence and substance of midwifery care. However, many direct-entry midwives wanted to alleviate the threat of potential arrest and to practice without fear of ill-treatment for their clients during a transfer. The CPMs I spoke with had an acute awareness of the development of standards for direct-entry practice and its potential threats to their model of care. With that awareness, they were satisfied with the CPM licensure, and they were energized by the options available to them as professionals.

CPMs were interested in developing transport guidelines and protocols with their local hospitals and EMS. One midwife had already accomplished this with her hospital while others, as part of the CMA group, were working on creating a professional packet and presentation to share with hospitals and EMS staff. Furthermore, they plan to promote and educate their communities about midwifery. Increasing public awareness of midwifery and the options of midwifery care is a goal of the CPMs. Some CPMs felt that midwives were responsible for promoting midwifery within their community. Meredith mentioned that traditionally a midwife was someone who networked in the community and part of being a midwife was "putting yourself out there in the community." These thoughts and goals are each congruent with Davis-Floyd's descriptions of a postmodern midwife. The postmodern midwife is savvy, networking and negotiating the medically dominant culture to satisfy the needs of her practice and her clients (Davis-Floyd and Davis 1997; Davis-Floyd and Johnson 2006). They are "…midwives who are educated,

articulate, organized, political, and highly conscious of their cultural uniqueness and their global importance" (Davis-Floyd and Davis 1997: 320).

Certified Nurse-Midwives Goals

> *My new line is that having a degree in midwifery means you have a degree in eternal hope, always have hope.*
>
> *Ingrid, CNM*

Nurse-midwives' goals for the future of midwifery merge into two general themes (see table 5 in Appendix A). Each in their own way, nurse-midwives are advocating for and promoting midwifery within the medical community and encouraging the growth of nurse-midwifery. Furthermore, they desire improved relations with physicians and/or developed relationships with certified professional midwives for the betterment of pregnancy and birth.

Advocating, Promoting and Encouraging

The Virginia chapter of the ACNM recently lobbied for funding to start two birth centers in areas that are impoverished and/or where women are underserved. The state granted them funding for two executive director positions. They are in the midst of deciding where to build the centers and how to obtain the additional funding that will be needed (Virginia Chapter of the ACNM 2007). Nurse-midwives historically were invested in serving underserved populations (Rooks 1997: 389), and this funding can further contribute to this work. Nurse-midwives are confident in the potential and capacity of midwifery to alter situations for better encouraging a change in the medical approach to childbirth. Thus nurse-midwives are promoting midwifery to reach women from all different regions, socioeconomic status and backgrounds.

Teresa is hoping to increase women's access to nurse-midwifery care and simultaneously to increase job opportunities for nurse-midwives, as she has been working to open a birth center for several years.

> There are women here who are talented, educated and they need to be able to stay here and raise their families and be able to practice their profession without moving out of the state. So, I resent that. There are women here who would make excellent midwives but they can't go and get the clinical because they have to be here. Working a job or taking care of their kids. That is my goal is that everyone women should have the option of midwifery care. So that is where I am going with it. We need more midwives.

Furthermore she is involved in promoting and practicing "group prenatal care"[6] which she hopes to incorporate into the birth center. Sarisha is also involved in facilitating "group prenatal care." She visits medical schools giving presentations on the concept of "group care" hoping it will be valued and continue to grow. Sarisha expresses that this may be one way to infiltrate the medical model of pregnancy and childbirth. One of her goals is to reduce the power of the residents and physicians while increasing the power of women.

Some midwives shared a desire for physicians to be trained with nurse-midwives. Sandy explained that when medical students are trained with nurse-midwives they "get it"—they understand what midwifery is and its benefits. She feels that this would be a significant boost to the acceptance of midwifery by physicians. Sarisha works in a medical college. Although physicians are not trained with nurse-midwives, she is encouraged that her presence in that environment may influence some residents. Johnson and Davis-Floyd suggest that increasing physicians' knowledge of midwifery and their

[6] Group prenatal care involves a doctor or midwife meeting with a group of pregnant women, all with similar due dates. This encourages peer support for the mothers while decreasing the power of the physician or midwife in the situation. This was designed with the intention of increasing clients' authority and autonomy in pregnancy and birth while decreasing the authority of the physician or midwife.

