BIRTH AND THE DIVISION OF LABOR: THE MOVEMENT TO PROFESSIONALIZE NURSE-MIDWIFERY, AND ITS RELATIONSHIP TO THE MOVEMENT FOR HOME BIRTH AND LAY MIDWIFERY A CASE STUDY OF VERMONT

by

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ABSTRACT

BIRTH AND THE DIVISION OF LABOR: THE MOVEMENT TO PROFESSIONALIZE NURSE-MIDWIFERY AND ITS RELATIONSHIP TO THE MOVEMENT FOR HOME BIRTH AND LAY MIDWIFERY. A CASE STUDY OF VERMONT

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This is a study of the changing social organization of the work of birth attendance. I examine the process by which a profession (obstetrics) emerged and achieved hegemony, dominating an extensive division of labor. This relationship was subsequently challenged by several social movements which politicized birthing practices and critiqued physician hegemony.

This is a case study of Vermont; the primary source of data is interviews with nurse-midwives, lay-midwives, physicians and others. This material was supplemented by an informal content analysis of state newspapers as well as an extensive review of historical, sociological and medical and nursing literature which enabled me to locate the processes studied both historically and nationally.

Drawing on Larson's (1977) neo-Marxist analysis, I examined the processes by which nurse-midwives attempted to professionalize within a highly articulated medical division of labor.

This study focuses on conflicting claims to occupational jurisdiction and the processes by which a client revolt (the

home birth movement) and client reform movements (in-hospital birth reform) alter the work terrain, creating new opportunities for emerging occupations (lay-midwives and nurse-midwives) and resulting in conflicts over the division of labor. It also examines the process by which segments of the dominant profession (colleague-centered physicians, especially obstetricians) resist or attempt to co-opt challenges to their monopoly while other segments (client-centered physicians, especially family practitioners) augment client revolts and align themselves with emerging occupations.

I concluded that within the hospital, the institutional matrix of the dominant profession, nurse-midwives have located a market which is inherently subordinate.

Acceptance of this location in the medical division of labor would assure that nurse-midwifery would never achieve one of the primary goals of professionalization: autonomy in practice. At the same time, the growth of nurse-midwifery practice in the obstetrician headed "team" has the effect of undercutting an independent market for midwifery services. This effectively places CNMs in hospital practice in market competition with lay-midwives and nurse-midwives in independent practice.

Potential directions of occupational trajectories and interoccupational relations are suggested.

The industrialization
of love, of birth,

this is the last besieged castle
the last tower
and of this particular war
this is the last hour

the great, pink walls
of this genetic treasure cave
are being shaken
and this will be the final city
ever taken.

Judy Grahn. "Like a Woman
in Childbirth Wailing."
The Queen of Wands.

Only now, we name ourselves....
we know ourselves to be made from
this earth. We know this earth is
made from our bodies. For we see
ourselves. And we are nature.

Susan Griffin.
Woman and Nature

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Introduction

This is a study of the changing social organization of the work of birth attendance. It focuses on conflicting claims to occupational jurisdiction and the processes by which client revolts (the home birth movement) alter the work terrain, creating new opportunities for emerging occupations (lay-midwives and nurse-midwives) and resulting in conflicts over the division of labor. It also examines the process by which segments of the dominant profession (physicians, especially obstetricians) resist or attempt to coopt challenges to their monopoly while other segments of the profession (especially general practitioners) augment client revolts and align themselves with emerging occupations.

This case study of the movements for home birth, lay-midwifery and nurse-midwifery in Vermont points to more general processes in the changing organization of work and occupations. It addresses Larson's (1977) assertion that a division of labor is dynamic and results from both larger societal transformations and collective responses to them. It examines the manner in which occupational collectivities pursue strategies aimed at locating and monopolizing turf in a division of labor by acquiring both "license and mandate"

from the state for the exclusive performance of their services (Hughes, 1964). Occupations' claims to this status derive in large part from their assertions of unique expertise. The ability of emerging occupations to successfully claim expertise requires that they either discredit the dominant profession's claims to a monopoly on relevant knowledge or persuade it to delegate a portion of its expertise and related task performance. The role of an activated clientele may be pivotal in enabling emerging occupations to gain state sanction for their claimed expert status (Kronus, 1976).

Larson (1977) notes that occupational collectivities engage in a process of unification, standardization and, typically, credentialing in an effort to create a specific commodity which is both useful and salable. At the same time they endeavor to construct a market for their specialized skills and services (the commodity). Emerging occupations may be aided in this process by client revolts which redefine both the object of the service (e.g., pregnancy and childbirth as normal processes) and the nature of the skilled assistance it requires (e.g., supportive, non-interventive care). This may have the effect of creating a new market for the services of new kinds of occupations. However, Larson suggests that some markets may be "inherently subordinate" because of the structures in which they exist. Thus while an occupational collectivity may monopolize

specialized work it cannot be an autonomous profession since its relationship to its market is controlled and mediated by institutions or organizational collectivities to which it is structurally subordinate. An examination of this question enables me to ask if it is reasonable to speak of the process of "professionalization" by an occupational group (nurse-midwifery) which is structurally subordinate to the dominant profession.

Background

In the 1960's and 1970's in the United States, the convergence of several social movements on the issue of health care created an environment in which birthing practices came to be critically evaluated and the professional power of obstetricians challenged. In this context, two major strategies developed which aimed at birth reform and/or the creation of birthing alternatives. First, within the medical system, childbirth educators and a few medical care providers worked to reform hospital birthing practices and to prepare birthing parents for hospital births. Second, outside the hospital, some birthing parents began to create their own alternatives, especially home birth. Increasingly, a new health care provider, the lay-midwife, aided by a few defecting physicians, attended them. As this phenomenon began to spread among physicians' white, middle-class, paying clientele, organized medicine sought to eliminate it.

Another occupation, the nurse-midwife, emerged in this changing context of childbirth practices. As I will suggest, the nurse-midwife is somewhere between these two strategies of birth reform and birthing alternatives and incorporates elements of each. Like the more medically-oriented childbirth educators (such as Lamaze prepared childbirth instructors), nurse-midwives seek to professionalize in order to improve their status, facilitate their autonomy and to carry out their reform-oriented approach to childbirth and the care of pregnant women. They have endeavored to locate a suitable niche in the medical division of labor. But, like lay-midwives, nurse-midwives, although under physician control, are more client-centered than the vast majority of obstetricians and they encourage client involvement and participation.

Begun in the 1930's and originally serving the underserved, nurse-midwives developed with independence and autonomy remarkable for a nursing specialty. By the 1960's however, nurse-midwives were largely being drawn into the physician-dominated, hospital-based medical division of labor to meet projected obstetrician shortages. Their numbers and their schools began to expand, as did their salaries, and their claims to a special contribution to health care began to shift somewhat. Still, the framework from which they developed was nursing, a care-giving, rather than a cure-providing occupation. In addition, the early influence of British

midwifery in their shcools, afforded them a view of childbirth as a normal event. Thus, latent tensions between nurse-midwifery and obstetricians, which were minimized when nurse-midwives functioned relatively authonomously (with physician back-up) serving "marginal populations," began to emerge as nurse-midwives worked more closely with obstetricians to whom they were structurally subordinate.

Meanwhile, lay midwives and home birth parents, pursued a strategy of deprofessionalization in order to create viable birthing alternatives outside the hospital. The challenged obstetricians' claims that the hospital was the only safe place for birth and physicians the only safe attendants (or supervising attendants). In contrast to physician-oriented childbirth educators, the home birth movement generated more independent-minded childbirth educators who included in their courses critical perspectives on hospital birth as well as preparation for home birth. This movement thus developed both an ideology in which childbirth was reconceived and a strategy for realizing its goal of alternative birth. In so doing, it significantly altered birth reform.

Thus, the period of the 1960's and 1970's was a time of particularly dynamic change in the social organization of birth and birth attendance in the United States, though there was also strong medical resistance to fundamental change. In this context, I chose to focus primarily on the occupation of nurse-midwifery since it both changed its locus

of work during this period and increasingly became wedged between the client revolt and the medical profession's response to it. While the home birth movement critiqued hospital birth and created alternatives to it (including potential competitors for the turf of nurse-midwives), organized medicine sought to shape nurse-midwifery to fit into the obstetrician-headed team while attempting to eradicate home birth. Meanwhile, a few general practitioners broke ranks with the medical establishment and used their professional status to support home birth and lay-midwifery.

Nurse-midwives carefully sought to make the most of this turn of events by continuing their professionalization efforts while regarding themselves as birth reformers and client-centered practitioners.

Methods of Study

In order to understand the interplay of these elements and actors on a smaller scale, I undertook a case study of Vermont. The case study is not a method best suited to observing either the organized actions of a profession's leadership or national trends in birth reform, but it was the method best suited to my purposes. What the case study can illuminate is the manner in which relatively complex social processes play out in a particular social context over a specific period of time. It is an approach which constitutes, "...a way of organizing social data so at to preserve the unitary character of the social object being

studied" (Goode and Hatt, 1952: 331).

This study is exploratory, aimed at understanding a complex of events and actions rather than testing present hypotheses. It also embodies elements of social history. As an examination of social movements in an arena of work, this study sheds light on the reasons, and the methods by which individuals worked in collectivities to either promote or block social change. Thus, I chose to study a small population of actors in a clearly delineated area, (the state of Vermont), over a relatively short period of time, (1970-1980). This enabled me to examine in detail events which, in the larger sweep of historical research and social theory are typically overlooked or obscured. Such complex social phenomena leave few artifacts and rapidly metamorphose into new forms. A "snapshot" such as this study, may be able to represent some of the relationships and directions of motion.

Vermont is an attractive study site for several reasons. Nurse-midwives have worked in the state in various capacities for over ten years, however, their position in actual practice is still being negotiated. Legislation enabling the practice of nurse-midwifery is of relatively recent origin and legislation concerning lay-midwivery practice has been discussed at some length in the state legislature in the past few years. During the period examined by this study, the practice of lay-midwifery was extra-legal (outside the legal system). The movements for home birth and lay-midwifery had recently

been active in the state. In addition, this study site had the advantage of allowing me access to four different settings in which nurse-midwives practiced. The final focus of my research shifted to northern and central Vermont since my entreé to southern Vermont was restricted. However, the activities in the area under study were relatively removed, particularly for the nurse-midwives, from those in the south.

I chose Vermont as a study site primarily because it afforded me entreé. A friend of mine was a practicing obstetrician/gynecologist in one of the study sites. This physician provided me with initial contacts among the lay-midwives from whom I acquired additional names creating a snowball sample. (This particular physician seemed to have a relatively unique, if not wholly neutral, position in the diverse population of subjects interviewed. At no time did I sense that this physician's sponsorship inhibited either access to subjects or the candidness of the interviews.) I obtained the names of the nurse-midwives from the American College of Nurse-Midwives.

I interviewed ten nurse-midwives including all the practicing nurse-midwives in the northern two-thirds of the state and two nurse-midwives who worked as instructors of nursing. In addition, I interviewed five practicing lay-midwives (two of whom referred to themselves as "birth attendants") and two former lay-midwives. Midwives themselves estimated a population of eight to ten midwives (more if birth attendants were included) in the area of the state

studied and my sample included most of the central actors. To round out my study, I interviewed four physicians, two childbirth educators and two home birth parents who were also health care workers. This last group of interview subjects was chosen because they were important actors in the processes under study, they had special access to information or a favorable social location which enabled them to achieve an overview.

Interview subjects did not neatly fit into the categories of home birth mother, nurse-midwive or lay midwife, etc. This indicates the complexity of the process of social change in which these actors were involved and suggests their "careers" in these movements. For example, one former lay-midwife was a childbirth educator while another was applying to medical school. Some of the nurse-midwives were also home birth mothers or former childbirth educators.

While my focus throughout the research was on nurse-midwifery, I also interviewed most of the central actors in the home birth movement. Unfortunately, I was never able to contact a "lay" midwife in the southern portion of the state. She was actually a Canadian-trained nurse-practitioner who could not legally function as a nurse-midwife in the United States and she was a key actor in the promotion of lay-midwifery legislation.

As my research in the state continued, I came to realize the importance of other actors and managed to interview some

of the most active among them, including childbirth educators and a defecting physician. If I had had more time, I would have more thoroughly sought out general practitioners since at least a few of them either attended home births or covertly supported the practice. For example, two or the lay-midwives I interviewed worked as physician's assistants with physicians sympathetic to home birth. Also, interviews with staff nurses would have improved my understanding of hospital birth reform.

I chose the method of open-ended in-depth interviewing (ranging from 1 to 2½ hours) in order to elicit subjects' interpretations of events and social relationships, in their own words. Much of my interview schedule was comprised of informational questions interspersed with questions about the respondant's opinions.

Since both the claims of occupations and the challenges raised by a clientele in revolt concern, among other things, the social construction of reality, interpretation of events and the terminology used to describe them is particularly important. The quite specific nature of many of the questions asked helped to draw the subjects into the material. The fact that I asked a few major questions in many different ways, allowed the respondant's perspective and interpretation of events to emerge. Toward the second half of the interview, even those subjects who indicated initial wariness appeared to be quite candid. In addition, in analyzing the

data, the several interpretations of events and relationships both created a composite picture and enabled me to sort out collective perspectives.

Most of the interviews with the nurse-midwives were conducted in their offices during work or lunch hours. Two nurse-midwives I interviewed at home, one because it was unavoidable (she had c a r trouble and apologized for my inconvenience) and another, the nurse-midwife in independent practice, because she chose to and in any case did not have an office. A third interview began at work and continued through the lunch hour at the nurse-midwife's house. In contrast, most of the interviews conducted with lay/independent midwives took place in their homes, though I met one at the physician's office where she worked and spoke with her during lunch at a restaurant.

The location and nature of the interviews suggested to me different kinds of practice. Not surprisingly, the nurse-midwives spoke with me in locations which increased the social distance between us while the lay-midwives spoke with me admist their home clutter. Interestingly, the nurse-midwives who chose to meet me at their homes were both influenced by alternative birth orientations, and were sympathetic to home birth. The conversations with them were more like the casual interviews with the lay-midwives in their homes. I experienced a similar situation with my interview of the defecting family practitioner who had been engaged in home birth. The social distance was minimized and an easy rapport

was readily established.

In retrospect, while this method proved to be much more time-consuming than other methods (for example, mailed questionnaires) it did provide detailed and grounded information--and a gestalt--which was relevant to the questions this study asked and which could not have been otherwise obtained. In addition, since much of my interest concerned complicated relationships, and differences, between and among subjects and groups, as well as material which subjects might regard as sensitive, I decided that actual on-site interviewing would be the most appropriate method.

I began conducting interviews using a structured interview schedule and I continued to use it as a framework for the interviews. However, as I began to grasp the larger complex of events associated with birthing in the state, as well as the subtleties of the relationships, I was more able to direct the interview to the specific expertise and awareness of the particular subject. It was for this reason that I chose to interview some subjects with special or unique expertise and information in the last phase of interviewing. Interviewing was begun in June, 1980 and was completed in September, 1981. A few subjects were re-contacted to check information or to discuss developments in their situations or practices.

