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Midwifery in the United States

Gwen Welch

Honors Senior Project
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Introduction

While not every woman will be afforded the opportunity to participate in pregnancy in their lifetime, it can be agreed upon, almost universally, that childbirth is one of the most powerful moments in the female experience (Infertility). For hundreds of years, female midwives were essential in the labor process, recognized for their wisdom and held in high regard for their skill. So what changed? In this paper I intend to explore how the profession of midwifery has transformed and evolved within the United States both in medicinal practice, and social attitude. From 1750 onward, the traditional beliefs and practices of natural childbirth were lost to a scientific, and increasingly rationalized perspective on the progression of labor. Men began to heavily dominate the field of medicine as well as midwifery, which resulted in a number of drastic changes within the profession. To put it quite simply, the challenges faces by women midwives were endless and have had severe effects on the way midwifery is both viewed and practiced today.

Brief Literature Review

The scholarly literature on midwifery offers a variety of different viewpoints. Each of the voices behind these works carry a different opinion; some write from an entirely historical perspective and others see the profession as non-scientific, as nothing more than the work of witches. It should be noted that the works used to inform this research all see midwifery not only an incredibly important medical profession but also, a lost art. My research takes an idealized approach to the discussion of this topic, hoping to push the reader to readily support the work of midwives.

History

It was not until the eighteenth century, that the United States saw a significant shift in both the social atmosphere and the medical practice of midwifery. Young men began returning from Europe after attending school, educated in their medical practices and eager to share newfound knowledge (Wertz, 29). The U.S. was just finding its footing in medicine as these men returned, and it was their influence that would shape the institution of medicine that we have come to know today. Given that the United States had been fairly isolated from medicinal developments up until this point, it is no surprise that Americans placed such a high value on the education and knowledge being brought to them from abroad. This new knowledge proved incredibly helpful in regards to the success of more complicated births; with advancements and tools that meant a greater chance of survival for both mother and child (Wertz, 20). But it would be this same knowledge that would overpower years of experiential wisdom that had been passed down through generations of women.

It is agreed upon throughout many scholarships that for hundreds of years prior to these developments, dating back to our ancestors, childbirth and the raising of children were jobs left entirely to women (Rosslin, 11). Childbirth was viewed as a social event (See Image 1), where women of all ages would both attend and aid in a woman's journey through labor, and it was rare to see a man (besides the husband) in attendance. The women who assisted in births would gain



Image 1: Social birth (Rosslin, 31)



Image 2: Birthing Chair (Wertz, 14)

knowledge through experience and guidance from older midwives, and then it was up to them to continue the cycle, passing information down to other women they deemed fit to practice (Wertz, 6). This style of midwifery was particularly unique because all care was based on the needs of the expectant mother such as her preferred laboring position, and who she wanted in attendance at the birth. Most births of this era were conducted in the home, and women would cycle through a variety of positions – on her knees, squatting, or sitting on a carefully crafted stool (See Image 2) – which was intended to give each a woman a sense of control over her labor process (Wertz, 13). It was for this reason that childbirth was, and continues to be, one of the most powerful expressions of female solidarity known to women, despite their gradual disappearance from the practice of midwifery.

One of the primary reasons for the decline in number of women from this profession was a lack of organization. Women midwives had practiced loyally for so many years within their communities that they saw little need for forming a collective group, believing it seems, that their long-standing devotion and depth of experience would surely continue to secure their presence at births (Wertz, 46). Ultimately, this was not the case. Male doctors with their formal education, had seen the success and progression of institutionalized medicine in Europe, and intended to bring the same practice back to the United States. With strong opinions, and a collective voice it would not take long for them to entirely dominate the world of medicine.

Women midwives' voices and ideals however, were soon drowned out by the relentlessly growing practice of "new midwifery".

"New Midwifery" had developed in France under the direction of doctors who had been focused on the scientific and anatomical progressions of childbirth. They were interested not only in furthering their understanding of the process itself, but gaining more control over an event that they had very little personal knowledge or experience of (Wertz, 29). Given that labor is an experience exclusive to the female gender, it was all too apparent to these doctors that there were aspects regarding childbirth that they would never be able to understand – they did not like this. The result of their frustration was extensive studies of the uterus and birth canal. As their knowledge expanded, they began to define birth as "A natural process that followed its own laws, as a machine with shapes and movements of its own..." but in doing so, "...The French removed its potentially awesome aspects and removed its emotional and spiritual associations from their consideration." (Wertz, 30). By removing emotional and magical associations from birth, there was increased feeling of control for these young doctors, an authority they greatly desired.