exposure to midwives will lessen the barrier between midwives and physicians (2006a). "Some doctors train in hospitals where nurse-midwives practice and thus are able to observe first-hand the benefits of midwifery care. Physicians we have interviewed are often awed by the midwife-attended births they witness…" (Johnson and Davis-Floyd 2006a: 500). While the possibility of nurse-midwives and physicians training together in Virginia is an aspiration, Virginia is also lacking a location for nurse-midwives in-training to do their clinical work. Teresa explained that the growth of nurse-midwifery is restricted because Virginia does not offer clinical opportunities. There is a nurse-midwifery graduate program in Virginia but it does not offer clinicals, and physicians are not trained there.

There is an expressed lack of employment for CNMs in Virginia. Opening birth centers, training doctors with nurse-midwives and increasing educational opportunities for CNMs in Virginia could create new employment options for nurse-midwives.

Relationship Building

CNMs would like better relationships with physicians and the larger medical community. Katie expresses that she would like improved connections with physicians—even if they do not theoretically support nurse-midwifery creating better health care opportunities for pregnant women.

> Even if the medical community can never acknowledge that home birth care by midwives is shown to be safe, whether they are a nurse-midwife or if they are not a nurse-midwife…Even if they can't support that, if somehow we could just interface better. I just think that the women in Virginia would only benefit and certainly midwives would too.

Most midwives expressed a desire to increase the availability of collaborative relationships with physicians; they were often frustrated with physicians perceiving them as competition.

Sandy expresses her desires:

> I would like for the medical community and the midwifery community to become more collegial. I think doctors are sometimes threatened that nurse-midwives want to be entirely independent with no association with doctors. And that's not ever really been the goal of nurse-midwives anyway. I like having a collaborative relationship with physicians, I like working together. I think teamwork is the best approach. So, in my dream that realization would spread all over, you know. It would be nice if we could engender some kind of a medical culture like they have in most of the European countries where midwives take care of most of the lower risk patients and doctors take care of most of the higher risk patients.

Nurse-midwives envision a relationship with doctors built on equality and mutual respect for each other's skills. Better relations can increase the opportunities for certified nurse-midwives to practice and promote better health for women.

The Virginia ACNM did not oppose the CPM legislation, a monumental act between the two groups when compared to other states, creating an advanced opportunity for a relationship to develop. As mentioned in an earlier section, CNMs and CPMs are currently collaborating in Virginia to support "positive change in birth." All of the nurse-midwives in this study supported CPMs through licensing and promoting positive change in birth. One nurse-midwife expressed personal uncertainties about collaborative practices. She supported certified professional midwives (in fact her daughter was planning a home birth with a CPM at the time of our meeting) but was unsure how and if a collaboration might work. Some nurse-midwives were interested in connecting with the community of certified professional midwives and some expressed desires to associate professionally with certified professional midwives. Some CNMs already have

established associations with CPMs. Katie, a home birth CNM, and Dawn, a CNM training to be a CPM, each felt connected to the CPM community, and they appreciated the knowledge and support they felt from the CPMs. Katie said, "…[T]here are two to three of them that I feel particularly close to, that I think it is all understood that if we are up in the middle of the night with a difficult labor and we need somebody else's hand even if they are two to three hours away, we can at least call them and say hey what do you think?" This is an example of how midwives construct knowledge based on a horizontal plane rather than a vertical plane (Davis-Floyd and Davis1997). Katie consults with CPMs regarding her practice of midwifery, and as mentioned earlier Katie would also like to consult with physicians. She is open to incorporating various types of knowledge into her understanding of pregnancy and childbirth. This confirms Davis-Floyd's assertion.

The licensure of CPMs allows CNMs and CPMs to consult publicly, advancing and hopefully expanding their network of support. Some CNMs mentioned an interest in practicing cooperatively in association with CPMs. Ingrid shares:

> I think it would be awesome. I think there is so much to learn from each other… so I see that as flowing and then you are the CPM at a home birth and you have a problem then you can bring that patient to wherever I am and that patient is still going to get midwifery care. Then if more problems develop we then move her on to a physician who is at least very sensitive and aware of midwifery care and what that means.