My ability to anticipate issues in home birth and birth reform was enhanced by my earlier field work in childbirth

education. This research, which I did in Lansing, Michigan in 1979, increased my familiarity with medical, birth reform and home birth terminology and concepts. In addition, these experiences improved my understanding of the issues of concern among those elements of birth reform and alternative birthing. I also became a member of NAPSAC (the [Inter]-National Association of Parents and Professionals for Safe Alternatives in Childbirth) and read its newsletter. In 1980, I attended NAPSAC's eastern regional conference in Williamsport, Pennsylvania, and, during the course of writing the dissertation, I attended the NAPSAC-sponsored Alternative Birth Crisis Coalition Conference in Washington, D.C. in 1982. I also assembled and examined an extensive collection of home birth and birth reform literature.

To gain greater familiarity with nurse-midwifery, I reviewed the literature in the "new health professions" (cf. Bliss and Cohen, 1977) including the "expanded role of the nurse" (Teasley, 1978). I also attended a conference on nurse-midwifery education in Philadelphia in the spring of 1981 and regularly read the Journal of Nurse Midwifery.

These experiences helped me to both get a feel for the issues and the movement participants' vernacular and to locate the case study within the larger social movements and national scene.

While I was not an objective observer, neither was I clearly a partisan. I shared with birth reformers and home

birth parents the critique of professional hegemony but my loyalties were split. After all, my sponsor who facilitated my entree and supported my work was an obstetrician, a progressive person and a dear friend. In addition, my interviews with nurse-midwives included frank discussions of the problems of "professional women" in which I participated gratefully. At the same time, the independent midwives included "outsiders" by virtue of their work who understood and empathized with my marginal status as a lesbian. In some ways, my own ambivalence worked to my benefit, when a few of the interview subjects asked me, after my introduction to the interview, which side I was on, I could honestly explain my ambivalence. This satisfied them, and they seemed to appreciate that I was not about the business of testing some hypothesis on them or gathering up confirmation for some preconceived argument. Nonetheless, I did encounter some resistance from a few interview subjects. A few people eyed me critically, as an academic, I might be university--and thus professionally-oriented. Some resented the fact that I was watching them participate in their lives and offering no assistance. I felt considerable ambivalence about this myself. In addition, as a lesbian with no children of my own, I felt very ambivalent, and even somewhat ridiculous, moving about in actively and overtly heterosexual circles abounding with babies. Hopefully, my profound marginality in these circles did not obscure my vision; it did provide

me with a source of detachment.

Confidentiality is of particular importance in this study even though as one subject quipped, "Half of the state of Vermont is keeping a secret from the other half." Some of the information I obtained would place respondants in an awkward position. However, this seems to be because the information would have to be formally acknowledged and dealt with rather than because the information is truly secret. Further, since virtually everyone who has a central stake in this information has already been interviewed, it seemed fruitless to attempt to obscure the state about which I was reporting. Because the study population is small, every effort has been made to obscure the identity of the subjects who revealed truly "inside" information. Some sensitive issues I have chosen to avoid altogether.

I used several other sources of information about the situation in Vermont. One of the midwives with whom I spoke supplied me with copies of the proceedings of hearings before the Health and Welfare Committee of the Vermont House of Representatives concerning the licensing of lay-midwifery practice. In addition, she shared with me an extensive collection of clippings from state newspapers pertaining to home birth, lay-midwifery and birth reform. Other information was obtained through correspondence or telephone interviews with other actors involved in important events or from whom particular important pieces of information could be

acquired or checked. From the Vermont Public Health Department, I obtained copies of their annual publication of vital statistics as well as information about locations of hospitals and numbers of obstetrical beds. The State Board of Nursing Practice provided me with information on legal guidelines for nursing practice. A physician passed on to me a letter from the State Board of Medical Practice (Appendix) which I later consulted for a position on medical support for birthing alternatives.

While I brought to the study previous field research, familiarity with the literature on professions and social movements and training as a medical sociologist, I have sought to generate sufficiently varied and in-depth information to allow issues to emerge from the data. Glaser and Strauss (1967) suggest a method of analyzing data which is aimed at generating explanatory frameworks derived from the location of emerging patterns within the data.

However, I regard this suggested methodology as an ideal type and think that few, if any, researchers are actually able to "face the data alone," free of preconceived expectations which color their vision. Nonetheless, I have attempted to allow patterns to emerge from the information I gathered. I have also endeavored to avoid forcing the data into previously developed and perhaps ill-fitting frameworks.

I came to this research with hunches about the complex of events I was studying. I had derived these from my examination of theorists such as Larson (1977) and Freidson (1970a).

Thus, the method of data analysis which I used might best be described as the grounded modification of theory (Glaser and Strauss, 1967: 2).

The Organization of the Study

Subsequent chapters provide an overview of the broader social movements of which these examined in the case study are particular versions and moments. While I am not suggesting that Vermont represents a microcosm of national trends, it is a useful vehicle for understanding a part of the social processes which make up the national whole. Those characteristics which are unique to Vermont, or make this case special, indicate the varied circumstances under which changes in birthing practices and the development of the professionalizing occupation of nurse-midwifery occur.

In chapters two through four, I lay the ground-work for the case study which follows in chapters five through eight. In chapter two, I describe the manner in which, after the ascendence of allopathic medicine and the elimination of the lay-midwife, several social movements converged on the issues of health care, politicizing childbirth and its organization.

In chapter three, I examine the historic process by which allopathic medicine achieved professional status and came to dominate the medical care system. This enables me to consider both the general process of professionalization

as well as the specific situation in which allopaths' achievement of professional status conferred upon them the ability to mold and dominante subordinate occupations in an expanding medical division of labor.

Chapter four consists of a brief history of nurse-midwifery in the United States focusing on its development and efforts to professionalize on the margins of an increasingly obstetrician-dominanted medical division of labor. I note broader changes in the medical division of labor which resulted in medical efforts to draw nurse-midwives into hospital-based obstetrical care. In chapter five, I take up the case study describing the manner in which nurse-midwives were drawn into the medical division of labor in Vermont.

The movement for home birth and lay-midwifery is addressed in chapter six. Here I consider the goals and strategies of the movement, actually a client revolt, and the emergence of lay-midwifery as an occupation. I focus on the manner in which this movement has altered the social environment of birthing in Vermont.

In chapter seven, I consider the manner in which Vermont's obstetricians responded to growing lay criticism and attempts at intervention (birth reform) or innovation (home birth). Obstetricians and hospitals attempt to reassert normative hospital birth through conservative birth reform while some other physicians tried to create progressive and substantial changes through birth reform. Having looked at changes in

the social organization of hospital birth, in chapter eight I examine the manner in which nurse-midwives negotiate for professional status in these altered contexts. Finally, in my concluding chapter, I consider the way in which the findings of the case study shed light on questions about changes in the division of labor and the social organization of childbirth.

It is my hope that this case study, located within the larger social movements and historical context, will enable the reader to feel, as I do, a closeness to these people--mostly women--who are actively engaged in making history in a crucial social realm, the social organization of childbirth. They are negotiating and struggling to change their social world and they do so with little fanfare, day by day.

Chapter II

The Politicization of Childbirth Practices

Introduction

Childbirth practices in America have become contested terrain both within and without the medical establishment. At least two social movements have actively and explicitly challenged the professional hegemony of American obstetricians in the press, the courts and in daily life. These activities by the Feminist movement and the Home Birth movement, met with the active response by obstetricians to reassert their hegemony, have made problematic a sphere of social reality which was previously taken for granted. The organization of childbirth has become politicized; it has become a social problem.

Birthing as a Social Issue

In the United States, during the first half of the twentieth century, childbirth increasingly became regarded as a medical event, typically referred to as a "delivery." As allopathic physicians usurped birth attendance from lay midwives, they both reshaped the social meaning of the event and gradually altered both its location and the social relations of the participants. By the 1950's and until the relatively recent past, both the place of birth and the

appropriate attendant were virtually undisputed and alternatives were largely unavailable. There were two notable exceptions to this trend. For many generations, "granny" midwives and, since the 1930's a handful of nurse-midwives, have served poor, minority and/or isolated populations (Litoff, 1978; Lee and Glasser, 1974; Cox, 1973; Mongeau, et al., 1961; Maternity Center Association, 1956). Among the middle classes, birth reformers have, since the mid-1900's, sought more "natural" hospital deliveries, calling for the option to have births in which the mother was "awake and aware" (Karmel, 1959; Read, 1944).

In recent years, the appearance of consensus about childbirth and birthing practices has been replaced by a heated and thorough-going debate concerning almost all aspects of childbirth, especially the role, status and autonomy of the woman giving birth and the person(s) attending her. To better understand this change we need to consider the larger historical scene, since some of the actors previously involved, as well as some ideological positions, are reappearing, if in altered forms.

Historical Overview and Reinterpretation

For most of the 19th century, the (lay) midwife was the typical birth attendant for the vast majority of women, as indeed she has been for centuries. Even after the turn of the century, midwives held their ground against competitors, continuing to attend at least 50 percent of all births in

the U.S. However, by the late 19th century the rise of allopathic medicine had begun in earnest and by the time of the Flexner Report of 1910, the "men midwives" (physicians) were edging out (lay) midwives. This occurred first among the middling and upper classes and later among the working and poorer classes as well (though less completely). Allopaths, especially obstetricians, eventually restricted or eliminated their female competitors through legislation and licensure, though public relations campaigns were also important. Midwives' numbers not only declined dramatically as their practices were legally restricted or outlawed, they also became geographically restricted. Fully 80 percent were reported living in the South by 1930 (Litoff, 1978: 58; 141). They were allowed to persist on the fringe of the health care system because they provided services to those whom physicians could not or would not serve.

Recent literature has re-examined and challenged the mainstream history of this period which is typically related from the perspective of the now dominant medical establishment (Shryock, 1936). The new scholarship challenges the interpretation that the historical transformation in birthing practices and birth attendance constituted an evolutionary process in which progress occurred as the skilled experts (obstetricians) replaced untrained and inept caregivers (midwives). These studies have taken up issues of power, inequality and social conflict, which they see as crucial

factors in this shift to medical control of birthing. It is important to observe, and should not be surprising, that as the current social and political climate in this area changes, the interpretation of the history which preceded it is re-examined.

An instructive example of this historical reinterpretation is Litoff's (1978) examination of the ideological and political struggle between physicians and lay-midwives and their supporters prior to the development of medical hegemony in birth attendance. For the first three decades of the 20th century, a lengthy and heated debate took place between proponents and opponents of midwives. (Though the impact would be far-reaching, the actual contest was largely confined to legislatures, public health offices and medical societies.) Physicians typically called for the elimination of the midwife on the grounds that, due to her ignorance, she was responsible for the high rates of infant and maternal mortality which plagued the U.S. Further, they asserted that her status as common birth attendant had the effect of degrading the prestige of obstetrics as she inappropriately competed for some patient populations.

In contrast, the midwives' supporters argued that, like it or not, the midwife's common attendance at births was a reality and she should receive training. At least until some other solution was found, she should be drawn into the nascent medical division of labor, perhaps in a manner

comparable to that of her British counterpart. This could be done, it was suggested, through state licensing and regulation. The midwives and supporters countered the physicians' charges of midwives' incompetence by observing that much of the high infant and maternal mortality rates was the result of practices of ignorant and impatient physicians, who were themselves often carriers of deadly "childbed fever." Kobrin (1966) suggests that such charges by midwives were not without grounds. She discusses a 1912 study of obstetrical education in the U.S. which was conducted by an obstetrician from Johns Hopkins; he concluded that obstetrics was clearly the weakest area of medical education. Kobrin (1966: 353) summarizes his findings:

> ...the result of this neglect of obstetrics... was that poor facilities and poor professors were turning out incompetent products who lost more patients from improper practices than midwives did from infection.

Examining data on maternal and infant mortality for the first three decades of the twentieth century, Devitt (1979) analyzed the statistical case for the elimination of the (lay) midwife of that period. He concluded that the midwives' performance was, overall, superior to that of physicians, and that physicians overcame midwives in spite of, not because of, their statistical outcomes (see also Jensen, 1976). In spite of this poor showing, obstetricians remained on the offensive, asserting their irreplacability by stressing that the event of birth was a potentially dangerous one.

Claiming a special contribution to health care and demanding that their field was of significance to the well-being of the populace, they argued that normal births were the exception and expertise was necessary to deal successfully with abnormal births. Thus, obstetricians struggled to define childbirth as a medical event for which their services were required. Donegan (1978) argues that the shift from woman-attended to man-attended births involved a redefinition of the event from care-oriented to cure-oriented, in part to justify male presence in the context of the prevailing emphasis on modesty for women.

Concomitantly, while the recognition of principles of asepsis and practices of antisepsis had been central in the obstetricians' claims to superiority in birth attendance, these practices were only haphazardly followed. Particularly in hospitals, where 50 percent of all American women and 75 percent of urban women were giving birth by 1939, and where infections were both more likely and more potent, such laxity was devastating (Wertz and Wertz, 1977: 133).

Indeed, much of the routinization and standardization of procedures and thus the dehumanization of medicalized childbirth, resulted from the deadly outbreaks of puerperal fever and physicians' struggles to cope with it while maintaining their claim to being the woman's best attendant in childbirth. In this context, "the medicalized posture became one of manipulation, intervention and active combat," in the hospital

birth environment, (Wertz and Wertz, 1977: 137). While the hospital which was being touted as "safer than home" for birth actually housed potent infectious bacteria, women were being encouraged to regard their homes as germ-ridden (Ehrenreich and English, 1978).

Not only did obstetricians claim safer births in hospitals, they offered patients less painful delivery through the use of anesthetics. These claims and promises, coupled with the supposed advantages of hospital delivery (such as 24 hour staffing and preparation for any calamity) helped assure the emergent norm of hospital delivery with an obstetrician in attendance.

Allopathic domination of birth attendance did not mark an end to a contest over access to and control of the domain of birth. Within the ranks of "regular" doctors, competition between the general practitioners and the obstetrical specialists continued for decades, part of a larger competition between the generalist and specialist practitioners throughout allopathic medicine (Stevens, 1977). Obstetricians emphasized scientific medicine and cast the physician as scientist and expert in childbirth attendance, which they renamed "obstetrics." The rise of obstetrics, concomitant with the rise of hospitals, and ever more closely linked to them, thus involved not only a change in the designated birth attendant but also in the nature of the "delivery."

The transformations in birth attendance in Britian

represented a struggle that pre-dated, paralleled and was later tied to the American experience. In her examination of the competition and conflict between physicians and midwives, Donnison (1977) indicates the importance of actors' access to and control of related technology as well as their ideological claims to, among other things, the superiority of their technology and their exclusive use of it. Similarly, Sablosky (1976) emphasizes the use and control of forceps in the dispute over the terrain of childbirth in America. In both cases, male physicians controlled and employed these technologies and inventions. In addition, they were often charged with hasty and unnecessary intervention with their tools, often to justify their presence and their higher prices.