Throughout the nineteenth century, similar patterns continued. The practice of medicine was largely unregulated within the United States and both doctors and midwives were competing to attend births. Rising competition was not the only major challenge women of this time faced though. Cultural attitudes regarding the proper place for women in society were shifting quickly, and it was becoming less and less acceptable for women to practice any form of medicine. It was common belief that the dedication and intelligence to achieve a mastery of medicine were not characteristics that could be possessed by a woman, and therefore they should stick to "what they know" – in other words, caring for their family and the home (Wertz, 47). Only women brave

enough to face the condemnation of family, friends and greater society would seek out medical education during the nineteenth century, and very few would be successful.

The largest obstacle for women, beyond societal judgment, was having the funds necessary to pay for schooling (Rothman, 53). New educational institutions were appearing across the United States, but with a lack of regulation, they were often far more concerned with profit than proper instruction. This meant a substantial lack in resources, and little hands on training or instruction from experienced medical practitioners; which ultimately resulted in an outstanding number of individuals who were considered “professionals”, but in fact had very little formal training (Wertz, 51). Unlike Europe, the U.S. government had very little interest in assisting its citizens in their medical education and provided no supplemental funding to any medical program, least of all midwifery. Young women raised in an upper or middle class family were more likely to be afforded the opportunity for higher education, but even this was a rare occurrence. On the off chance they did attend these so-called schools, it was far more likely that they pursue being a doctor then a midwife, eagerly seeking a position of power in a crippling patriarchal society (Wertz, 48). It has been theorized that many women were beginning to grow tired on the constraints placed on them by traditional Victorian values of the nineteenth century, and sought to reestablish their place within the social order.

It is important here to pause and note that although women began to disappear from the practice of mainstream midwifery, they still had a strong presence in rural towns and communities throughout the United States. It was not uncommon for women who were uneducated, had immigrated to the America or were too poor to afford the services of a doctor, to seek out a local midwife to assist them through labor (Rothman, 54). Higher class individuals saw the use of a doctor as an indicator of their own prestige, and social class became highly

indicative of whether an individual would receive proper medicinal care. Should a woman of lower class be able to afford a doctor to assist her during her labor process, there was no guarantee of quality, “The culture’s position on the relative social worth of different social classes influenced doctors views about whose health was likely to be endangered, how their endangered health affected the whole society, and what treatments, if any, were suitable” (Wertz, 69).

By the early twentieth century, the need for standards in medical education was all too apparent. Doctors were largely unregulated in practice and had “little sense of limits”. With no one holding them accountable, they had no sense of responsibility other than to protect themselves. A study conducted in 1910 revealed that “Over 90% of doctors were without a college education, and most had attended sub-standard medical schools” (Wertz, 55). As this became public knowledge there was a push for tougher state laws, stricter standards regarding the education of medical students, and finally, someone to hold doctors accountable. It would take years for this to actually form a coherent shape but by the end of the twentieth century, the United States would have formally institutionalized both the education and practice of medicine.

Rather than protecting natural birth, the institutionalization of medicine had an increasingly negative effect on how doctors chose to participate in the labor process (Downe, 73). They began to value interventions, particularly medication, to help the woman manage her pain. In theory, this is not a bad idea, as long as it is *used in moderation* – which of course, it wasn’t. Today we see extensive use of a variety of drugs intended to both speed up labor and decrease the amount of pain experienced by the woman. There is very little trust in the body’s ability to manage these things, despite the fact that women have been giving birth naturally since the beginning of time (Rothman, 15). Of course some will argue that is these same technological

advancements that have saved the lives of women and their babies around the world, but as of today, there is no actual concrete evidence to prove so.

Many of the changes that occurred in the twentieth century are still all too relevant to the world of midwifery today.

The number of interventions during childbirth are rising, the rate of cesarean birth are unusually high, particularly in low risk births (See Image 3), the many technological