Some midwives mentioned the power of the consumer advocacy that pushed for the CPM licensure. As nurse-midwives have, for so long, worked from inside the medical system to assert independence, they may be motivated to engage other avenues of support. Ingrid explained that the future of nurse-midwifery in Virginia is dependent

upon consumer advocacy. Her nurse-midwifery position at the hospital was created as consumers demanded nurse-midwifery care.

> Then, it just spreads and spreads and spreads, because what is going to make midwifery successful is women. It is the community demanding it. I am where I am because the community spoke up, people called (inaudible), they wrote letters they said, "We want midwifery at (specific hospital)." When I got laid off, it was at another practice, (specific) hospital had not opened yet. The plan was that the midwives were going to be at (specific hospital) and then we got laid off. Now there were not going to be any midwives at (specific) hospital. The community, they picketed, they protested, they wrote letters, and here I am and I have twelve people due every month. Which the powers that be are blown away at the demand, I am like (inaudible) because the community wanted it, and I think state wide that is what is going to happen. That is what I believe.

As CNMs are increasingly out of work in Virginia, and there have been several large firings of nurse-midwives practicing in Austin, San Antonio, New York, Cleveland and Washington, D.C., nurse-midwives may progressively engage more consumer support (Daviss 2006: 420; Wagner 2006: 125).

Certified nurse-midwives expressed a decrease in job opportunities for nurse-midwives in Virginia. They are promoting nurse-midwifery within the medical community hoping to increase the opportunities for nurse-midwifery. They are also hoping to build better relations with physicians. Some are increasingly interested to engage with CPMs, and they are encouraged by the power of consumer advocacy to obtain a more independent presence in the medical community.

Chapter 7: Discussion

This research project was an exploration and an examination of midwifery in Virginia; consequently, many questions and topics have arisen which deserve further consideration.

There is a lively discussion amongst midwives and academic communities concerning midwifery as practiced by certified professional midwives and certified nurse-midwives. Nurse-midwives and direct-entry midwives have questioned and debated "who is a real midwife?" (Davis-Floyd 2006a: 40). This research confirms the complexity of that question. Many texts discuss the differences and similarities between nurse-midwives and direct-entry midwives. Through my research I found that both CNMs and CPMs explained their roles as midwives in the same terms. Simonds and Rothman suggest that the difference is not between the groups of midwives but really between the value systems under which each group develops.

> These are not just different occupational groups. These are different worldviews, different value systems, despite their common source. And the difference is not necessarily between the two types of midwives but between the systems in which they operate. So while their attention may be drawn to each other and their fears may be for the damage each can do to the other, it is the medical system that creates the conditions under which these conflicts arise (Simonds and Rothman 2007: 291).

Simonds and Rothman indicate that the medical community has created and complicated this issue. Developing within different value systems, midwives' practices are affected, and perhaps their realities are jaded by the long shadow of the medical system. Despite the differences between the groups, I found it striking that both nurse-midwives and certified professional midwives described their role(s) as midwives in the

same manner. This suggests that at the core they are really more similar than is often discussed, and it signals the inability of the medical system to co-opt nurse-midwives to a more medical approach to childbirth.

Simonds and Rothmans suggest that the value systems create these two distinct entities of midwives and the findings of my research further complicate this discussion. Both nurse-midwives and certified professional midwives explain their roles as midwives similarly. Each group explained their responsibilities to educate women about birth, guide them through pregnancy and birth and guard the birth process. It is important to acknowledge this finding in relation to Simonds's and Rothman's discussion. They suggest that nurse-midwives and direct-entry midwives are not just different occupations, but that they hold "different worldviews." Despite the differences of the value systems and alternate world views expressed by Simonds and Rothman, my research finds nurse-midwives and certified professional midwives embracing similarities in regards to the way they explain their role(s) as midwives. While Simonds and Rothman explain that the medical system creates conditions for conflict to arise between the two groups, my research suggests that the medical system has created the conditions, and increasingly opportunities, for the nurse-midwives and certified professional midwives to be in accord with one another.