Berliner (1975) has suggested that from the outset, allopathic medicine viewed the body as machine-like organ systems subject to both disruption and cure from external sources; the germs which caused illness could be best attacked by scientifically trained physicians. Oakley (1979) observes that a paradigm still central in obstetrics is that of the woman's body as machine to be maintained and "actively managed" by the specially trained obstetrician, leaving postpartal women to feel a loss of self-control and self-esteem. The political implications of this obstetrical management and mastery of women are obscured both by the nature of the medical intervention (which represents itself as objective) and by dominant ideology about gender (which asserts that what

transpires in childbirth and the meaning given it are "natural" rather than socially and culturally created and thus mutable). In this way, the event of birth has been "medicalized," claimed by obstetricians, and given a particular mechanistic/scientific form. This juncture represents both the completion of a social and political struggle and the rapid growth of a technology-oriented medical system. Developments in obstetrical practices continue toward greater specialization in training, testing and procedures. For example, the rise of neonatology finds a space for a new speciality to fit between the obstetrician and the pediatrician. Additionally, increasing use of sophisticated technology and machinery and ever more active management of delivery appears likely (Goodlin, 1979; Marieskind, 1979).

The basic transformations in childbirth practices in the U.S. since the late 1800's may be briefly summarized. Childbirth was first typically regarded as a natural, if arduous and sometimes hazardous experience appropriately attended by (lay) midwives who were women. By the second decade of the 1900's, with the ascendance of allopathic medicine, childbirth had increasingly come to be included within the purview of the (white, male) allopathic physician's medical practice. Lay midwives were largely absent from the birthing scene by the 1930's, and hospital-based obstetric specialists employing forceps, anesthesia and, not infrequently, surgery, had defined childbirth as a medical event requiring the services of an obstetrician. They

had managed to gain the bulk of the market for themselves and had become a dominant profession which regulated and restricted competitors with the help of the state.

Social Movement and Trends Which Gave Rise to Recent Challenges to Obstetrical Hegemony and the Politicization of Childbirth

After this lengthy process of the professionalization of allopathic medicine, the rise of specialization and the medicalization of childbirth, we may ask why there has emerged a new era of debate about childbirth in America. Such interest and activity was "overdetermined" in the sense that several social movements came to focus on health and health care, while economic realities of rapidly rising medical and hospital costs created a social climate in which medical practices were more critically examined. Partly because the control by obstetricians was so complete in such a fundamental area of life, particularly women's lives social movements which were separate initially have begun to coalesce or at least intersect on this issue. If, as Zola (1972) and the Ehrenreichs (1978) suggest, the medical establishment is an especially effective institution of social control, such a convergence on this issue by groups seeking social change is not surprising.

The Women's Movement

In the second wave of the Women's Movement which arose in the United States in the late 1960's, women's control of

their bodies--both physical and spiritual integrity and autonomy--emerged as perhaps the central principle of Radical Feminist theory, and it has come to represent a key activist goal. That this focus on women's reproductive and bodily self-control is not new is evident in Gordon's (1976) documentation of the protracted struggle for reproductive freedom waged by women in the U.S. since the mid-1800's. Control of reproduction was a core issue in Firestone's (1970) ovular feminist treatise, and its centrality was reaffirmed in Rich's (1976) more recent examination of the social construction and degradation of motherhood (see also Fisher, 1979).

The focus for control of reproduction has been primarily on access to and safety of contraception, abortion, and gynecological care; in addition, the movement challenges professional and male control of medical care and information and the sexism women face as both patients and providers (Dreifus, 1977; Scully and Bart, 1977; Waldron, 1977; Barker-Benfield, 1976; Fee, 1975; Lorber, 1975; Ruzek, 1975; Ehrenreich and English, 1973b; Frankfort, 1972; Hole and Levine, 1971: 278-304, 355-362). With the 1971 publication of the movement pamphlet Our Bodies Ourselves, widely distributed and later published by a mainstream publishing house, (Simon and Schuster), the issue of pregnancy and childbirth began to enter the feminist agenda and the Ehrenreich and English pamphlet (1973a) Witches, Midwives and Nurses neatly tied together themes of Radical Feminism

with childbirth and healing and further politicized both birthing practices and the role of women as birth attendants (see also Corea, 1977: 209-261).

Deprofessionalization and (female) lay control of health care are central goals of the women's health movement, which grew out of the larger women's movement (Ruzek, 1978). This activist health movement, which has mushroomed since the early 1970's, focuses on women's physical health and aims to dramatically alter the content and delivery of health care through a two-pronged approach. First, activists work to educate women about their bodies, especially their reproductive organs, via self-help groups; this is coupled with a critique of the medical establishment and medical practices. Second, feminists have created autonomous clinics, the Feminist Women's Health Centers, which provide health care (focusing on reproduction) and educational services. These clinics are organized and run by (lay) women who structurally seek to deprofessionalize medical care by hiring physicians to perform restricted technical services (Health Center Staff, 1977; Women's Community Health Center, 1977; Mareiskind, 1975; Mareiskind and Ehrenreich, 1975). The feminist movement for self-help in health care has its roots most immediately in the second wave of the Women's Movement in the U.S., but it must be understood within a broader self-help tendency and tradition in the U.S. This tradition has deep historic roots and has manifested itself in a variety of ways.

Self Help in Health Care

In spite of the dominance of allopathic physicians in American health care, the movements for self-care have persisted (cf. Levin et al., 1979; Howell, 1978). The Popular Health Movement of the 1830's and 1840's actually managed to turn back the allopaths' first major effort at hegemony by championing populism in health care. Since colonial times, self-help has been a watchword in American culture and it persists as a countervailing theme to professionalism and the authority of expertise (cf. Risse, et al., 1977; Beecher and Stowe, 1870). Recent versions of self-care such as diets of natural foods, vitamin therapies and interest in alternative healing techniques may be an outgrowth of the counter-cultural movement of the late 1960's. This libertarian movement sought to overcome alienation and cultural malaise through a return both to "nature" and to more "natural" behavior (that is, less inhibition and greater physical and mental integration). It created a counter-culture which persists in varied forms and which has influenced the dominant culture. In contrast to the counter-culture's interest in Eastern philosophies and arts to promote well being, the dominant culture offers counterparts such as a multitude of exercise machines, sports clubs and the immense popularity of running. Items such as the blood pressure cuff are offered for sale with the claim of increasing self-knowledge of one's well being; a multitude

of organizations compete for the emotional self-knowledge and self-help market. (Indeed, Lasch [1978] has argued that our culture has become narcissistic and our society therapeutic.)

But while the self-knowledge and self-help tendency may create new markets for gadgets and therapies, it is double-edged and retains its (often latent) tendency to be critical and challenging of extrinsic control. Ivan Illich (1975) may be taken as a spokesperson for at least the more radical elements of the movement for self-care. He asserts that our lives have been medicalized and we have been lulled into a physically, psychically, socially and culturally damaging dependence upon physicians. Emphasizing that this dependence must be stopped, he calls for what is essentially an anarchist's vision of health care: self-care with a restricted medical back-up. (As we shall see, the homebirth movement puts forth a modified version of this system.) Somewhat less radical, but more practical and influential are the self-care journals, such as Prevention or Medical Self-Care.

Citizen Activism: The Consumer Movement in Health Care

The consumer movement also aims to tip the balance of power in medical care in favor of lay people. Such a tendency is never fully absent in a capitalist society where social power is characterized as purchasing power and the motto caveate emptor is offered to the discontented.

The present basis for the health care consumer movement may well have been laid in the federally-funded neighborhood health centers, part of the Johnson administrations' War on Poverty in 1960's (Twaddle and Hessler, 1977: 267). Programs such as this were a respone to the Civil Rights and Black Power movements which, among other issues, had put forth an angry critique of the inadequate health care received by minority and poor populations. Health centers funded by the Office of Economic Opportunity, although eventually scrapped by the Nixon administration, set a precedent for consumer participation in health care delivery and provided the impetus for further consumer activism. Activists who demand or engineer such changes in medical care are characterized by Alford (1975: 191) as "equal health advocates."

> (They) seek free accessible, high quality care which equalizes treatment available to the well-to-do and the poor. They stress the importance of community control over the supply and deployment of health facilities.

While the radicalism of the 1960's may have diminished, radical and reform movements did not terminate with the end of that decade. Boyte (1979) examines grassroots citizen organizing and activism in the 1970's. Generated from several discontented sectors of the population, this trend is evident in a variety of organizations, such as Fair Share, National Welfare Rights Organization, ACORN, and Gray Panthers. Many of these organizations took up health care as an issue of concern. Boyte (1979: 4) summarizes

developments of the 1970's:

> ...major developments merged in an increasingly self-conscious citizen's movement.... A groundswell of spontaneous grassroots activism among formerly quiescent groups of the population--like senior citizens, farmers and consumers--brought many tens of thousands of Americans into conflict with corporate giants and government officials. And the emergence of a coherent body of organizing and fundraising techniques resulted in the creation of several dozen enduring, multi-issue citizen action groups. Together, the strands of protest constituted signs of emerging "citizen action as a way of life."

Among those seeking reforms in health care, some have argued that consumers' needs would best be met by better organization and management of the medical care bureaucracy (Roemer et al., 1975). Another position, 'market reform' (cf. Alford, 1975), represents a substantial and growing sector of the consumer movement in health care. In this view, medical care is a commodity and the patient who purchases it is the consumer; the hope for reform rests largely on the expectation that market forces, when properly activated, will give rise to a health care system which better meets (at least the informed) consumers' needs. Toward this end, activists embark on strategies of patient (consumer) education, and the creation of reforms aimed at allowing consumer choice among several alternatives, thereby asserting consumer demand through "dollar votes." In short, physicians and hospitals are regarded as expert (if sometimes excessively traditional or monopolistic) sources of care who are selling their services to consumers whose rights as buyers are

to be respected (Belsky and Gross, 1975; Freese, 1975; Gaver, 1975). Much of what transpires in childbirth education and prepared childbirth classes constitutes consumer education even as it also socializes participants into a more self-controlled patient status (Rothman, 1978). Such activism is not without effect; consumers are increasingly willing to challenge the expertise of professionals (Lopata, 1976) even as they have for some time consulted one another for information about whether, when, how and where to seek medical care via the "lay-referral system" (Freidson, 1970a).

Concern with Rising Costs and Physician Practices

The cost of medical care is a central issue of the consumer movement and is a concern shared by many others. Dramatically rising medical, and particularly hospital, costs have been responsible for a sizeable portion of the inflation rate as well as growing interest in cost-benefit and cost-effectiveness analyses of medical care. Control of spiraling health care costs is an oft-heard theme, especially within the federal government. For example, the 1976 Forward Plan for Health, after considering the sobering national economic context and the dramatically rising federal outlays for health care, concluded "until costs can be contained, Federal policy-making in health care will be dominated by these basic economic considerations" (Collen, 1976: 1).

Several authors have discussed related issues: the economic impact of inappropriate priorities in health care

(Lave and Lave, 1970), problems of resource allocation (Hiatt, 1975; Fein, 1968), and the structural inadequacy of the health care delivery "system" which both creates waste and fails to meet needs (Roemer, et al., 1975). Working from a Marxist perspective, a number of critiques of the U.S. health care industry have asserted, among other themes, that the system is better equipped to generate profits than to meet the nation's health needs (Ehrenreich, 1978; McKinlay, 1977; Navarro, 1976; Waitzkin and Waterman, 1974; Ehrenreich and Ehrenreich, 1971). Even private industry is more critically examining the costs of medical care and physician practices (Forbes, 1977). The facts that hospital costs are the most rapidly rising medical costs and that obstetricians are among the top paid physicians (Corea, 1980), are gaining visibility as issues. In this light, assertions by some home birth activists that up to 90 percent of all births are essentially normal and do not require hospital confinement or obstetric services contain considerable economic import.

While costs generated by the health care industry are closely watched, physicians' practices are ever more closely examined and criticized. Several authors have criticized physicians' practices, challenging the scientific basis and application of medical practice in the past (Ehrenreich, 1974), the influence of non-medical factors in prescribing mood-modifying drugs (Waldron, 1977), ethnocentrism among providers and insensitive treatment of women and minorities

(Weaver and Garrett, 1978), and physicians' use of hormones (Seaman and Seaman, 1977) or unnecessary surgery (Rodgers, 1975), as a "cure" for women's normal anatomy and physiology. Finally, Millman's (1977) study of the processes by which physicians rationalize and cope with mistakes indicates the extent of the careful scrutiny under which medicine, physicians and physician practices have come (see also Bosk, 1979).

Thus, several trends and social movements have facilitated a growing and critical interest in the practice of medicine and the social ramifications and economic impact of allopath's monopoly on healing. In addition, criticism from other quarters is emerging. While these will be examined in greater detail in the chapters to follow, they warrant mention here.

Encouraged by the women's movement, general social trends promoting health care (rather than medical care) and the growing need for care-giving for the chronically ill (where there is no cure), nursing is more actively struggling to achieve professional status and autonomy. Like subordinates elsewhere, nurses are privy to the hidden side of medical care and if and when they break their silence, a critical picture of medicine is likely to emerge (cf. Duff and Hollingshed, 1968: 66-88). Further, professionalization moves by nursing are likely to reveal that physicians are as inclined to protect their professional interests as they are to protect the nation's health. Meanwhile, advocates of alternative birthing practices are quick to point out that organized

medicine seeks to stifle most alternatives even (or especially) where they provide superior health outcomes among middle-class patients (NAPSAC NEWS, Spring, 1981).

Birth Reform

There have been numerous efforts to ameliorate problems or reform birth practices; many have concentrated on education and training programs for prospective parents. Organizations such as the International Childbirth Education Association (ICEA), The American Society for Psychoprophylaxis in Obstetrics (ASPO), Lamaze prepared-birth classes (cf. Schueler, 1976) and the Bradley method ("husband-coached childbirth"), prepare parents for more "natural" hospital deliveries.

Perhaps more importantly, there has been growing support for both home birth and lay midwifery (Gilgoff, 1978; Bean, 1977; Arms, 1975; Gaskin, 1975; Lang, 1972). A relatively new organization, which casts itself as a "prochoice" movement (though it ironically seems anti-abortion), champions home birth as a viable option among others. Calling itself the National Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC), it has successfully brought together at its annual conferences a wide spectrum of people concerned about birthing practices and options. The proceedings of the conferences are published (Stewart and Stewart, 1979; 1977; 1976). This organization openly challenges normative hospital birth as is evidenced by the

title of their most recent compilation: Compulsory Hospitalization and Freedom of Choice in Childbirth. Other pro-home birth organizations represented at NAPSAC conferences include: The Association for Childbirth at Home, International, The American College of Home Obstetrics (G.P.s), and The Farm, a rural commune in Tenneseee which supports, practices and teaches home birth attended by lay midwives, and publishes The Practicing Midwife, a periodical apparently widely read by lay midwives and by some nurse-midwives as well.