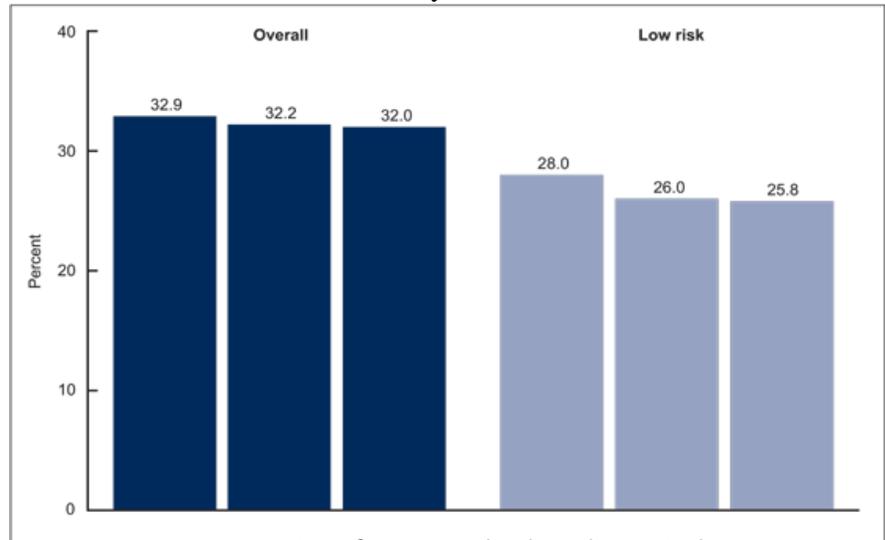


Image 3: Rates of Cesarean birth in the United States. (Births in the United States, 2015)

advances that have occurred in the last twenty years have given us a control of

birth that is unnatural (Pearls of Midwifery). I believe much of this can be attributed to the transition of births out of the home setting into a hospital environment that is inherently associated with fear and death. Nevertheless, 99% of all births that occur in the United States, still take place in a hospital (Pearls of Midwifery). It is innate to human nature to attempt to control that which we do not completely understand, and birth is no exception to this.

Modern Perspectives

When it came to researching the practices of present day midwives, I was lucky enough to be able to conduct a series of interviews with midwives about their personal experiences practicing midwifery in the twenty-first century (Modern Perspectives on Midwifery). While the opinions held by these midwives cannot be generalized to all who practice, it is safe to say that based on their responses, there are common values present among the majority of modern

midwives, both male and female. In the long run, it is the goal of these midwives to return to a more traditional and natural form of labor, “Birth is sacred and I feel the need to protect that process” (Beard). This means fewer interventions both in regards to use of pain medicine and technology, but also allowing the women to have a voice in the course of their treatment is handled (Oakley, 30). Midwives want to put control back in the hands of the woman which means: recognizing her uniqueness and needs as an individual, supporting the normal physiological process of birth and establishing a woman as an active partner in her own care (Pearls of Midwifery). Sometimes this means long and difficult births, but as we all know, patience is worth it, “A midwife’s work is to sit and wait with the woman. Studies show that even having another woman in the room just patiently waiting improves the outcome for the birth and the mother has a better experience” (Welch).

Each of these midwives has been practicing for a number of years, and can confidently say that there are some significant differences between doctors and midwives regarding their presence at a birth, “TIME. Midwives spend MUCH more time at the bedside than do doctors. Although midwives, ultimately, are there to protect the health of the mom and baby, they are also motivated to protect the mother’s experience, which I think differs from most doctors” (Barlow-Reed). Even with the same goal in mind, the journey to the end can vary drastically. Kate Pelosi, a veteran midwife, put the difference between midwives and doctors most elegantly of all,

“While I have observed many physicians provide patient care that is woman-centered, I do believe they most often come from a very medical view of labor and birth which leads them to feel they need to “manage” or “direct” this potentially “hazardous” process and dictate the experience a woman needs to safely negotiate the experience. Midwives generally have a deep belief in birth and are guardians of the physiologic process and use interventions very judiciously rather than routinely. We see it as our duty to help the

woman have the birth experience that will help them cross that bridge from pregnancy to parenting. The process is important physically, emotionally, psychologically and for many women, spiritually” (Pelosi).

All seemed to agree that the key to successful care is that which completely revolves around the woman as an individual. Welch noted that this is an issue present not only in midwifery, but across the board when it comes to medical practice. The United States is in the business of moving patients in and out of hospitals as quickly as possible and we have yet to achieve a standard of care that adequately cares for all individuals.