Further adding to this discussion, I became aware of a connection between the two groups that I had not anticipated. Some of the CPMs had worked in a medical field, and some of the CNMs had personal experience with direct-entry midwifery. I spoke with CPMs who had worked or were currently working as labor and delivery nurses; other CPMs worked in a medical profession prior to training as a CPM. Also, I

interviewed a CNM who is studying to be a CPM, and I talked with a CNM who was first trained as a direct-entry midwife and who associated socially more with CPMs than CNMs. In my research the line between CPM and CNM was not nearly as firm as I envisioned. This suggests a division between direct-entry midwives and nurse-midwives that is not clearly defined, a blurred division between the groups; potentially, this could have various implications for the growth of midwifery in Virginia and the nation. This could dissolve the divide that previously existed between the two groups; this could shed light on the burning question "who is a real midwife;" and it could increase networking and connectivity for midwives. Having connections in both arenas could advance opportunities for midwives and possibly increase the options available to pregnant women. This also questions Simonds and Rothman's discussion that midwives develop under different value systems. If midwives cross over into alternate systems-for example, if a CPM studies to become a CNM—then they are actually a product of both systems and perhaps they really are not more a product of one than the other. Furthermore, this reality could be midwives' reactions/responses to the conflict set up by the medical system.

The professionalization of the CPM in Virginia has allowed CPMs to act as independent agents procuring goods and services as needed. Crucial to being in the position of independent agent is the networking and communicating. The opportunity to actively seek consultation has been a significant change for CPMs, and it often becomes an important topic of conversation when they gather together. Discussing supportive doctors was an important means of informal networking for the midwives. During both of the focus groups with CPMs, the conversations about their individual experiences with

physicians veered to sharing notes on which physicians were willing to help midwives and their clients. One midwife would mention the name of a supportive doctor that other midwives may not have heard of, then they would inquire about the doctor. This opened potential resources to the midwives and increased the potential for positive interactions with physicians.

Dawn: Some of it is the community support of family doctors willing to give RhoGAM if the family has been to his practice. We have somebody in Avondale who is willing to do that and that helps a lot. So, we are sending everybody to him. He gets all of our clients because he is willing.

Laura: Is that Jones or Gardner?

Dawn: Jones.

Laura: Are you all using Gardner, too?

Meredith: I have never heard of Gardner.

Dawn: They do births too. So, that is a possibility.

Meredith: A pediatrician who does births?

Dawn: No a family practice.

Katherine: He has been around a long time hasn't he? He was here when we lived here.

Meredith: Why have I never heard of him?

Laura: When I was a kid doing medical transcribing at XYZ he was a resident.

Katherine: Yeah.

Meredith: What was his last name?

Dawn: Gardner. Bob Gardner.

Dawn: He is with Colby, Simmons and Gardner. They are in a family practice group. That is good to know. We are always looking.

Listening to their interactions, I realized the immeasurable value of informal networking for certified professional midwives. Meredith explained that "grassroots activism" and informal networking was the heart behind getting the CPM licensure bill passed. The conversation in the focus group cited above was one of many occasions where one CPM was sharing with another CPM a resource to potentially help their practice. I heard discussions concerning where to get certain tools, how to perform particular procedures and convenient places to have lab accounts. Informal networking was cited as the force pushing CPM licensure through the legislation, and this study gives testament that informal networking and communicating is vital to the expansion and growth of certified professional midwives in Virginia.

Conversations and connections made during the focus groups speak to the potential of feminist methodology to empower participants during the research process. Meeting as a group not only allowed the midwives opportunities to collectively share their stories; it also created an opportunity for the advancement of their practices increasing their resource base. This addresses the value of feminist methodology—facilitating focus groups or arranging opportunities for participants to come together encourages "the advancement of an agenda of social justice for women" (Madriz 2003: 364). The above discussed conversation occurred during a focus group, and I was quietly ecstatic witnessing first hand the significance of feminist methodology. Encouraging participants' voices throughout the process, a flexible research schedule, a semi-structured interview format, and incorporating multiple methods allowed participants various opportunities to bring up topics and discussions of consequence and meaning for

them. All of these factors contribute to feminist methodology encouraging the empowerment of participants.

Whereas certified professional midwives were interacting with physicians and the medical community as free agents, certified nurse-midwives were engaging with the medical community from within. CNMs are more dependent on the medical community to support their practice. As mentioned earlier, Ingrid believes what will change nurse-midwifery is not the medical community, but women demanding nurse-midwives and better maternity care. As many CNMs currently find themselves unemployed, they may seek alternate means to gain increased autonomy. In Virginia, CNMs have witnessed and supported the CPMs in their objective to obtain licensure and autonomous practice. Some of the CNMs were interested in the idea of increasing relations between CPMs and CNMs, believing these connections could be avenues to increase support. Consumer support was key to the success of CPM licensure, and I speculate that some CNMs may progressively want to invoke more of a similar presence of consumer support. Wagner claims that for CNMs to gain autonomy they need to assert themselves as independent of the medical community.