The Provider Oriented Movement to Re-assert Hospital Birth

Birth reformers have spent years educating prospective parents and attempting to establish rapport with obstetricians and hospital administrators in order to institute their desired reforms in birthing practices. They have finally begun to experience some success (Forrest, 1979; Parfitt, 1977). These hard-won in-hospital alternatives in childbirth include the acceptance by the hospital and some attending obstetricians of the (restricted) presence of the father/coach in labor and the delivery room. Many hospitals exhibit greater willingness to allow "rooming in," that is, extended periods of mother-infant interaction in contrast to the traditional rigid feeding schedule and visits of short duration. The efforts of ASPO/Lamaze-prepared or Bradley-trained parents (including the strategy of bringing suit) have created greater provider concern for the parents' experience of childbirth and have, to some extent, overcome obstetrician

resistance to "natural childbirth" or deliveries in which the woman is "awake and aware." Indeed, some hospitals are now allowing fathers into the delivery room while Cesarian sections are being performed (this is significant as it coincides with a noticeable rise in the C-section rate [Marieskind, 1979]). Some sections are performed under local anesthetic so that C-sectioned mothers too are "awake and aware." Whether or not such practices constitute meaningful options or merely accommodations to the more adamant patients remains to be seen. It is clear that such birthing options are severely limited and vary considerably by hospital, attending physician and the patient's and coach's strength of will (Bean, 1977).

A birthing option repeatedly sought by reformers and widely touted by participating hospitals is the "birthing room." This variant hospital birth setting is typically described as "home-like" and is portrayed as a comfortable place staffed by caring workers in which consumers will have a good birth experience--with a ready medical back-up should anything go wrong. Birthing room literature sometimes explicitly states that this alternative aims to bring those who had planned a home birth back to the hospital (for their own good). The birthing room is often suggested as the antidote to the segmentalization and routinization of typical hospital delivery since both labor and birth take place in the same room.

There is a growing emphasis within the medical establishment on creating, or allowing the creation of birthing alternatives within the hospital; such alternatives are frequently coupled with the employment of nurse-midwives. Obstetricians who, in the past, vociferously opposed the institution of midwifery in the medical division of labor have begun to look upon it more favorably (Cannings and Lazonick, 1975). Parfitt (1977: 110-111) explains,

> Nurse-midwifery was officially recognized in 1971 by the professional organization of the medical/obstetrics community, the American College of Obstetricians and Gynecologists (ACOG). The Nurse-midwife, stated ACOG, 'may assume complete care and management of uncomplicated maternity patients while serving as a member of an obstetrics team." (emphasis mine)

Thus, nurse-midwives, especially those who practice in hospitals creating new birth settings are increasingly being touted as the solution to the developing struggle in the care of birthing women (Thiede, 1977). This strategy may derive from conservative obstetricians' intentions to "oil the squeaky wheel" by placating and thus silencing home birth activists critical of the hospital. Some more progressive physicians may see it as a vehicle to humanize and thus revitalize obstetrics. In any case, institution of such reforms, though apparently increasing, is still severely limited. As of 1976, nurse-midwives attended only one percent of all births in the U.S. (Rooks, 1976).

Locating the nurse-midwife squarely in the midst of this struggle may have the effect of placing the (female)

nurse-midwife rather than the (male) obstetrician, in the position of defending hospital birth and challenging lay midwifery and the home birth movement. However, the willingness of nurse-midwives to accept this role should not be assumed. While nurse-midwives find themselves forced to take a position in the struggle over childbirth practices, their perspective is far from unified and at least some members aim to thoroughly consider the position of the home birth movement and lay midwifery before committing themselves. For example, at the 23rd annual convention of the American College of Nurse Midwives, discussion topics included birthing rooms and lay midwifery. Further, nurse-midwives are not completely spared criticism from advocates of lay midwifery (arms, 1976). Some argue that nurse-midwives are trained within the medical--not midwifery--paradigm and thus may be intended to function more as an extension of the obstetrician than as an independent midwife who shuns unnecessary medical intervention (see Rothman, 1978 for a discussion of these paradigms).

Nurse-midwives are increasingly caught up in the debate over home birth. Some nurse-midwives have called for a re-examination of ACNM's policy on home birth (cf. Litoff, 1978: 144). Its 1973 policy, determined by the executive board, endorsed only the "hospital or officially approved maternity home as the site for childbirth..." although the position has softened since then. The 1978 speech by the

president of the ACNM, Helen Burst, to the College included a keen recognition of the increasingly difficult position into which nurse-midwives were being put. After discussing consumers' demands to have the option to determine their birth experience, she explained,

> Unfortunately, the alternatives (to traditional obstetrical practices) the nurse-midwife often proposes are frequently rigorously opposed by physicians. In a very real sense, nurse-midwives are caught in the middle of the conflict between the consumer and the physicians. The nurse-midwife in spirit, heart and philosophy, is with the consumer. But the nurse-midwife legally and professionally has to work with the physician, and it is the physician who has the power in the health care system.

She concluded her speech by asking her colleagues to be openminded concerning the issue of lay-midwifery, and she acknowledged the growing number of practicing lay-midwives in the U.S. (Burst, 1978: 3).

Summary

Both childbirth practices and attendants have changed dramatically in the last hundred years in the United States. Despite struggles by lay midwives and their supporters, the ascendance of allopathic physicians continued relatively unabated. It culminated in a hospital-based system of medicalized childbirth in which specialization and intervention increased, giving rise to current standards of practice which encourage "active management" of labor and birth by obstetricians.

However, movements as diverse as conservative birth reform, consumer activism and radical feminism have sought modification and alterations in birthing practices and provider-consumer relationships. The medical profession has responded with strategies aimed at warding off lay criticism while maintaining normative obstetrician-attended hospital births. In this context, obstetricians become particularly interested in shaping the development of nurse-midwifery, but evidence suggests that nurse-midwives have their own agenda in mind.

Chapter III

The Professionalization of Allopathic Medicine and the Medical Division of Labor

In order to more fully understand the development of nurse-midwifery, it is necessary to examine the context in which it began and in which it is attempting to professionalize. I have already briefly discussed the historical transformation in birthing practices and birthing attendants in the U.S. To this understanding, I must add an examination and analysis of the structure of the medical system of care provision, particularly the medical division of labor and the dominance and centrality of allopathic medicine within it. The ideological transformation of childbirth from a family or community event to a medical event was a necessary component of the establishment of allopathic pre-eminence at birth. However, that in itself guaranteed neither the new attendant's status, income nor its ability to resist incursion from rivals making similar claims to medical competence.

I shall examine the manner in which allopaths, one sect of healers among many, were successful in their attempt to professionalize, eventually coming to control a highly articulated division of labor in a burgeoning and profitable medical industry.

First, let us examine the concept of professional status. What is its significance and what is meant by professionalization, the process by which groups attempt to achieve it? Several authors have taken up these questions but I will limit my discussion to major authors whose work has the most immediate bearing on my own. For Freidson (1970a) the crux of professional status is autonomy. A profession is able to determine the content of and rules about the appropriate performance of its work, however, he notes that professions do not invariably determine and control the context in which the work. Or, as Hughes (1964: 78) observes,

> An occupation consists, in part of a successful claim of some people to license to carry out certain activities which others may not, and to do so in exchange for money, goods or services. Those who have such license will, if they have any sense of self-consciousness and solidarity, also claim a mandate to define what is proper conduct of others toward the matters concerned with their work.

This license to the exclusive performance of particular tasks derives in part from the occupation's claims. These include assertions of a service ideal and ethical standards of behavior as well as a monopoly on a relevant body of knowledge. The profession, "claims to be the most reliable authority on the nature of the reality it deals with," (Freidson, 1970a: xvii). However, such claims do not translate directly into professional status, since that status is not only normative, it is also structural. The basis of the professional status of medicine is political; the state

has, "deliberately granted the profession autonomy, including the exclusive right to determine who can legitimately do its work and how the work should be done" (Freidson, 1970a: 72). Thus, a profession may be said to have "legitimate organized autonomy," that is, it is essentially and legitimately free from external, lay control and intervention.

How does an occupation arrive at this very special status and why does the state grant it this autonomy? The occupation itself has neither the resources nor the credibility to single-handedly cause the state to bestow such privileged status. Neither is the profession's status necessarily the outcome of strong consumer support, although some professionalizing occupations have benefitted from that (Kronus, 1976). In fact, such popular support was noticeably lacking for allopathic medicine during its bid for professional status in the U.S. Early allopathic moves toward professional status were turned back by the Popular Health Movement of the 1840's. Instead, as Freidson (1970a: 72) suggests,

> A profession attains and maintains its position by virtue of the protection and patronage of some elite segment of society which has been persuaded that there is some special value in its work. Its position is thus secured by the political and economic influence of the elite which sponsors it--an influence that drives competing occupations out of the same area of work, that discourages others by virtue of the competitive advantages conferred on the chosen occupation and that requires still others to be subordinated to the profession.

Professionalization and Class Interests

Berliner (1975) takes up the issue of elite sponsorship emphasizing the pivotal role of material support for allopathic medicine's professionalization project from economic elites. He argues that the influential Flexner Report of 1910 marked a watershed in the allopaths' process of professionalization because it was the outgrowth of a confluence of interest between allopathic leadership and certain industrial capitalists. Rockefeller was already enamoured with scientific medicine and scientific medical research prior to the Flexner study. For its part the Carnegie Foundation had taken considerable interest in the development and role of professions, viewing them as potentially, "stabilizing influences in their communit(ies)" (Berliner, 1975: 587).

The Flexner Report, carried out under the auspices of the Carnegie Foundation, was widely perceived as a neutral evaluation of medical education (unlike the partisan AMA study conducted in 1906). However, as Berliner observes, not unlike the previous AMA study, the basis for the evaluation of medical education was a school emphasizing scientific medical research, in this case, Johns Hopkins. Thus, the Flexner study post-dated and paralleled a study conducted by organized elements in allopathic medicine who had already begun to undertake the task of reforming the occupation.

Upon completion of the study, many medical schools were forced to close their doors, including the bulk of those

training women and minorities. In contrast, allopathic medical schools received over $154 million dollars from foundations ($66 million from Rockefeller alone) to facilitate medical education reform toward scientific medicine and medical research (Berliner, 1975: 589).

The reason for the intense interest in medical education by representatives of the industrial capitalists was, according to Berliner, the convergence of paradigms. Industrial capitalists in particular were faced at the time with the thorny problem of facilitating further capital accumulation while maintaining social order, that is, they sought to legitimize and entrench the existing social relationships with regard to the mode of production. During a period of intense social unrest, scientism emerged as a vehicle for creating reforms which were ultimately conservative; they conserved the existing system inhibiting radical transformations in fundamental social relations (cf. Kolko, 1967). Berliner (1975: 574) explains,

> The response of the capitalists as a class manifested itself in the transformation of social problems into technical problems. Problems whose actual basis was social and hence whose solution was political were transformed into problems of science whose solution was technological.

In this context, scientific medicine, which construed illness and disease as resulting from specific etiology (cf. Dubos, 1959) was preferred by capitalists to holistic approaches. Allopathic medicine focused attention on individual pathology

and construed the body as machine-like (a metaphor likely to be attractive to industrial capitalists). It is thus individuated medical care and diverted attention from both social and environmental causes of illness and collective orientations to medical care and health promotion.[2] Thus, Berliner implies, allopathic medicine was sponsored in no small part as a vehicle of social control.

Because of this convergence of ideology, scientific medicine, as undertaken by the university-educated elite of allopathic medicine, was intensely promoted by industrial capitalists, Berliner argues.

However critical the initial convergence of ideology between the professionalizing occupation and its sponsoring elite, the protected status of the profession enables it to develop along its own course. At the same time that its

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[2]This mode of individuation of medical care derives in part from a medical acceptance of Spencerian ideology creating what Sedgwick (1974) calls "medical individualism." This is a model of care-giving based on a contract model deriving from a fee-for-service orientation and privatizing care-giving. Medical individualism tended to restrict access to "first quality care" to those able to pay, that is, able to enter into the contract. It was later to create a system of sponsorship of hospital patients by physicians. Several authors have critiqued the manner in which a two or three-tiered system of care-provision has emerged, in whch those unable to pay are either turned away or transformed into teaching or research material thereby receiving lower quality care or experimental treatments often linked with active staff evaluations of social worth and efforts at social control (Jones, 1981; Scully, 1980; Ehrenreich and Ehrenreich, 1978; Lorber, 1975: Reissman, 1974; Shaw, 1974; Zola, 1972).

potential for the production of ideology is enhanced, it is freer to diverge from that of the sponsoring elite, Freidson suggests. For example, we have already seen that federal efforts at cost-containment in health care are inhibited by increasingly active (and expensive) medical intervention into conditions (such as childbirth) which are, in some other nations with better overall health outcomes, thought not to require medical intervention.

Nonetheless, Freidson (1970a: 73) observes that having elite and state-sanctioned autonomous professional status does not constitute a timeless guarantee, rather, "...if a profession's work comes to have little relationship to the knowledge and values of its society, it may have difficulty surviving."

Expanding on Freidson's analysis, Larson (1977) observes that the great wave of professionalization in the Western world emerged along with the rise of industrial capitalism while its roots extended into the larger transformation from the feudal mode of production to capitalism--typically referred to as the process of "modernization." In a period of profound social transformation, previously unavailable occupational opportunities emerged and professionalization represented a collective enterprise by participants to locate, and control, and eventually, monopolize markets for their standardized services. Larson refers to this new form of organization around the cash nexus as a "collective mobility project."

Previously established professional collectivities were tied to and ideologically liked with older and declining elites. But, new professionalizing occupations were emerging, led by organizers and reformers "organically" tied (thus ideologically linked) with the rising class, the bourgeoisie. Where traditional professions had served elites or functioned in elite-controlled spheres, new professionalizing occupations sought to locate new and broader markets. Where traditional professions emphasized exclusivity and status markings, the emerging professions burned the candle at both ends, sometimes invoking status markings but more typically stressing training, education, and systems of credentialing as guarantees of competence.

Occupations successful at the collective mobility project eventually enjoyed higher incomes, higher status and often, freedom from lay intervention. According to Larson (1979: xvii), "professionalization is...an attempt to translate one order of scarce resources--special knowledge and skillls--into another--social and economic rewards." This translation is a lengthy process.

In order to begin to establish market control, associations of producers of services had to define a cognitive base. Once this base was at least approximately delineated, the occupation could begin to use it to make claims of superiority and to create monopolies over access to it, that is over teaching and training (necessitating a break from

apprenticeship training systems where standardization could not be guaranteed).