It would seem though, that the biggest challenge facing midwives today continues to be the social and cultural attitudes surrounding childbirth that are based on very little factual knowledge. As women disappeared from the work of midwifery, so did their values, “Not being known, understood or valued in the medical world [is the biggest challenge faced by midwives today]” (Chiodo). But that is not all. What I heard most frequently from these midwives was that there is a culture of fear associated with labor that we have been unable to rid ourselves of,

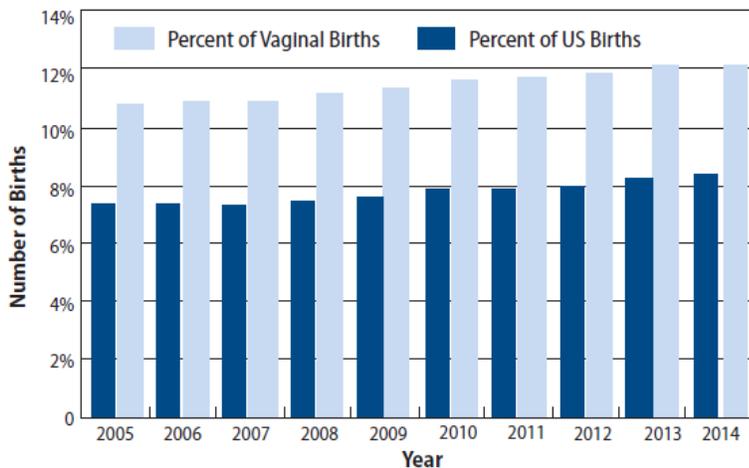
“Fear. Doctors fear of loss of power. Doctors fear of loss of income. The medicalization of childbirth. A normal event has been made abnormal by fear. I know that when you have a complication, like a hemorrhage, or a baby whose shoulders get stuck, or a baby dies before the birth, it makes you afraid. You second guess every part of what you did. Could I have done something different and changed the outcome? And all those normal births fade in the face of the one abnormal event” (Welch).

A major consequence of this fear is the intervention-based practice that I mentioned earlier. We are so terrified of the worst case scenario becoming our personal reality, we will do anything and everything to control the labor process. But the reality is, birth is safer today than it ever has been, “We need to give women back the confidence that their body was perfectly designed to conceive, nurture and birth a baby. And not be afraid” (Welch). And that is just what these

midwives intend to do. They continue to practice midwifery with passion and love, patiently awaiting the day when their true value and worth will be realized.

Midwifery has been the subject of constant controversy throughout United States history.

Percentage of Births Attended by Certified Nurse-Midwives and Certified Midwives, 2005–2014



Births: Final Data for 2014. National Vital Statistics Reports; Vol 64, No 12. 2015

Image 4: Graph depicting presence of midwives at births in recent years. (Martin, JA)

We have seen women midwives battle social and political stigmas time and time again, and watched the rapid evolution of medicine through institutionalization. Clearly there are benefits and consequences to every aspect of these developments, but I believe sincerely that midwives have come

out stronger for their battles. Natural birth continues to be sought out by women, and finally, the morals and ideals maintained by the traditional midwife are beginning to reappear (See Image 4). One can only hope that we will continue on this path, with midwives changing lives, one birth at a time.

“So at this time in my life I know I cannot change the world. But I can still make a difference one mother and one baby and one family at a time”

– Helen Welch

Works Cited:

- American College of Nurse-Midwives. "Evidence-Based Practice: Pearls of Midwifery." 2012, PowerPoint file.
- Beard, Chris, Angie Chiodo, Helen Welch, Christine Barlow-Reed, and Kate Pelosi. "Modern Perspectives on Midwifery." E-mail interview. Oct. 2016.
- "Births in the United States, 2015." *Centers for Disease Control and Prevention*. Centers for Disease Control and Prevention, 19 Sept. 2016. Web. 08 Dec. 2016.
- Bourgeault, Ivy Lynn, Cecilia Benoit, and Robbie Davis-Floyd. *Reconceiving Midwifery*. Montreal: McGill-Queen's UP, 2004. Print.
- Bryar, Rosamund. *Theory for Midwifery Practice*. Houndsmills: Macmillan, 1995. Print.
- Downe, Soo. *Normal Childbirth: Evidence and Debate*. Edinburgh: Churchill Livingstone/Elsevier, 2008. Print.
- "Infertility." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, 15 July 2016. Web. 01 Mar. 2017.
- Jordan, Brigitte. *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden and the United States*. 2nd ed. Montreal: EPWP, 1980. Print.
- Oakley, Ann. *Women Confined: Towards a Sociology of Childbirth*. New York: Schocken, 1980. Print.
- Lay, Mary M. *The Rhetoric of Midwifery: Gender, Knowledge, and Power*. New Brunswick, NJ: Rutgers UP, 2000. Print.
- Martin JA, Hamilton BE, Osterman MJK, Curtin, SC, Mathews TJ. Births: Final Data for 2014. National Vital Statistics Reports; Vol 64, No 12. Hyattsville, MD: National Center for Health Statistics. 2015.
- Roslin, Eucharius, and Wendy Arons. *When Midwifery Became the Male Physician's Province: The Sixteenth Century Handbook: The Rose Garden for Pregnant Women and Midwives*. Jefferson, NC: McFarland, 1994. Print.