> Another key strategy for midwives must be to push for autonomy—recognition that midwifery is an independent health care profession with its own certification, licensure, and state boards—and for an egalitarian relationship with doctors. From the beginning, nurse-midwives elected to join the nursing and physician camps in order to survive, though midwifery is not the practice of nursing or medicine. They did survive, so they can't be faulted, but now they're faced with the hard task of extricating themselves from both camps. Direct-entry midwives have taken a lot more heat for being out-of-hospital independent practitioners, but, in their position, achieving autonomy, though not easy is less difficult. (Wagner 2006: 125).

I did not hear any nurse-midwives express a desire to divorce themselves from the medical community. They mostly discussed working for change from within—increasing occasions for doctors to train with midwives, altering doctor and client relations through prenatal group care, and working to develop opportunities, such as birth centers, for autonomy in nurse-midwifery. Consumers were in part responsible for nurse-midwives' first acceptance into the hospital during the Alternate Birth Movement, and as Ingrid explained, mothers were successful in demanding a place for nurse-midwives at the hospital where she is employed. If other CNMs feel like Ingrid—that women are the key to change—there could be an increased movement toward engaging consumers to effect change. Virginia could be an opportune site for this type of development considering the growing relationship between CNMs and CPMs in Virginia, and the supportive consumer base.

Medical authoritative knowledge in childbirth makes the medicalization of childbirth appear "natural." As Jordan explains authoritative knowledge is invasive, establishing what seems to be a natural order, where "all participants come to see the current social order, that is, the way things (obviously) are (1997: 56). "It is the knowledge that the community sees as legitimate…and appropriate for justifying particular actions by people engaged" (Jordan 1997: 58). Culturally, this sets the stage for what expecting mothers seek in maternity care. Through my research it becomes more clear that medical authoritative knowledge not only informs consumers of the way birth happens, but they are actively restricting the options available for birth. Some women and families want a medicalized approach to birth—they want to know the sex of their baby prior to birth and/or they want to plan the day their baby will be born via

induction or elective cesarean. The degree of their commitment to these decisions can be speculated as influenced by the deep-rooted medical approach to childbirth in the United States. However, some women do not subscribe to a medical approach to childbirth. They support midwives and alternative options in birth; accordingly, midwifery threatens medicine's hold on childbirth. While the medical community restricts options, midwifery creates alternatives. Midwives historically lacked resources and educational credentials to support themselves and influence institutions (Rooks 1997). Furthermore, the communities they served also lacked a privileged voice, preventing them from supporting midwifery through consumer advocacy. Some of the burdens of the past still confront midwives, but through licensure and the power of consumer support midwives can now publicly advocate for themselves. Increasingly, consumer advocates and midwives contribute to the public knowledge of childbirth informing expecting mothers of alternatives for birth.

Hartley suggests that the increased use of managed care will increase the number of nurse-midwives practicing (1999). This study questions Hartley's findings, as all of the nurse-midwives in this research discussed a lack of job opportunities for nurse-midwives in Virginia. As nurse-midwives suggest in this research, physicians have a strong hold on the future of nurse-midwifery: they are often the composers of hospital by-laws restricting the entry of nurse-midwives; commonly they are unwilling to collaborate with nurse-midwives; and as in the situation of XYZ Insurance, physicians own insurance companies that limit nurse-midwives through reimbursement. Physicians have considerable power protecting their specialty of obstetrics. A lack of positions for nurse-midwives may be specific to Virginia, but Wagner (2006) and Daviss (2006) report large

lay-offs of nurse-midwives in other states suggesting this is not just a Virginia issue. While Hartley predicts an increase in the number of nurse-midwives and a decrease in physician dominance, the nurse-midwives in this study are experiencing a lack of available jobs for themselves and their nurse-midwife friends. This finding prompts further investigation into the effects of managed care and the stronghold that physicians have in deciding the fate of maternity care.