It was in control of the educational process that the basis for monopolization of a market was laid, since it was in the educational process that the "production of the producers" of services took place. This control was critical, Larson suggests, because the actual commodity being produced was not the task performance itself but the professional person performing the services. Thus it was in education that the negotiation of cognitive exclusivity could be realized and claims to superior knowledge, skills and task performance (as well as professions' assertions of high ethical standards) could be translated into a reliable and standardized product: the producer. According to Larson, the Flexner Report and the reforms associated with it represented and echoed the broader nation-wide process of "...rationalization of production which had arisen to meet the anarchy of competition and the excesses of laissez-faire," (1977: 163). At the same time, these successful reforms marked the culmination of the process of professional unification (determining who was in and who was out). The de facto restriction of medical education (and thus professional practice) to white men of the middle and upper classes probably improved the profession's prospects for success. As Hughes observes (1964: 44),

> The movement to 'professionalize' an occupation is thus collective mobility of some among the people in an occupation. One aim of the movement is to rid the

> occupation of people who are not mobile enough to go along with the changes.

However, once this process was completed, the struggle for position within the professions emerging system of internal stratification began in earnest.

Internal Stratification in Medicine

In the wake of the Flexner Report and subsequent reform of allopathic medical education, the sucess of the AMA in controlling the profession appeared to be assured. After all, its desired outcome--the scientifically trained generalist physician--was rapidly becoming a reality. AMA control of state licensing boards provided a check on both would-be competitors and its own graduates. But even as these reforms were being instituted, they were becoming outdated, the movement in allopathic medicine was toward specialization, as Stevens (1976: 116) observes,

> As the basic licensing process was 'solved,' the scramble for specialization was on. The AMA had focused on the university as the center of medical training; it was doubtful whether it would be able to achieve the same domination of medical training at the graduate level which it had achieved so spectacularly in its undergraduate program. To do this would be to involve the extension of its influence over all aspects of medical practice, including the hospitals and the increasingly independent specialist groups.

The hospitals themselves had grown dramatically from 1800 to 1920, paralleling the rise of allopathic medicine and helping to shape it. Though hospitals in one form or another had existed for centuries, they had historically

been tied to religious charity, death houses, or state supported poor houses. While they may have provided vehicles for medical and surgical training, they did not provide paying patients; in fact, patients who could pay shunned hospitals until around the turn of the century when they began to be drawn into them. We shall examine later how nursing is tied to this trend, for now it is useful to note that this trend was both the outgrowth of and further impetus for the rapid development of surgery.

With more widespread understanding of the principles of asepsis and greater attention to the practices of antisepsis, surgery became more viable and surgical specialization, including subspecialization such as gynecological surgery, was creating what we would now call a growth industry. Feeling the pressure of the developing trends in the structure of medical organizationand practice, the university-trained generalist's education was increasingly being augmented by internship (hospital apprenticeships). Where previously these internships were few and guaranteed special privileges to those who completed them, by WWI they had become increasingly a component of standard medical education.

The AMA Council on Medical Education (composed largely of medical professors) had become interested in internship programs and thus in the hospitals in which the interships took place. The AMA considered undertaking the task of examining and reforming internship and hospitals but was

discouraged from this venture when Carnegie funding for the project was not forthcoming. Meanwhile, The American College of Surgeons, formed in 1913 as the second specialist organization in the U.S., decided to undertake the project itself. By 1916, the College had received a Carnegie grant for this purpose and, after being formally joined in the project by the American Hospital Association, it set about to reform and standardize hospitals.

Thus, the AMA was never able to gain full control of graduate medical education and training, specifically internships and residencies. The outcome might have been different had they been able to assert leadership in hospital reform. As it was, a specialist organization, the College of Surgeons, was able to wrest control of this (expensive) leadership role. Here, as elsewhere, the AMA, which functioned as the spokesperson of the generalists, took second place to specialists.

Though generalists continually attempted to resist subordination to specialist over the next fifty years, specialization continued to be more lucrative and prestigious. When finally, general medical education and internship came to be construed as the basis for specialist residency programs, the die was cast and generalism continued to decline into its current virtual oblivion. (However, the power of the AMA has not declined similarly, for example, Brown [1973] argues that it currently functions as something like a holding company for specialist interests.) A recent attempt to create

specialization in general practice via residencies in "family practice" has had some success in attracting students, but many of the other problems of generalist vs. specialist remain.

The State and the Relationship With a Lay Clientele

Medicine needed to differentiate itself from the lay public, unify and differentiate itself from competitors, and standardize the production of professional producers. At the same time it had to locate a market. Larson suggests that for medicine this situation was particularly problematic because of the unique characteristics of the potential market. In this aspect, as in others, state intervention was critical, and establishment of a monopoly was necessary for the success of the professionalization project. In healing, the market is potentially wide-open and encourages competition. In this context allopaths were faced with the task of constructing a market for their services.

> The 'premodern' situation culd not be overcome by medicine so long as consumers, when they changed providers, also changed medical commodities: in such a situation we cannot speak of one market for medicine, but of many (Larson, 1977: 20).

Thus, realization and control of a market for the commodity required the elimination of competing commodities, that is, other producers of services. This necessitated assistance from the state since the location and control of the market could be realized without state intervention facilitating a monopoly (via accreditation of educational facilities and

licensing of their graduates).

> The universal need for medical services represents a tremendous asset for a category of professional producers only after they have succeeded in establishing a monopolistic hold on their market. Until then, the universality of the need operates in reverse, breeding competition (Larson, 1977: 21).

Both Freidson and Larson point out the important role played by the state in granting the medical profession legitimate autonomy and thus a market monopoly. Nonetheless, they also emphasize that this crucial turn of events does not in itself guarantee success for the profession. Medicine is a "consulting profession" (Freidson, 1970a: 17) and, as such, requires active use by a lay clientele. Though the profession and the state may, in partnership, eliminate competitors, they cannot coerce the lay public to consume medical services. Freidson indicates that while "...the survival of medical practice depends on the choice of laymen to consult it. Choice to consult cannot be forced; it must be attracted" (1970a: 21). Larson develops this point, emphasizing the role of ideological production and internal unification within the profession facilitated by reformers and leaders in the professionalization project.

> The actual effectiveness of (legally enforced monopolies of practice) depends on the parallel constitution of a 'monopoly of credibility' with the larger public (1977: 17).

Where these authors point to ideological persuasion as the profession's ultimate vehicle for the creation of a consulting clientele, Illich (1976) emphasizes its coercive

strategies for extension of its monopoly. He accuses medicine of creating a "radical monopoly." In this extreme monopoly not only is access to competing products severely inhibited, but even the choice not to consult is discouraged as self-care is undermined.

> (R)adical monopolies disable people from doing or making things on their own...they impose a society-wide substitution of commodities for use-values by reshaping the milieu and by 'appropriating' those of its general characteristics which have enabled people so far to cope on their own.... The malignant spread of medicine...turns mutual care and self-medication into misdemeanors and felonies (1976: 42).

In contrast, Freidson (1970a: 17) explicitly counters Illich's charges by asserting that medicine has never had,

> ...anything like a complete monopoly over healing services, either formal or informal. It is still virtually impossible to prevent a patient from treating himself (sic) or from seeking help from friends and relatives.

In regard to childbirth and the home birth movement, this debate will be most relevant.

In summary, persuasion of elite sponsors and creation and control of state vehicles for development and maintenance of monopoly were critical in allopathic medicine's process of professionalization. At the same time, the professionalizing occupation needed to locate a market for its services among the lay public and convince a clientele to consult it. These are the larger ways in which professionalization has historically occured for medicine. But examined at the micro level of analysis, professional status is both realized

and recreated in face-to-face interactions with other workers. The work place becomes the arena in which occupational turf is claimed and defended.

Professional Turf

On the level of day-to-day work performance, how do participants in an occupation create and recreate (or maintain) professional status? Kronus (1976) suggests that another way of construing the professionalization process is to look at the delineation and defense of "turf." The "turf" is a socially created social space which typically consists of particular task activities, whose performance an occupation has monopolized. Freidson suggests that for allopathic medicine the crux of these task activities is the ability to diagnose illness, to cut and to prescribe medication. As previous dicussion of the literature indicates, these task activites will be construed by the profession as necessary and central to the facilitation of particular outcomes, for example, effecting a cure. Further, the associated producers will assert special expertise in the knowledge about and performance of these tasks.

Once task activities have been delineated and monopolized, their socially created parameters, "task boundaries," must be carefully maintained. Pressure from competitors frequently takes the form of incursion on task boundaries; Kronus suggests that incursion must be successfully resisted in order for the profession to maintain its turf and thus the basis

of its claims for professional status.

Professions, like other elements of social life, are dynamic and it would be inaccurate to suggest that the turf of an occupation does not change. Friedson was careful to describe only the most fundamental tasks as the crux of medicine. I have already suggested, as have other authors (Reiser, 1981; Stevens, 1976; Hughes, 1964), that the nature of medical practice has changed fairly dramatically since the Flexner report of 1910. The rise of scientific medicine and specialization coupled with increasing reliance on sophisticated technology has created a kind of medical system and medical practice quite unlike that of the generalist-centered primary care provision of seventy years ago. Nonetheless, as Kuhn (1964) and Larson suggest, the profession's prospects have been tied to the success of its paradigm in explaining and predicting phenomena. This paradigm has come to form the base of the occupation's created status and, barring a major (and disruptive) paradigmatic shift, the "turf" of allopathic medical practice will continue to derive from this base. Thus, medicine's paradigm, cognitive base, or social construction of reality, give it some room to move in terms of turf; at the same time, a paradigm imposes very real limitations and demarcations.

At least one observer suggests that by so actively embracing technology and by delegating tasks to subordinates, physicians are finding themselves transformed beyond recognition becoming more like technicians or managers than primary

care-givers (Maxman, 1973). The parameters and thus limitations of the medical paradigm are also closely examined by Rothman (1978) who compared medicine's construction of pregnancy, and childbirth with that of lay/empirical midwives.

Thus, the turf may change somewhat but ultimately both incursion by competitors and presentation of alternative pardigms must be actively resisted.

Finally, some authors (Bucher and Strauss, 1961) have suggested that the process of professionalization may be fruitfully understood as a social movement. Others, (for example, Larson, Hughes), have emphasized the collective aspect of the undertaking and the necessity for individuals among the associated practitioners to accept the primacy of collective goals and strategies in their pursuit of the "collective mobility project."

A social movement orientation to professionalization highlights, among collective strategies, assertions of "special contribution" (including special knowledge and skills, with the added sense of mission). The participants not only endeavor to persuade relevant elites, they simultaneously create and project an image; while that is a strategy, it is also an aspect of the larger process of development of ideology. Strategies and ideology are expected to be linked, contradictions tend to produce conflict or at least dissent within the ranks.

Thus, the process of professionalization can be seen as

something more than simply a rational collective creation of better paying work which confers higher social status. Participants are likely to believe in the work they are doing, participate in the recreation of the ideology and take on all or parts of the ideology as their own world-view with a sense of personal mission. This shared world-view is one manifestation of the boundaries of the professionalizing occupation, in addition to those other markings previously discussed, for example, credentials, license, etc. As with other movements, segmentation, conflict and schismogenesis are possible, though perhaps less likely since the collective undertaking promises material rewards.

Strategically, professions and professionalizing occupations negotiate and maintain their turf through alliances; clues to both ideology and strategy may be suggested by "colleagueship" the process by which particular others come to be construed as colleagues. Finally, mechanisms for recruitment into the profession/professionalizing occupation as well as those aimed at resisting the defection of members may be fruitfully examined.

The Development of the Medical Division of Labor

A central characteristic solidifying the pre-eminence of the medical profession is its location in and relationship to the medical division of labor. As Freidson notes, the medical division of labor is, overwhelmingly, organized around the medical profession and its turf. In fact, Freidson

(1970a: xvii) suggests that a profession is distinguished from other occupations by the fact that it is, "...an occupation which has assumed a dominant position in a division of labor so that it gains control over the determination of the substance of its own work." Describing medicine's claimed mandate to determine the nature of the social reality with which it deals, Hughes (1964: 78) explains,

> (The mandate) include(s) a successful claim to supervise and determine the conditions of work many kinds of people; in this case, nurses, technicians, and many others involved in maintaining the modern medical establishment.

The medical division of labor is noteworthy, according to Freidson, in that it is ordered not by historical accident or pluralistic competition for turf, but by the medical profession itself. Questioning the notion that the performance of particular task activities is crucial in the placement of medicine in the medical division of labor, he points out that many tasks once regularly performed by physicians have now been delegated to other workers. Instead, he emphasizes that it is social relationships which define the medical professionals and paramedical workers:

> What the physician does is a part of a larger technical division of labor and sometimes not a very distinct or generic part. It is the physician's <u>control</u> of the division of labor that is distinct (Freidson, 1970a: 48).

Paramedical occupations, in contrast, are more noteworthy for their, "relative lack of autonomy, responsibility, authority and prestige" (1970a: 49). Nonetheless, they are closely

associated with practitioners in a lucrative, powerful and prestigious profession and that propinquity colors their own work and ideology. Further, Freidson observes that some other occupations, performing functionally comparable tasks may be characterized as "quacks" rather than paramedical personnel, because they are outside the control of the dominant profession.

Thus, the current medical division of labor emerged after the ascendance of allopathic medicine around which, and largely by which, it was organized. The previously existing unorganized division of labor in healing was superseded and largely replaced by medical/technical workers subordinate to allopaths who function primarly in hospital-based work structures. Not all competitors were eliminated, some, like pharmacists, continued to remain independent, if restricted, while others, such as nurses continued the age-old function of care-giving but under strict medical control. Subsequently, many new, largely technical occupations would emerge. As early as the second decade of the 20th century, the diagnostic laboratory, which became more widely used after WWI, created a new realm of work for chemists and pathologists and, subsequently, growing ranks of lab technicians (Reiser, 1981: 143).

With the early impetus toward specialization in medicine hospitals began to emerge as the central site of medical practice. With the provision of federal funding for extensive national hospital construction--the Hill-Burton legislation of 1948--the hospital's central role in care provision

was solidified and it further penetrated rural areas. Along with the rise of the hospital system, an extensive division of labor in medical care began to emerge. More and more tasks previously performed by physicians were being delegated to assistants of various sorts, in addition, new tasks were being developed and delegated, for example, respiratory therapy. As medical practice became more technically and mechanically oriented a whole new realm of paramedical occupations opened up: the technicians.

Why is the control of the division of labor so important to organized medicine? Brown (1973) argues that the allied health occupations have the potential to conflict with physicians for turf. In fact, many technically specialized subordinates have greater expertise in their particular area of work than does the supervising physician. Recognizing this potential competition, organized medicine has sought to control these other occupations and has largely been successful.

The medical industry is essentially labor-intensive and skilled workers labor in various relatively small-scale organizations. Thus control of the market cannot be achieved through control of capital.

> The means of production are the applied skills, knowledge and labor of people rather than of machines. Therefore, efforts to create, change, monopolize, or benefit from a relation to the means of production require direct and conscious intervention in the occupational structure (Brown, 1973: 436).

As the industry expanded, it created an increased demand for skilled workers. This demand could have been met in one of two ways. First, more physicians could be produced. (In fact, ever since the AMA gained control of medical education and licensing it has sought to limit the production of physicians in order to decrease competition and raise practitioners' incomes.) Second, new health/medical workers could be created receiving considerably lower incomes and performing work which is physician-structured and controlled. The latter is the dominant approach.