Rothman, Barbara Katz. *Giving Birth: Alternatives in Childbirth*. New York: Penguin, 1984.
Print.

Wertz, Richard W., and Dorothy C. Wertz. *Lying-in: A History of Childbirth in America*. New
York: Free, 1977. Print

Modern Perspectives of Midwifery Interview Notes:

Questions:

1. What initially drove you to be a midwife?
 - Is this the same thing that drives you in your profession today? If no, what is the thing that drives you to do this work every day?
2. What is the biggest challenge midwives face in the medical world?
3. In your opinion, what is the most difficult aspect of your job?
4. What is the most rewarding aspect of your job?
5. What would you say separates midwives from doctors when it comes to assisting in a birth?
6. How do you feel you are viewed in your profession? By greater society, doctors, etc.

Responses:

Chris Beard -

1. The reason I became a Midwife was like a lightning bolt. I just KNEW it was what I wanted to do. I decided to become a Midwife when I was 19 and didn't pursue my degree until I was 30 but I always knew I would do it.
2. I feel lucky to love the work that I do. The moment of becoming a family is the most important thing in the world for women. Birth is sacred and I feel the need to protect that process. In our modern world more than anything technology intervenes and not in a good way sometimes.
3. The biggest challenge we face is the creeping of intervention and technology. A c section rate of 33 percent when we are something like #57 in morbidity and mortality is shameful. Women need to be supported and empowered to do what their body was meant to do. I think that many of the interventions we assume are needed - are simply not. (GBS screening and treatment for every woman vs. risk based treatment, induction of labor, repeat c section vs. vaginal birth after c section, denying women food and drink, hurrying labor along with Pitocin etc.)
4. For me the most difficult aspect of my job is political. I have been a midwife for 25 years and am still explaining what I do and fighting for legitimacy. I believe CNMs are the experts in normal birth and I'd like everyone else to believe and recognize that as well.
5. The most rewarding part of my job is assisting the mom to place her newly born baby skin to skin next to her heart where s/he will remain as long as she breathes. Protecting that moment from outside intervention.
6. Midwives protect the normal. We know that the process is hard, takes time and takes encouragement. We want women and their infants to be in a circle of safety so recognizing when things are not normal is essential in our job. I appreciate MD partners to collaborate with I feel fortunate to work in a collaborative practice.

Angie Chiodo -

1. In my undergraduate years I was uncertain of where I would ultimately land. I tried to cover all my bases by completing my nursing pre-reqs, exploring areas of interest and largely focusing on my public health degree. I was leaning toward working in the nonprofit world because nursing did not seem like quite the right fit and I was passionate about working with women (young and old), at that time specifically, pregnant teens. In the fall after graduation, I attended a potluck for my husband's medical school class that he was about to enter and met my first nurse-midwife. I had never even heard the term midwife at the time. I spent the entire night asking her questions and left that night calling my sister to inform her I had finally realized what my calling was- I would become a nurse midwife. Nurse-midwifery encompassed all the things I was looking for, and what I was most excited about, was the ability to combine both clinical, relational and female advocacy work together.

This is absolutely what drives my work. I love connecting with woman and seeing them be brave in the midst of challenge, physical challenges, emotional, and spiritual.

2. Not being known, understood or valued in the medical world. Though our day-to-day job is challenged by lack of time and pressure to squeeze very intense and deep moments into very short periods of time, I would say we have gotten pretty skillful in working with this pressure (though certainly not ideal and will often lead to excessive stress and/or burnout), the bigger issue is belief in the importance of what we do from an administrative level and large scale level.
3. The feeling of lack of autonomy and being at times feeling like not a trusted and valued member of the care team. This was much truer in my first job in Detroit than at Kaiser, though there are still undertones of this there too.
4. Being with woman as they process and often transform their thinking while making decisions for themselves and their families. Also, I love the collegiality of my current job. The women (and sometimes men) that I work with are pretty amazing. I love being paired with specific nurses who help to make the transformation that many women go through in birth an empowering and even joyful experience.
5. Not just our belief in normal, but the art of engaging the normal process of birth (and really all women's health processes) and shifting the power to be in their hands/bodies/minds and being not just ok with that, but thrilled by it.
6. Sigh. The number of times I have had people say, "Oh you're a midwife? I have friend who is a doula too" or simply stare at me blankly not really sure if I'm a total hippy-weirdo or not. Doctors that are not OBs are really no different than this around the country, I would say the NW is an exception for the most part. That being said, many of my husband's ER doc friends have really no idea what the difference is between a nurse-midwife vs. a professional midwife vs. a doula. Even my larger family (aunts,

grandparents) talk about me as if I am either a nurse, a doula or perhaps just someone who likes pregnancy and childbirth ;).