Chapter 8: Conclusion

The purposes of this study were to explore the work of midwives and their experiences with the medical community, and to examine their goals for the profession of midwifery in Virginia. I approached this research using a feminist methodology engaging in individual interviews, focus groups and attending two midwifery meetings to collect data. The theoretical concept of authoritative knowledge was used to investigate midwives' experiences. This research confirms the struggles of midwives to practice in a culture that defines childbirth as a medical event. Midwives historically were challenged, and still are challenged, to practice midwifery in the United States. However, certified professional midwives' legal status in Virginia has challenged the dominance of authoritative knowledge in the hospital, and nurse-midwives' practices of working with physicians and presenting alternate forms of prenatal care have all stretched the prevailing notions of pregnancy and childbirth. This research also highlights the progress of midwives as they have goals to advance midwifery and the health of women and babies. Rooks explains that the United States has "lost [the] culture of the normalcy of birth" (1997: 463). I think this research is verification of the truth of Rooks's statement *and* testimony to midwives' commitment to creating, holding, facilitating and expanding a space for birth in our culture.

As women infiltrate typical male domains and occupations, for example the male medical model having authority on childbirth, their presence is accommodated (however reluctantly and to varying degrees), but they are expected to assimilate to the prescribed definitions of that space. They are expected to assume the values and skills of that male domain. Medicine is the prevailing authority on childbirth, making it somewhat

unthinkable that someone would consider an alternative. Just as Pierce found when researching female lawyers working in a stereotypical male occupation, women were expected to adopt a "male" approach to their work (1995). The value system was already in place, and to be successful they had to take on stereotypical masculine qualities. To go outside the typical aggressive lawyer tactics was not tolerated. While women increasingly infiltrate male dominated territory, as midwives and more directly nurse-midwives have done, they face resistance to their presence. They challenge the dominant authority with different values and appreciation of skill. The larger struggle is altering the base of what is seen as knowledge and its value. Midwives have increasingly been able to use scientific evidence to support midwifery in the United States; furthermore, the power of grassroots and consumer support can yield change.

Midwives seek to educate and empower women through birth, and it is not surprising that midwives and proponents of midwifery translate these core values into an active and thriving grassroots movement. Women's abilities to make choices about their bodies have been restricted repeatedly, affecting different communities in different ways. Forced sterilization, restricted access to abortion, and limited access to health care have all been imposed, causing women (and men) to go outside of the system to advocate and create change. Grassroots movements have been successful in the past to effect change on societal institutions. Nurse-midwives have been working for change from within medicine for decades. During the Alternative Birth Movement, which was a segment of the Women's Liberation Movement, women demanded different services from hospitals and increased options for care. Hospitals and doctors accommodated them to a degree; however, they never relinquished control of defining childbirth and pregnancy. Allowing

nurse-midwives in, but still maintaining some control over their practice, has prevented the midwifery model from flourishing under the medical establishment. Nurse-midwives have seen direct-entry midwives succeed in reaching autonomy through grassroots support; they are increasingly engaging with direct-entry midwives, perhaps interested in the power behind those movements, as they have successfully created change. CNMs and CPMs in Virginia have promising interactions particularly when compared to other states in the country. This is significant as Virginia is regarded as a potential model of relations for other states.

This study is limited in that I had a relatively small sample. There are many voices that were not represented in this paper. Increasing the size of the sample may invite a wider range of responses and ideas. Nevertheless, the combination of methods was valuable to the depth of the project. It would have been impossible for me to appreciate and understand midwives had I not engaged with them. From discussions about when to meet, to sharing a cup of tea with them, I learned so much about their work, their lives and their mission. Furthermore, using multiple qualitative methods was valuable to this research, as it allowed the individual nature of midwives' experiences with the medical community to be highlighted and recognized. Quantitative methods, on the other hand, may not have captured this important piece of the midwives' experiences. Bringing people together to converse, sitting down one-on-one or just observing interactions and discussions is invaluable, leading to increased awareness of the context and real life situations of informants. Their voices resonate in my thoughts, affording me a unique opportunity to engage them in this paper.