While it may appear that expansion and bureaucratization of the hospital structure dooms physicians to proletarianization and subordination to managers and administrators, Brown cautions against this conclusion.

> As physicians lost direct control over production organizations, they gained control over producers through the AHA (American Hospital Association), JCAH (Joint Commission on Accreditation of Hospitals), CME (Council on Medical Education), and medicare organizations (1973: 437).

As Larson noted, a critical juncture in the process of professionalization is the occupation's acquisition of the control of its education. Agreeing, Brown points out that organized medicine has sought to short-circuit the professional aspirations of its subordinates by maximizing physician control of their education. For example, the federally sanctioned CME (Committee on Medical Education of the AMA) includes among its functions the accreditation of schools

and certification of graduates in medicine and several subordinate occupations. It can use this position to inhibit the development of occupations by failing to accredit their educational programs. Other health occupations may be similarly undercut by other arms of organized medicine.

> The JCAH can and has threatened to withdraw its accreditation from hospitals which offer training in unacceptable occupations. The AAMC (American Association of Medical Colleges) and individual medical colleges control access to the necessary clinical training facilities in teaching hospitals and university medical centers, and can agree to refuse to allow training for developing occupations. The development of nurse-midwifery has been slowed by the reluctance of hospitals and medical schools to approve training programs. Obstetricians have been most active in blocking the development of this occupation (Brown, 1973: 438-9).

In other comparable strategies, physicians have either opposed the licensing of subordinates, in order to stymie their professionalization attempts, or have sought to control licensure. Physicians often predominate on licensing boards of subordinates. With these concerns in mind, let us take a look at the development of nursing.

Nursing as a Professionalizing Occupation

The occupation of nursing is the prototypical example of the fact that professional status is not achieved merely by emulating the characteristics of other professions (for example, developing a body of knowledge, developing a code of ethics, raising educational standards). The piece that

was missing from the outset in nursing was the requisite social power to determine its own fate. Though leaders in nursing attempted in a rational way to achieve professional status, their success was at best partial. In large part, this was because they were ultimately unable to extricate themselves from the control of the medical profession and hospital administrators (themselves physicians, historically). Certainly a critical factor in the inhibited development of autonomy in nursing was the fact that nursing was an overwhelmingly female occupation in a male-dominated medical hierarchy which was itself part of a male-dominated society. As the following discussion suggests, because of its inherent subordination, the development of nursing might be more accurately construed as "underdevelopment."[3] The more nursing was drawn into the medical mainstream and hospital care and the greater were the numbers of nurses and kinds and uses of the nurse, the more firmly was their subordination entrenched and the more fundamentally was the occupation as a whole exploited for the benefit of these who dominated them.

As was the case with hospitals, early nursing functions were associated with religious charity. While as early as the 1100's an order of the Beguines provided care to lepers, the first nursing order was begun in 1633 under the auspices of the Catholic Church (Pelley, 1964:22). By the 1700's,

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[3]This is a term originally used to describe uneven and exploitative economic development of dependent third world nations by capitalist coutries (cf. Cockcroft, et al., 1972).

nursing in England and Germany had come to be linked with prison reform and growing social consciousness. Fitzpatrick (1977) observes that Florence Nightengale, influenced by this trend, set about to upgrade, secularize and standardize nursing in England in the 1800's. Nightengale also worked with some success to differentiate nursing education and nursing practice, separating her own training school from the hospital. At the same time, she worked to clarify the difference between trained nurses and untrained care-givers (sometimes working at cross purposes with midwives) (cf. Donnison, 1977). She also developed a code of rules for nursing which bore a greater resemblance to the "cult of true womanhood" (Welter, 1966), and military discipline than it did to a professionalizing occupation's code of ethics. Nonetheless, Nightengale's contribution to nursing was pivotal and far-sighted. For example, she introduced the concept of "health nursing" which anticipated nursing's later developments in primary-care-giving and health promotion (Fitzpatrick, 1977).

Rational and far-sighted though it was, Nightengale's model of education for nurses did not take hold in the U.S. Although an organized feminist movement had begun in the mid-1800's and the Civil War had created a demand for hundreds of women trained as nurses (many by women physicians), only a few comparably organized schools were begun in the 1870's and 1890's. These were created largely by upperclass women reformers. While the number of nursing schools grew

dramatically in the latter part of the 19th century, most were associated with hospitals and drew not elite women, but working and middle class women who needed wage work (Ashley, 1977; Cannings and Lazonick, 1975).

By the late 1800's, the U.S. population had become predominantly urban and as community-oriented mutual care-giving further broke down, a demand for both private-duty nursing and hospital nursing grew, as did physician's use of hospitals. As allopathic medicine claimed for itself the function of curing illness, it increasingly was prepared to delegate bedside caring to others, those others were nurses (Ehrenreich and English, 1973).

Nursing was, from the outset, construed as subordinate to the medical profession; its tasks were delegated to it by physicians who continually characterized the work as simple-minded if not superfluous. The Goldmark Report of 1923 (the nursing version of the Flexner Report) acknowledged,

> We have the extreme view expressed by many physicians that for bedside care the present nurse is 'over-trained;' that her charges are so exorbitant as to be prohibitive to all but the very rich; that the nurse is merely the doctor's 'extended hands;' hence, that any biddable girl can quickly be trained to obtain the necessary deftness and skill to carry out his orders (Goldmark, 1923: 162, quoted in Cannings and Lazonick, 1975: 198).

The medical view was not only an outgrowth of arrogance but a largely successful strategy to undermine organized nursing's claims to special knowledge and skills which differentiated it from the lay public. In a manner akin to the capitalists'

discovery that the degradation and segmentalization of work makes workers more vulnerable to replacement (cf. Braverman, 1974), physician efforts to carefully circumscribe nursing's role enabled medicine to successfully depress efforts at professionalization by effectively utilizing the growing reserve army of unemployed women. Medicine was essentially closed to women (Walsh, 1977), while nursing was a rapidly expanding woman's occupation. Discrimination against women in employment throughout the economy truncates women's opportunities for wage work. This creates greater vulnerability to exploitation by placing women workers in a "female job ghetto," (cf. Howe, 1977; Blaxall and Reagan, 1976) and intensifying competition between women for jobs. As Brown (1975: 174) notes,

> Few occupations are open to women whereas many are open to men. Out of 80 major occupational categories listed in the 1970 United States Census, seven occupations contain 43 percent of all women workers. One of these occupations is nursing. Non-white women are concentrated in service and labor occupations.

Historically, nurses worked long hours for extremely low wages or no pay at all, ostensibly receiving training. In fact, the development and expansion of the nursing labor force facilitated and encouraged the growth and expansion of hospitals (and helped fill the coffers of medical schools) in part because cheap, subordinate nursing labor power made such undertakings by physicians profitable (Ashley, 1977). An 1894 statement by a nursing educator summed up the

situation, "Practically, then, the hospital secures nursing for $12 a month on its payroll, which at its market value would bring at least $15 a week..." (Deck, 1894, quoted in Cannings and Lazonick, 1975: 193). The vast majority of hospital laborers were, until the 1930's, nursing students who typically worked more than a forty-hour work week. This meant that nurses were unable to determine the content of their education most of which was "learning by doing." The hospital nursing supervisor was answerable to the hospital director whose interest typically contradicted that of the nursing leadership.

Meanwhile, organized medicine had, as previously noted, become increasingly interested in hospitals in the 1910's and 1920's. Ashley (1977: 86-7) points out that this expanded interest included an overt focus on nursing. While the Goldmark Report of 1923 was the product of a Rockefeller-funded study of nursing education, the committee which undertook the project was composed not exclusively of nurses but of elite male physicians with ties to prestigious medical schools, RNs and some other women. Its suggested reforms were moderate, particularly in contrast to those of the Flexner Report; it recommended, for example, the licensing of registered nurses to distinguish them from the growing ranks of untrained "practical nurses," (Cannings and Lazonick, 1975: 197).

During the 1920's and 1930's, numerous AMA committees

undertook studies of nursing. In 1927, the AMA's position on nursing was that:

> All surveys, studies and recommendations shall emanate from the American Medical Association and not from any newly constituted independent organization. The problem of nursing education and service is a vital one to the public and to every physician. It is a problem in which we should exert and evidence opinions and recommendations and accomplish their institution. It is a service we owe to the public, to hospitals, to training schools and to fellow members. The American Medical Association should, yea must, undertake its solution and formulate the result and principles when they are announced. We become negligent and shirk our responsibilities and forfeit guiding direction if we delegate the task to others (JAMA, May 21, 1927, quoted in Ashley, 1977: 87).

Thus organized medicine sought to supersede nursing in confronting and resolving the problems of nursing education many of which it had helped to create. Concomitantly, leaders in nursing education, in an effort to upgrade their educational facilities decided to cooperate with the American Hospital Association. While the nursing educators hoped to create affiliations with colleges, or failing that, high high schools in an effort to provide solid scientific training, Ashley concludes that their efforts were largely unsuccessful and had the unanticipated effect of strengthening AHA control of nurses' training. Finally, in the 1940's the National League for Nursing changed course and set its own standards for accrediting nursing schools. Nonetheless, "...collegiate education for nursing did not take hold until the late 1940's and early 1950's, and hospital schools remained

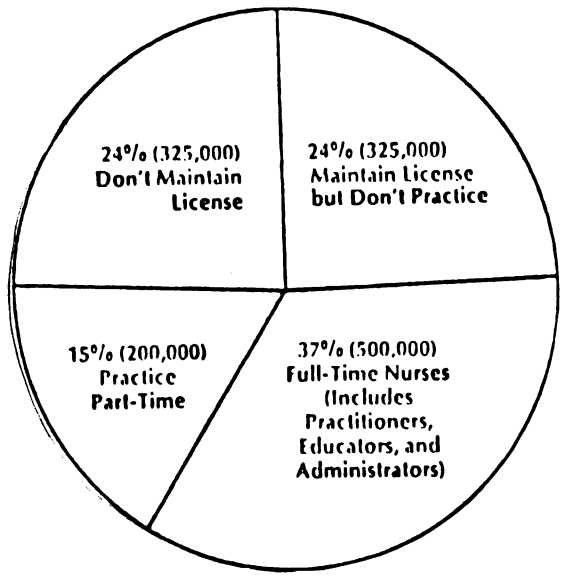
the chief route of entry for most nurses" (Fitzpatrick, 1977: 824). When, after WWII, junior colleges emerged and produced two-year RNs, three levels of nurses emerged--2-year programs, 3-year hospital programs and baccalaureate degree programs--all of which were called RNs and took the same licensing exams. Frequently, they did the same work in hospitals.

Nursing Practice

It has been suggested that professional socialization of baccalaureate nurses does not actually prepare them for the routine and subordinate work they are likely to be engaged in. It may be, as the title of Kramer's (1975) book suggests, Reality Shock--Why Nurses Leave Nursing, a depressing realization. For while nursing education has improved dramatically and prepared nurses for more knowledgeable and autonomous work, the circumstances in which they work stifle their independence. In fact, the dropout rate among graduate nurses is so high that it cannot begin to be explained by factors such as competing familial responsibilities. It is well above rates for comparable predominantly female occupations, such as primary education. The following chart illustrates the distribution of activity among graduate nurses based on 1970 data (Sadler, et al., 1972: 60).

Figure 3.1

Distribution of Activity Among Graduate Nurses



It is certainly plausible that many innovative and independence-oriented nurses are driven out of traditional nursing practice by the repetitive and mundane nature of much of the work. Many others, perhaps out of economic necessity, are compelled to submit to performance of routine tasks. Hofling, et al., (1960) conducted a study in which hospital ward nurses were given erroneous orders for medication over the phone by a researcher impersonating a physician. While phone orders are typically discouraged by hospitals and several factors visibly indicated the "physician" had ordered an excessively large dosage, researchers were surprised at the nurses' overall uncritical willingness to

carry out orders. Bullough (1975) has argued that nurses have been socialized into subordinate behaviors (for example, passive-aggressive behaviors or coyness) which makes it difficult for them to accept opportunities for increased independence if and when they become available. However, rather than "blaming the victim," Brown (1975) points out that such behaviors are components of broader gender behaviors and, with Henley (1977) and Kanter (1977), emphasizes that they are more symptoms than causes of social, legal and economic power differentials of social actors. Where promotion out of this routine execution of orders has been formally available to some nurses, it has historically taken the form of administrative, rather than care-giving work.

While Brown (1975) has observed that compared to other women's occupations, nursing wages and working conditions (for example, steady employment) are not particularly bad, Cannings and Lazonick (1975: 189) suggest that, "When educational credentials, skills, and responsibility are taken into consideration, nursing workers in general are poorly paid relative to other occupational groups in the U.S. economy."

Leaders in the nursing professionalization movement might well have not foreseen the intense subordination of nurses in hospitals. Even in the Goldmark Report of 1923,

the concern with hospitals was a concern about nursing education, not employment. In 1920, only about 10 percent of nurses worked in hospitals. Most RNs engaged in private-duty nursing in which they were not immediately subordinated to physicians. During the "Progressive Era" public health nursing developed rapidly as reformers became concerned with sanitation in urban areas and diseases among the lower classes. Here too, nurses were relatively autonomous in their daily work. But during the Great Depression, private-duty nursing contracted sharply as the market for it shrank; families were simply unable to afford it. The glut on the nursing labor market drove down nursing wages sharply, ultimately making many hospitals willing to close their nursing schools and hire graduate nurses. Then, during the 1930's, hospital-based medical care grew dramatically, an outgrowth of, "...the development of capital-intensive medical techniques...(b)ut perhaps more important...the development of hospital insurance," (Cannings and Lazonick, 1975: 199). Thus, as external opportunities for nursing employment contracted, institutional nursing employment expanded. The result was that nursing as a whole was brought more firmly under medical control.

Once in the hospital, the internal stratification of nursing became more pronounced and overt. Organized nursing had not been able to resist the earlier medical and hospital development of the lower-paid and more tractable licensed

practical nurse. However, the RNs were able to gain some control over the licensing of LPNs and to subordinate them in the hospital division of labor. Further subordinated were the growing ranks of nurses' aides, positions frequently occupied by women of color. So, by 1950, the process of internal stratification of nursing had come to be institutionalized and drawn into the highly articulated division of labor in medical care (Cannings and Lazonick, 1975: 201).

The Expanded Role of the Nurse

Embarking on a new direction in the quest for professional status, nursing has developed clinical specialists, for example, nurse anesthetists. While they present competition to anesthesiologists, they have successfully resisted medical efforts to eliminate them. One reason this and other nursing specialties represent competition to physicians is that the nurses work for considerably lower wages; they have proved attractive to Health Maintenance Organizations, among other medical delivery systems (Neuhoff, 1977; cf. Ellwood, et al., 1971). In response, physicians have developed as substitutes, technicians who have lower skills and are under the control of both organized medicine and individual physicians in practice (Brown, 1975: 178).