Helen Welch -

1. I had the right qualifications to begin a career in medicine when I left high school. My parents wanted this for me. I didn't. There were not a lot of options in 1977 and so I applied to nursing school. I had always loved babies and thought I would like to be a pediatric nurse or a neonatal ICU nurse. In my nursing school I did a rotation on the pediatric floor and hated it! I was devastated at the time as my career plan just went up in smoke! Fortunately the next rotation was with an amazing midwife called Caroline Flint. She worked in the community providing prenatal care and postpartum care to women and then attended them at birth where the woman chose. Either home or hospital. I LOVED EVERY minute. I knew from those few weeks I would go to midwifery school and this was the work I wanted to do
2. I was very young when I qualified as a midwife. I loved being with women during labor and birth. And LOVED catching those babies. I knew the work was important. I knew that treating women well in labor was important. But I did the work more for me than for them at that point.
As I have matured I see so much more. That being with women at this time in their life is an honor and a privilege. And those who provide care at that time have the ability to impact the woman for the rest of her life. Positively. Or negatively. Women remember moments of their births with crystal clarity for the remainder of their years. So if they have a bad experience it can affect them for the rest of their life. Counter to that, if you can help create a happy birthday you can empower her and she will take that strength and courage into her role as a new mother.
It doesn't matter what the labor brings. Labor is a journey. What matters is the way she is treated. With respect. With love. With compassion. Did you really listen to what she wanted? Not what you wanted for her but what she wanted. Too often we project our own fears and anxieties onto women and fill them with fear
You mustn't do this
You mustn't eat that
This or that will hurt the baby
We need to give women back the confidence that their body was perfectly designed to conceive, nurture and birth a baby. And not be afraid.
3. As you know I now get very tired. 14 hrs. work at night is long. And hard. But still after 35 years I still find it an honor to bear witness to a woman draw on her deepest courage and power to give birth (with or without pain medicine!) And to watch the relationship between a woman and her partner strengthen during the course of the labor and birth. The moment when the woman realizes her partner will be at her side in her deepest darkest most vulnerable hour. And the partner realizes this woman is stronger than (s) he ever thought possible. They then take this into parenting this new being. (Lucky baby I say!!) A nurse once said to me that you get to hold a woman's soul for just a while when she is in labor. You hold it. Very gently. Taking great care of it. While she does her work. And then, before she is aware the baby comes and you slip it right back as if it never left.

And I still have women come up to me in the street and tell me I made a difference. I said the right words at the right time. I made her feel strong and courageous.

And I had a Dad come up to me last week in the hall. "Helen! You. You. My baby is a year. I will never forget. He was number 3. I thought I knew it all. I thought I didn't want to see. But you had me put my hands on that baby as he was being born. And I gave him to my wife. And I will never forget that moment. Never."

So at this time in my life I know I cannot change the world. But I can still make a difference one mother and one baby and one family at a time

3. Fear.

Doctors fear of loss of power

Doctors fear of loss of income

The medicalization of childbirth. A normal event has been pathologized (made abnormal) by fear. I know that when you have a complication, like a hemorrhage, or a baby whose shoulders get stuck, or a baby dies before the birth. It makes you afraid. You second guess every part of what you did. Could I have done something different and changed the outcome? And all those normal births fade in the face of the one abnormal event

The fact that babies come 24x7 and that means someone has to be up at night. Night shifts are and get harder the older I get

The endless fight to keep birth normal. I have been doing this for 35 years and I am still fighting to reduce the rate of interventions such as induction of labor

4. The amazing mothers. Not all. But I still get blown away by the strength and courage that a woman will express.

5. Countries that use midwives as the primary care providers for women in pregnancy and at birth have lower rates of interventions such as use of medicine to speed up labor, cesarean, episiotomy and better outcomes for mother and baby with lower mortality and morbidity rates.

Anyone can attend a normal birth

The work of the midwife is to recognize the normal and patiently watch and wait intervening only when things are becoming abnormal to try and guide them back on track

Medicine is about waiting for the disaster. Most doctors would say they hate labor sitting. They like to come in right at the moment of birth and catch the baby.