As midwives described their roles as midwives, the struggles they face to practice and their enjoyment of being a midwife, always at the core of their work was a genuine interest in helping women and babies. That was at the heart of their motivations. One midwife specifically said to me, "Thank you Corey for all you are doing for women and babies." I could not help but think: I have done nothing; it is you the laboring midwives that have done so much.

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Appendix A

Table 1 Research Question 1: Three Iterations of Analysis (to be read from the bottom up)

	RQ#1: What do midwives believe the role of a midwife is?	
	APPLICATION TO DATA **3rd iteration**	
	Role of Support	
	PATTERN VARIABLES **2nd iteration**	
Educator	Being with women	Guardian
	INITIAL CODES **1st iteration**	
Share wisdom Inform teach educate guidance	Support self-care Encourage Reassure Affirm Empower Listen Being with women Honoring women	guardian Holding space for women Protecting interests Mute hospital effects Advocate Allow for individuality Maintain normalcy Holding space for birth

Table 2 Research Question 2: Three Iterations of Analysis (to be read from the bottom up)
CPM

	RQ#2: What are their experiences with the medical community?	
	APPLICATION TO DATA **3rd iteration**	
	PATTERN VARIABLES **2nd iteration**	
Frustrations and restrictions from doctors and medical community	Doctors willing to support clients Doctors willing to support midwives	Empowerment through licensure
	INITIAL CODES **1st iteration**	
horrible/negative individually		
asked to leave	supportive individually	Willing to establish guidelines
don't want to see or work with	took transfer	can confront now that legal
disrespected	support from FP or pediatrician	can stay with client in hospital
Dislike us	helped because knew them before	listened to midwife during transport
Prevent us from being successful	worked as a nurse/had credibility	helped find medication
Arrested		

Table 3 Research Question 2: Three Iterations of Analysis (to be read from the bottom up)
CNM

	RQ#2: What are their experiences with the medical community?	
	APPLICATION TO DATA 3rd iteration	
Lack of support for nurse-midwifery	Support for nurse-midwifery	Navigating midwifery and medicine
	PATTERN VARIABLES 2nd iteration	
lack of support from physicians restrictive policies of hospitals and medical societies	working collaboratively or unhindered by physicians	Navigating midwifery and the medicine
	INITIAL CODES 1st iteration	
Negative individually Protect turf Doctors don't want to work with restricted by liability insurance Required to be employs of doctors Hospitals won't hire midwives Hospitals have restrictive policies Medical societies and medical staff make practice difficult	Supportive individually Collaborate Can bridge respect Equal partners Can work together Doctors help us get medicine Want to help us practice Trust Can practice without physician in house	No one understands what I do have to balance needs of client with hospital needs hospitals have to change by-laws for us Hospital staff questions the way I attend a birth Pushing hospital to see birth differently

Table 4 Research Question 3: Three Iterations of Analysis (to be read from the bottom up)
CPM

	RQ#3: What are their hopes and goals for the future of midwifery in Virginia?	
Maintenance and Expansion	**APPLICATION TO DATA 3rd iteration**	Relationship building
Maintaining what they have recently gained Expansion	**PATTERN VARIABLES 2nd iteration**	Increase connections Develop relationships
holding ground maintaining advocate in communities presence in Richmond expand medicines can legally carry through legislation increase clientele increase numbers of apprentices and CPMs increase networks for apprentices and CPMs	**INITIAL CODES 1st iteration**	make relationships in community transfer guidelines with EMS and hospital staff support CNMs come together with CNMs for positive changes in birth community builder

Table 5 Research Question 3: Three Iterations of Analysis (to be read from the bottom up)
CNM

	RQ#3: What are their hopes and goals for the future of midwifery in Virginia?	
	APPLICATION TO DATA 3rd iteration	
Promoting, advocating and encouraging growth of nurse-midwifery		Relationship building
Promoting nurse-midwifery to medical community Encouraging the growth of nurse-midwifery	**PATTERN VARIABLES 2nd iteration**	Improving relationships with medical community Developing relationships with CPMs
Decrease doctor power-group care Train doctors with midwives Working to establish birth center/find support for birth centers Increase access to nurse-midwifery care Increase job opportunities for nurse-midwives Increase training opportunities for nurse-midwives	**INITIAL CODES 1st iteration**	more collegial with doctors and medical community interface better with doctors need more truly collaborative practices with doctors explore possibilities to relate professionally with CPMs bridging communities