In the late 1960's, programs for training the newly created pediatric nurse-practitioner were developed with the blessings of the leadership of pediatrics. They received a mixed response from practicing pediatricians (Baron,

1971; Bell and Misbach, 1971). But physicians were increasingly being alerted to the benefits of hiring nurse-practitioners, including both extending their own practices, providing care not previously practicable and, through proper management, realizing a good return on the investment (Oken and Golden, 1975: 352).

By 1974 there were over 100 programs providing training for "role extension" for nursing (Oken and Golden, 352). Despite its apparent success on the educational front, the concept of nurse practitioner or nurse-clinician has received active debate in nursing journals. For example, Murphy (1970) emphasizes the difference between role-extension--the addition of new tasks to nursing routine, or horizontal extension of duties--and role expansion--broadening the scope and autonomy of nursing, or vertical expansion of nursing function and practice. Many support the concept of the "role extension" or the "expanded role of the nurse" as presenting a viable opportunity for nurses to achieve professional status and in so doing, demonstrate the independence of which nurses are capable (MacPhail, 1976; Mauksch, 1975).

Some nurses argue that what is really needed is not new expanded roles for a few nurses but recognition of "...the unnumerable independent decision-making functions... nurses (already perform):

> Nurses may take histories, observe symptoms, even suggest diagnoses and treatments, but they are careful to only 'suggest' since

> the physician is the one who is legally responsible for making the diagnosis and ordering treatment. This is why it's kept very quiet when nurses write prescriptions over the physician's signature on the prescription blank. Physicians may write innumerable p.r.n. (to be given as needed) orders to cover any expected contingencies, but little consideration is given to the fact that it is the nurse who decides when the medication or treatment is needed. Nurses' opportunities to operate as independent practitioners have been limited by the fact that nurses cannot provide nursing care required by a non-institutionalized person and bill for third-party payment. The physician, though, can hire the nurse, pay her a salary and bill for her services given to the patients (Yeaworth, 1976: 8).

Thus, nurses need to seek greater recognition of their actual work and further independence as a group, this position argues. While it is typically suggested that this be achieved through further efforts at professionalization, more and more voices charge that professionalism, (the ideology of professions, or acting as though one had professional status, including a service ideal), has gotten nursing nowhere fast (The Boston Nurses' Group, 1978). Increasingly, nurses are organizing into unions (Sexton, 1982), however, this still seems the minority position among nurses.

Still others (Rogers, 1975) have pointed out that the "expanded role of the nurse" was largely the outcome of medical interests for meeting "manpower" needs without producing competitors for physician salaries. By accepting physician-structured training (cf. DHEW, 1976: 3556), Rogers argues

nurses are giving up or at least undercutting their own claims to unique nursing contributions and are becoming junior doctors. Meanwhile, Brown (1975) points out, should nurse-practitioners consider competition with physicians, medical schools have developed a counter-part practitioner, the physicians-assistant, designed to undercut them (cf. Schneller, 1976).

Nonetheless, nurse-practitioners appear to be more satisfied with their work and receive considerably higher incomes than other care-giving nurses. They successfully perform primary care-giving functions, including managing cases, frequently improving outcomes. Patient acceptance has been generally quite high, especially when accompanied by physician support. Acceptance by pediatricians, internists and family practitioners has been good. Again and again, nurse-practitioners anticipate and value an expanded scope of autonomous practice as well as collaborative relationships with physicians (Dunn and Chard, 1980).

Medicine has helped to spawn new health practitioners who, to a greater or lesser extent, have come to value the autonomy associated with professional status. Nurse-practitioners are organized into national associations and are actively pursuing their own interests. The development of their occupations, as well as their effects on nursing's continuing efforts to professionalize, will be intriguing.

One of these nursing specialities, or expanded roles, is nurse-midwifery to which we turn next.

Chapter IV

The Development and Rediscovery of Nurse-Midwifery

Introduction

The nurse-midwife was a product of Progressive Era reformers' efforts to improve maternal and infant health among the lower classes. Due to their public health work, nurse-midwives were not drawn into hospital practice during the 1930's as were the bulk of other nurses, who then experienced intense subordination to physicians, routinization of work and fragmentation and stratification of the occupation. In fact, while nurse-midwives were always few and marginal in medical care, they were considerably more autonomous than their fellow nurses in hospital practice. After considering the history and development of nurse-midwifery in the U.S., we shall return to this observation.

The Early Development of Nurse-Midwifery in the U.S.

As early as 1911, the concept of a nurse with special training in midwifery was being suggested in America (Litoff, 1978: 122). However, the idea found little substantial support until the formation of the Maternity Center Association in New York City in 1918. The Association, originally comprised of nurses, mothers and obstetricians, was an outgrowth of the rising concern with public health. The (lay) midwives had largely been eliminated and fee-for-service medical

practice developed at the same time that the U.S. was rapidly industrializing and large numbers of immigrant workers were entering the country. The result was that large numbers of people were underserved or unserved.

The Maternity Center Association set out to improve maternity care, particularly ante-partal care, in the city; it developed a three-part plan to achieve this goal. By the end of 1920's, the Association came to regard its first two goals as effectively met through the establishment of maternity centers throughout the city and the more widespread provision of prenatal and rudimentary childbirth education to pregnant women and their families. It then turned toward its third goal, the improvement of antepartal nursing.

After having initially been thwarted in its effort by the Public Health Department, the Association developed a school for teaching midwifery skills to nurses. The Association for the Promotion and Standardization of Midwifery, Incorporated, an outgrowth of the Maternity Center Association, opened the first nurse-midwifery school in the U.S. in New York City in 1932. The school's stated objective was to "...prepare nurse-midwives to assume responsibility for the supervision, care and instruction of women during pregnancy, labor and puerperium, under the guidance of a competent obstetrician," (Maternity Center Association (MCA), 1955: 18).

The school, located in Harlem, was associated with a maternity clinic which both served the largely Puerto Rican population and allowed the nurse-midwifery students to obtain clinical experience. Emphasizing its public health orientation, the school required of its students a background in public health nursing which was then supplemented in the nurse-midwifery education. Clearly, the precedent of utilizing nurses specially trained in midwifery for "marginal" populations, with the aim of improving public health, was set in the first nurse-midwifery school.

The nurse-midwifery service was primarily a home-birth service in which nurse-midwives provided the bulk of the care for women whose pregnancies and births were proceeding normally, active care and back-up by obstetricians were readily available to the nurse-midwives. In light of this fact, it is particulary interesting to see that the data they generated are so good. In the first four years of its existence, the safety of the service compared very favorably with the surrounding area of the city (which generally represented a lower risk population). The MCA maternal mortality rate was 1 per 1000 live births, compared to 10.4 per 1000 live births in the surrounding area. Similarly, the rate of neonatal deaths (21/1000 live births) was less than half that of the rest of the district (Litoff, 1978). Data for the twenty year period 1932-1952 showed a maternal mortality rate of 0.9 per 1000 live births (MCA, 1956: 32).

While the Maternity Center Association's midwives served an inner city population, the public health role of nurse-midwifery had earlier and independently been undertaken in the service of a rural population in Kentucky. In the 1920's, Mary Breckenridge, a nurse from Kentucky, began an effort to improve maternity care for the rural poor in the mountains of her home state. After completing nurse-midwifery training in England, she returned and helped form the Kentucky Committee for Mothers and Babies. Together they embarked on the development of a nurse-midwifery service in Leslie County, Kentucky. So isolated and underserved was the area that nurse-midwives traveled by horseback and performed extensive public health nursing work. For example, an early project, undertaken at the request of the physician in charge of the state health commission, was the inoculation of residents to clear up diptheria and typhoid, which had been endemic to the region (Browne, 1968: 76).

The influence of British midwifery training and practice was strongly felt in both early nurse-midwifery programs, The early nurse-midwives in Kentucky, in what came to be known as the Frontier Nursing Service, were either British or were Americans trained in England. Although American-trained midwives became involved after the Maternity Center in New York City began graduating its first classes, foreign-trained midwives still predominated. So significant was the involvement of nurse-midwives from Britain that their

return to England in 1939, at the outbreak of World War II, necessitated the establishment of the Service's own school of nurse-midwifery in the same year (Litoff, 1978: 127).

In the Maternity Center Association's development of nurse-midwifery training, the nurse-midwife was construed as a blend of public health nursing, obstetrical nursing, midwifery training and close cooperation and consultation with obstetricians. This particular configuration was, "...designed to unite the best of medicine and nursing in the service of mother and family," (MCA, 1956: 22). While early physician supporters of nurse-midwifery characterized the occupation as physician extenders or obstetric technicians (Watson, 1931), the influence of British training and models of midwifery practice provided a counter-weight. The perspective of British midwifery contrasted with the developing interventive orientation of American obstetricians (Anisef and Basson, 1979). And, as the first nurse-midwife on the staff of the MCA school was trained in London, the influence of this alternative view was felt from the outset.

> As in England, the concept that child-bearing is a normal process was the dominant philosophy....The course stressed the normal process of the maternity cycle, while giving due weight to the recognition, evaluation and the care of deviations from the norm (MCA, 1956: 23).

Early Physician Involvement in the Development of Nurse-Midwifery

While much of nurse-midwives' training was drawn on the British midwifery model, control of the nascent occupation was in the hands of American obstetricians. The impetus for the development of nurse-midwifery came, in part, from the leadership of organized obstetrics. In addition, nurse-midwifery's continued existence has been contingent upon obstetrician support or at least the absence of organized opposition from the medical specialty which dominated its market. The previous analysis of medical involvement in nursing and other subordinate occupations, indicates that medicine demonstrates an active interest in the development of any occupation which represents potential competition.

From the outset, physicians have been actively involved in shaping not only nurse-midwifery education and practice, but also the occupation's ideology, including claims to a special contribution to care-giving. Benjamin Watson, an early supporter of nurse-midwifery was a professor of obstetrics and gynecology at Columbia University's College of Physicians and Surgeons. He sought to delineate the parameters of the occupation and clarify its relationship to obstetrics.

> I believe that the maternal mortality in this and every other country would be very materially reduced if the practice of obstetrics were in the hands of thoroughly trained midwives working in conjunction with and under the supervision of properly trained doctors....I believe that such a system would

> work out not only to the benefit of the patient but to the economic advantage of the doctor. To the latter would belong the whole responsibility of prenatal care and the determining of the ability of the patient to go through a normal labor.
>
> ...by a trained nurse-midwife, I mean a nurse who has a full general hospital and who subsequent to that has had a least a year's training in the delivery room, wards, clinic and outdoor practice of a maternity hospital. With such a training, she ought to be able to act as obstetric technician to a doctor. The doctor with a busy practice has an office nurse and technician who does his x-ray work, his blood counts and his chemistry...a nurse can become just as expert and reliable in conducting normal delivery as can a technician in doing a blood count or blood chemistry. ...there is a great opportunity to graft upon our present system of practice all the best features of the best type of midwife practice abroad.... I should like to see every obstetrical hospital with a staff of trained midwives so that when a doctor sends in his patients...he has the assurance that a normal delivery can be conducted in his absence (Watson, 1931, quoted in MCA, 1956: 13).

While several elements of his statement indicate a concern about nurse-midwife's subordination to the obstetrician, he nonetheless seemed willing to grant nurse-midwives an element of autonomy in practice and agreed that thorough training was required. Further, this argument for nurse-midwifery appeared in the New York State Medical Journal, and it is possible that he sought to address his readership in terms meaningful to them. Despite the overt concern with the interest of obstetricians in his article, he was roundly criticized by many of his colleagues in subsequent issues (Strachan, 1968: 72). It is likely that the obstetrician's leadership's support for nurse-midwifery was a self-interested

as that of the average practitioner, but it was less immediately subject to market forces and thus able to take a longer view. Therefore, Watson sought to instruct fellow practitioners in the potential benefits ultimately available to them in return for their support of nurse-midwifery. However, here as elsewhere, the process of agreeing on collective interests and subordinating individual interests to them was problematic.

The need to avoid antagonizing obstetricians while engaging their self-interested support was expressed by Dr. Lobenstine, a primary supporter of nurse-midwifery for whom the first New York clinic was named. He asserted that, "...(if) midwifery is to succeed in this country a means of bringing all midwives under medical supervision must be devised," (Kosmack, 1943, quoted in MCA, 1956: 14).

The extent to which obstetricians were involved in the formation of the first school of nurse-midwifery and the clinic associated with that school may be suggested by their representation on the boards of directors, the membership of which overlapped almost totally. Six of the eight members of the clinic's board were obstetricians. The executive committee of the organization, which was engaged in developing the nurse-midwifery school was comprised of three obstetricians and one nurse who was the organization's general director. One of the obstetricians who sat on both boards was the editor of the American Journal of Obstetrics and Gynecology

as well as chair of the medical board of the Association of Obstetricians and Gynecologists (MCA, 1956).

Nurse-midwives and the Professionalization Project

For its part, nurse-midwifery was initially less concerned with the issue of control of education and training (Larson's, "production of producers") than it was with establishing the education. Having begun to delineate (or have others delineate for them), a cognitive base--drawn in large part from British midwifery and public health nursing--participants in the occupation set out to establish additional education programs for nurse-midwives.

Graduates from both the Maternity Center Association and the Frontier Nursing Service were instrumental in creating additional nurse-midwifery services and schools. This was important for a number of reasons. First, it both demonstrated some key dimensions of the potential contributions of nurse-midwifery practice and helped to expand the available number of nurse-midwives. Outside nurse-midwifery-initiated programs, nurse-midwives tended to be drawn into public health nursing supervision (including efforts to train and/or restrict "granny midwives"), education of maternity nurses or practice in overseas nursing services. While such work met significant needs and broadened the influence of nurse-midwifery in nursing, it diluted nurse-midwifery and severly limited actual practice of the occupation in the U.S.

In the 1940's, two new services and schools were begun by nurse-midwives. From 1941 and 1946, the Tuskegee Program, which was aimed at training Black nurses in midwifery, graduated 25 nurse-midwives and provided high quality maternity services to rural Alabama. The Catholic Maternity Institute of Santa Fe, New Mexico, began its nurse-midwifery service in 1944 and in the following year developed a school in conjunction with the Catholic University of America. Operating until 1968, the school graduated over 90 nurse-midwives. The Columbia University Program admitted its first class in 1955, and John Hopkins began a nurse-midwifery training program in 1956. In 1958, the Maternity Center Association linked its educational program with Kings County Hospital and the State University of New York Downstate Medical Center. While the fortunes of the nurse-midwifery schools were mixed, by 1962 a known total of 750 graduates had been produced by six schools (American College of Nurse-Midwives, 1965).

The 1950's and 1960's marked a watershed in nurse-midwifery. Previously, the growth of educational programs was slow and uneven, then,

> ...in the middle 1950's the demand for maternity personnel having nurse-midwifery education began to rise. This heightened demand resulted in an increase in the number of nurse-midwifery schools. More educational programs have been initiated in the past twelve years than had been available in the previous 23 years. Most of these programs are on a post-baccalaureate level and more universities would initiate programs of

> graduate education with specialization in nurse-midwifery if qualified faculty were available to staff them (Runnerstrom, 1968: 90).