Midwives work is to sit and wait with the woman. Studies show that even having another woman in the room just patiently waiting improves the outcome for the birth and the mother has a better experience

Doctors talk of doing "deliveries". Midwives attend births

Pizza is delivered.

Babies are born

We celebrate our birthdays not our delivery days!!!!

6. So much more respect by many than when I started but still a long way to go!
Has to do with the professionalization of our role

The American College of Nurse Midwives insisted we all have master's degrees. That helped. They are our professional body and they are at the table at the highest levels fighting to have midwifery included in the voice for women and birth in the USA.

The American College of Obstetrics and Gynecology used to rule the roost. They still hold a lot of power but there is now a mutual respect between the leaders of the ACNM and ACOG I teach the new resident obstetricians (it's a 4 year training after medical school and we midwives attend births with them showing them how to keep it normal!!)

More obstetricians have worked with midwives as our numbers have grown so they are not as afraid of us. The younger OBs are happy to have us as part of the team.

A recent study showed the best birth outcomes happen when you have a midwife and obstetrician working together as a team on the labor unit

There are still some old school MDs who want nothing to do with us but that is mostly about fear of loss of their role (you don't need a highly trained surgeon to attend a normal birth) and therefore money. Babies have always been big business in this country since the early 1900s when doctors decided midwives were unsafe and that birth should take place in the hospital

Christine Barlow-Reed -

1. Ultimately, I think I was attracted to the activism aspect of midwifery. I remember hearing about "giving birth back to women" and trusting the natural process of the body and thinking that someone had just conceptualized a very basic part of my belief system. I didn't even realize it was my belief until I heard it verbalized and I thought, "Of course! You mean there are people who DON'T believe that???" Also, I wavered for a while between getting a degree in social work or midwifery. The fact that the fields often overlap was also attractive to me. I liked how midwives historically worked with the underserved and had the opportunity to listen to and assist with women's emotional struggles. It was only after I started my studies that I learned how much I enjoyed the science of nursing and the physiology of our bodies.

Yes, I would say so. I also find a lot of personal gratitude in the relationships that I form with my patients and with my colleagues. I also like the variety of my work. I like being in the clinic and helping a teenager choose her first method of birth control one day and then being in the hospital the next day, catching a baby.

2. We're dependent upon our physician colleagues to safely care for our patients. Those relationships can be difficult to navigate. The conflicts generally center around competition, vicarious liability, differences in clinical management and the feeling that one group is working harder than the other. I've worked in independent midwifery groups (both in and out of hospital) and in a physician owned practice and each have their benefits and challenges with regards to working with doctors.
3. There is a lot of "gray area" and judgment involved in being a midwife. It's not for the faint of heart. Having to make critical decisions which may affect the health of a mom/baby or a mom's memory or sense of satisfaction with her birth, in our very litigious society, when you are exhausted, can be quite difficult.

4. The relationships that I get to form with my patients and their families. Helping moms to have un-medicated births and seeing their resultant pride, strength and empowerment. Watching a mother and father in the moments after their baby is born; how they look at their baby, look at one another and kiss. It can still bring me to tears.
5. TIME. Midwives spend MUCH more time at the bedside than do doctors. Although midwives, ultimately, are there to protect the health of the mom and baby, they are also motivated to protect the mother's experience, which I think differs from most doctors. And, in some cases, they utilize fewer interventions or use interventions as later resorts.
6. I practice in Portland, OR, which is a midwifery bubble. I realize that it can be very different in other states and communities. But, in general, I feel as if society respects and idealizes my profession. It sees my work as mysterious, magical and full of joy. I fear that some homebirth or direct entry midwives may feel as if nurse midwives have "sold out", but I'm sure that that is not a belief shared by all homebirth midwives. There are probably many ways in which doctors view nurse midwives; as competition, collaborators, renegades, risk takers, dreamers to name a few. I think it varies from doctor to doctor.

Kate Pelosi -

1. I was drawn to midwifery after working as a labor and delivery nurse for several years. During my nurses training in Ohio in the very early 70's I had no exposure to or knowledge of midwives or midwifery. But after moving to Oregon I worked with two outstanding midwives at the university hospital here and observed the intimacy of their relationship with the women they cared for and was quickly inspired to consider that profession for myself. While I enjoyed providing care on labor and delivery to women, it was episodic without the opportunity for the continuity of guiding a woman and family through pregnancy toward labor and birth and ultimately to parenting. Having a trusting relationship with a woman not only through her pregnancy but across her life span gave me great rewards for many years. I also was drawn to providing care to vulnerable populations of women, those with fewer opportunities for advancement of their own health and found opportunities to do this even when in a private practice setting.

Currently, I have made a change in the way I practice midwifery and the change was primarily motivated by a personal need to have a more stable and predictable work schedule. As you know, midwives generally work long hours at any time of night or day or weekends or holidays. I did this willingly although I do believe it challenged my attention to my own family needs at times, which seemed somewhat in conflict with my value of promoting healthy families for the women I cared for. So now, I work just in the hospital and provide care to many women I am meeting for the first time. I have found that not only has this given me a work schedule that is healthy for me, I have the opportunity to introduce midwifery to many women and families who have never been exposed to the care offered by our profession.

2. I believe a major challenge midwives face in the medical world is a misunderstanding by both other medical professionals and the public about our scope of practice and our clear intentions of promoting health and wellbeing. We remain somewhat marginalized, under-utilized in many settings, limited in our independent practice. Many advances have been achieved over the years, but we have not been embraced as providing the model of care which is well proven to achieve optimal outcomes for women and children. Turf wars and competition continue to interfere with full utilization of our talents and abilities. The healthcare system (or lack of system) also impedes full utilization.
3. I find that always having to explain and defend my practice is a very difficult aspect of my job. The long hours for many years were challenging. While much of our work is joyful, the losses we support women and family through can be devastating but it remains rewarding to support a woman and family through grief as well as through celebration.
4. I remain inspired by the basic tenets of midwifery practice - engaging women as partners in their care, education, promoting physiologic birth, minimizing interventions, empowering women.
7. While I have observed many physicians provide patient care that is woman-centered, I do believe they most often come from a very medical view of labor and birth which leads them to feel they need to “manage” or “direct” this potentially “hazardous” process and dictate the experience a woman needs to safely negotiate the experience. Midwives generally have a deep belief in birth and are guardians of the physiologic process and use interventions very judiciously rather than routinely. We see it as our duty to help the woman have the birth experience that will help them cross that bridge from pregnancy to parenting. The process is important physically, emotionally, psychologically and for many women, spiritually.
8. As I alluded to earlier, I think much of society still confuses with traditional birth attendants who, over the years offered a great service to women and families but were essentially squeezed out by the medical profession, at least in this country. We also have a situation in this country where there are many pathways to midwifery with different standards of education so midwifery itself has contributed to confusion. In many university settings, midwives are now fully accepted and respected and members of medical staffs and engage in the education of physicians, so this is helping with accepting us as a profession. We are still unfortunately perceived by both some medical practitioners and some populations of the public as substandard or second class care providers. Again, this is changing but it remains painful at times after so many years of trying to prove ourselves.

Angie Fujioka –

1. After working with midwives and traditional birth attendants in Central America, I realized how central midwives are to accessing health care for the entire family including primary care, immunizations, preventative care and birth control. Therefore having a high potential impact on a woman and her family’s life and health. Also, I realized it would be

a very helpful skillset to have since most of the world's babies are born into the hands of midwives and I wanted to work in maternal child health in developing countries.

Yes, it is still what inspires to be a midwife, although due to personal choices, I've cut back a great deal on the international work to raise my family. However, I seek out any opportunity to consult in this field in addition to my day job as a clinical midwife.

2. Depends on your context. Domestically midwives are not granted the same scope of practice and legislative support in every state, so some have to fight harder than others to do and keep their jobs. One challenge is we do not tend to unite as well as nurses or MD's to advocate for our political advantage. Although we have seen improvements in the national midwifery association doing this on our behalf in the last few years since acquiring a legislative action department. In most parts of the US, midwifery is not well known or understood in the general public and misconceptions abound our scope of practice and training in developing countries. Key issues include: quality of education/training, nationally regulated credentialing, continuing education, practice guidelines, regulated scope of practice, limited human resources, burnout, and adequate compensation.
3. I'm frequently thinking about medico-legal liability and documentation within my clinical practice.
4. Playing a part in a woman or a midwife I'm training going beyond her expectations to achieve unexpected achievements.
5. Depends on the individual, but in general midwives tend to spend more time at the bedside with the woman and has more information about 2nd stage progression and can therefore tailor care regarding positions, for example, to facilitate the birth process.
6. Varies widely. People who understand what midwives do are very often appreciative, but there is still a fair amount of fear around the unknown for those that are not as familiar with our profession and how much safer birth outcomes results from a midwife attended birth especially within a clinical setting where access to higher level emergency care is available.