While in 1964, data indicated that of the fewer than 1,000 nurse-midwives in the U.S., less than 40 were engaged in active practice or teaching (Thomas, 1965, cited in Anderson, 1968), nurse-midwifery education had entered the mainstream of nursing and medical educational facilities, production was stepped-up and more graduate nurse-midwives were going into nurse-midwifery practice. In addition, where earlier, 1-year certification programs had been the rule, more schools were conferring master's degrees, some taking it upon themselves to train nurse-midwifery educators (Barnes, 1968: 43). Nurse-midwifery had been "discovered" as one nurse-midwifery educator noted, "Suddenly, in the last three years or so there is tremendous interest in this particular discipline. Before that, nobody was interested. Now, everybody wants to have a school for midwifery" (Keane, 1968: 101).

What I have been describing is a kind of "take-off" point in the education and development of nurse-midwifery. What is there to explain the change in the fortunes of the occupation? Is this the result of an active and unified professional organization?

In fact, a professional organization for nurse-midwives was relatively slow in developing. Nurse-midwifery's efforts to create a professional organization succeeded when,

in 1945, a special section on nurse-midwifery was established within the National Organization for Public Health Nursing (NOPHN). However, after NOPHN was disbanded in 1952, nurse-midwives were again without a formal organization with which to pursue their goals. After two years of being unable to find an appropriate niche in either the American Nurses' Association or the National League for Nursing, they decided to create their own organization. This also enabled them to create an maintain ties with other midwifery organizations abroad, many of which were not affiliated with nursing. By 1955, the American College of Nurse-Midwifery was begun. Later, in 1969, a merger with the American Association of Nurse-Midwives, based in Kentucky, formed the American College of Nurse-Midwives (Litoff, 1978: 127-8).

In 1962, the College conducted a study of its membership to acquire information about their education and practice. In the mid-1960's, almost wholly on volunteer time, members of the College began to develop standards of practice and set up criteria for the evaluation of educational programs. But by 1968, the ACNM still had fewer than 400 members (Kean, 1968: 100).

So, the impetus for the rapidly expanding development of nurse-midwifery in the 1950's and 1960's cannot be explained by a powerful professional organization. What then were the reasons for the emerging trends?

The medical profession and the federal government began to carefully examine the availability of labor power in medical care during this time period. Many analysts projected physician shortages (Peckham, 1968; Jacobsen, 1968), and consequently interest in so-called allied manpower was growing. In addition, concern with population control was emerging as an interest of federal government, some elites and others, and foundation monies were becoming available for these projects. (Interestingly, this concern coincided with the growth of the American Civil Rights movement and liberation movements in the Third World.) Labor power concerns were increased with the passage of federal third-party payment for the poor and the elderly, the Medicaid and Medicare legislation. As planners began to embark on the development of new "allied health workers," including the "expanded role of the nurse," they rediscovered nurse-midwifery.

During the 1970's programs for nurse-practitioners burgeoned. By 1976, nurse-midwives constituted only a small percentage of all nurse-clinicians (the terms are often used interchangeably, indicating in part their varied origins and the difficulty of unifying the concept). Nonetheless, in a 1976 study of nurse-practitioners education (Sultz, et al., 1976), (which included nurse-midwives) findings showed that nurse-midwives had the lowest certificate-to-Masters-student ratio (that is, they were upgrading their education more successfully). In addition, the faculty-to-student

ratio was higher in Master's programs than in certificate programs. And certificate programs relied more on physicians and less on nurses as teaching staff than did Master's programs. Further, nurse-midwifery programs compared very favorably with other nurse-clinician training programs in that they had more teaching personnel overall and those teachers were more likely to be nurse-midwives. Finally, the nurse-midwifery programs tended to have longer didactic components in both Master's and certificate programs, than other nurse-practitioner programs. They also were much less dependent upon preceptorships (apprenticeship training). This information indicates that nurse-midwives had been much more successful in upgrading and standardizing their education. They seem to have gained significant control of their education (thus, the production of producers) and this has helped them considerably to make claims to a reliable practitioner (product) capable of giving quality care in a specific area of expertise. That is, it enabled them to begin to assert a unique or special contribution to care-giving.

Delineation of the Occupation and Claims to Special Contribution to Care-giving

As early as 1966, the American College of Nurse-Midwives developed a definition of the nurse-midwife.

> The nurse-midwife is a registered nurse who by virtue or added knowledge and skill gained through an organized program of study and

> clinical experience recognized by the ACNM has extended the limits of her practice into the area of management of care of mothers and babies throughout the maternity cycle so long as progress meets criteria accepted as normal (ACNM, 1966, quoted in Olsen, 1964: 463).

The criteria of "normal" turn out to be central to the definition and practice and are not as objective as they may seem in this statement (Rothman, 1982), but we shall turn to this topic later.

Nurse-midwives were faced with the task of differentiating themselves from nurses engaged in related work, for example, maternity nurses, a task necessitated in part by their new-formed expansion but perhaps more importantly by their more subtle shift into hospital practice where daily interaction with maternity nurses and others was rapidly becoming a reality. What distinguishes nurse-midwives from others according to this definition, is the "management of care" that is, they are attempting to lay claim to an area of care-giving in which they are at least somewhat autonomous.

A neat distillation of the nurse-midwifery ideology is presented by Brennan and Heilman (1977) who enumerate the central characteristics of nurse-midwifery's claims to special contributions. They emphasize that nurse-midwives are women and as such can more easily have empathy and rapport with women. They are not doctors and are neither pathology- nor technology-oriented. Though they are able

to recognize pathology, they are tained to manage normal labors and births. Several authors stress that nurse-midwives are nurses, and thus bring a nurturing and family orientation to their care-giving, that is, they do not leave the social person in the waiting room while they examine the body (Runnerstrom, 1968). As Kean (1968: 98) suggests, many nurses enter nurse-midwifery out of a conviction that "...through midwifery they will be able to assist in providing a service that is really family-centered, rather than pelvis-centered or perineum-centered."

The nurse-midwives assert that, because of their special orientation to care-giving, they are non-interventionist and inclined to be flexible whenever possible--that is, they are client-centered. They sometimes cast themselves as patient advocates. They encourage prepared childbirth and the presence of fathers (or other significant others) at labor and birth. (The MCA was an early and outspoken proponent of prepared childbirth). Nurse-midwives provide labor support in addition to attending the delivery. Since they also are trained to provide prenatal, post-partal and interpartal care, nurse-midwives can provide a kind of continuity of care which is increasingly uncommon in the face of the trend toward further fragmentation of health care delivery. Accessibility is another asset of nurse-midwives, who pride themselves on having time to spend with clients to talk; in fact, nurse-midwives view patient education

as one of their purposes (MCA, 1956: 47). Additionally, nurse-midwives provide lower cost care since their incomes are dramatically lower than physicians'. Finally, nurse-midwives all seem to echo the sentiments that they should and do function as an integral part of the health care "team."

The Journal of Nurse Midwifery, the official publication of the ACNM, includes in every issue the following information which formally defines both the nurse-midwife and nurse-midwifery practice, (see Appendix B for ACNM documents):

> WHAT IS A CERTIFIED NURSE-MIDWIFE?
> A certified nurse-midwife (CNM) is an individual educated in the 2 disciplines of nursing and midwifery, who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives.
>
> WHAT IS NURSE-MIDWIFERY PRACTICE? Nurse-midwifery is the independent management of care of essentially normal newborns and women, antepartally, intrapartally and/or gynecologically, occuring within a health care system which provides for medical consultation, collaborative management, or referral and is in accord with the Functions, Standards, and Qualifications for Nurse-Midwifery Practice as defined by the American College of Nurse-Midwives.
>
> The Nurse-midwife provides care for the normal mother during pregnancy and stays with her during labor and delivery. She evaluates and provides immediate care for the normal newborn. She helps the mother to care for herself and for her infant; to adjust the home situation to the new child, and to lay a healthful foundation for future pregnancies through family planning and gynecologic services. The nurse-midwife is prepared to teach, interpret, and provide support as an integral part of her services (Journal of Nurse-Midwifery, 25(1), 1980).

These statements, based on formally agreed-upon guidelines adopted by the College in 1975, indicate the extended scope and more careful delineation of the occupation. In addition, after 1971, graduates of accredited nurse-midwifery educational programs were able to sit for the national ACNM exam, upon successful completion of which they became certified nurse-midwives and therafter took the initials CNM. We will hereafter refer to nurse-midwives, as they themselves do, as CNMs.

The Concept of the Team Approach in Maternity Care

Of even greater importance to the development of nurse-midwifery than the guidelines of its own organization, was the Joint Statement of Maternity Care (Appendix C, p. 298). This statement was written and endorsed by the American College of Obstetricians and Gynecologists (ACOG), the Nurses Association of the American College of Obstetricians and Gynecologists (NAACOG), and the American College of Nurse-Midwives (ACNM), and it represented several years of negotiation and collaboration.

With this statement, nurse-midwives were officially brought into the medical division of labor in a specified manner via the formal recognition of the team concept. With an agreed upon goal of the improvement of maternity care, the statement made several recommendations, largely specifying team members' contributions. The first two are as follows:

1. The health team organized to provide maternity care will be directed by a qualified obstetrician-gynecologist.

2. In such medically-directed teams, qualified nurse-midwives may assume responsibility for the complete care and management of uncomplicated maternity patients.

In addition, nurses and other health care workers were expected to contribute to the team according to their education and capabilities.

The team concept was not new, having been discussed in the medical and nursing literature for several years. For nurse-midwives it was perhaps the way to come to terms, as autonomously as possible, with Lobenstine's prediction that nurse-midwifery's success would require some structure of medical supervision. At the same time, it was a vehicle to acknowledge the contribution of maternity nurses in an effort to minimize boundary disputes in that area.

However, the team concept also represented some real drawbacks for nurse-midwives. Obstetrician-led teams meant that an expert in obstetric pathology and surgery would be supervising an expert (the NM) in normal physiology. Also, the notion of obstetrician-directed teams was a far cry from the successful founding practices of nurse-midwifery in the U.S., the Frontier Nursing Service and the Maternity Center Association. Begun in 1932, the Maternity Center Association developed its division of labor in health care in the post-depression years. During World War II, the demands on the medical staff encouraged restricted use of the physicians'

time. After physicians had conducted initial exams, patients whose pregnancies progressed normally were seen by nurse-midwives who also attended their births, if no complications appeared. This structure enabled obstetricians to focus on their specialty: pathology (MCA, 1956). Meanwhile, the duties of the nurse-midwives in the Frontier Nursing Service were indicated by the nature of their training,

> Our students are taught to give total care to the normal childbearing woman and her newborn baby; to recognize the abnormal for which the physician is called; and to institute emergency measures should it be necessary before the arrival of the physician (Browne, 1968: 78).

Furthermore, both services generated data on outcomes which were far superior to national averages, even on poor and thus, higher-risk populations. It also contrasts with conceptions of the role of nurse-midwives articulated by some nursing educators. For example, Coates (1968: 64-5) indicates that the nurse-midwives, "...share mutual responsibility for the care of patients and their families...with medical personnel" (cf. Barnes, 1968: 44).

Apart from the formal statement issued by ACOG, NAACOG and ACNM, the team concept in health care has been variously contrued. Some physicians have taken it upon themselves to define nurse-midwifery's contribution to the team,

> As for the role which (nurse-midwives) can play on the obstetric team, the transcendant contribution which they have to make is a unique, personalized form of attention throughout pregnancy, labor and the puerperium (birth).

> By training, temperament, and outlook, they are singularly fitted for this important mission. This is their main raison d'etre, (Eastman, 1953: 8-9).

While the team concept has been adopted formally by ACOG, some physicians are wary of the vagueness of the term and the possibility of broad or negotiable parameters. Some even regard it as a potential vehicle for the erosion of their professional power and pre-eminence. They seek to further clarify and circumscribe the meaning of the term, for they recognize that it could function as a Trojan Horse for some aggressive professionalizing occupation.

> The concept of a collegial relationship between the nurse and the physician is gaining wider acceptance, especially in nursing. Fundamentally this is sound.... However, the role of the physician as leader of the team is being challenged.... I am a staunch supporter of nurse-midwives, but as members of physician-led teams, (Thiede, 1978: 923).

In contrast, other physicians (in this case pediatricians) endeavor to critically examine both the potential and the sources of problems of health care teams. They recommend a model of collaboration in which the members' varied expertises and abilities are equally valued and attention is given to group processes, decision-making and communication.

> To function effectively, a group needs many acts of leadership; rather than one leader, it needs many leaders.... (D)epending on the situation and the problem to be solved, different members can and should assume leadership (Wise, et al., 1974: 541).

This phenomenon of physician willingness to negotiate team functioning is uncommon but nonetheless occurs; we shall subsequently see that while it is extremely rare among obstetricians, it is more common among family practitioners. Organized obstetrics thus creates for itself a potential problem albeit minimal, physician-headed teams create the possibility of the appearance of physicians who defect from the narrow definition of the team and seek to cooperate toward care-giving in a more egalitarian model.

The team concept is not only prescriptive, defining nurse-midwifery's functions and scope of practice, it is also proscriptive, outlining the boundaries of practice which must not be crossed. However, most subordinates are fairly sensitive to the limitations to their actions imposed by superordinates, even when they are not formally codified. As early as 1955, nurse-midwives recognized obstetricians' fears that nurse-midwives would compete with them and the Maternity Center Association tried to quell them.

> It cannot be emphasized too strongly that the nurse-midwife should not function as a lone worker, attempting to supply all the elements which enter into complete maternity service. Her strength and her skills are best realized as part of an obstetric team, supplementing, not supplanting, the other members (MCA, 1956: 115).

With the development of the team concept, independent practice for nurse-midwives came to be overtly proscribed. This position was started by an obstetrician involved in the Johns Hopkins nurse-midwifery graduate program (Barnes, 1968: 43).

> The nurse-midwife...will function in a medical center where adequate physician consultation is available and where she is a member of the team.... She will most certainly not go into private practice herself, nor will she move towards a return to domiciliary care (e.g., home birth).

A decade later, another obstetrician again spoke of this fear of nurse-midwives entering into independent practice and becoming involved in home births, among other proscribed activities (Thiede, 1978: 923).

> (T)here are nurse-midwives actively promoting home deliveries, free-standing childbirth centers, independent practice for nurse-midwives and even menstrual extraction and abortions by nurse-midwives. To be fair, in all the situations I know about, there have been physicians involved in these activities to one degree of another. While these views and activities are not necessarily shared by a majority of nurse-midwives, it seems unwise to establish programs that might enhance the concept of autonomy. In short, I think it is important to have the physician, along with the nurse-midwives, involved in seeing patients on a regular basis.

Restating the potential contribution to obstetrician-centered care, Maeck (1978: 926) emphasized the team approach.

> Today, (the nurse-midwife) is a very competent, competitive professional.... Midwifery is a valuable and natural counterpart of obstetric care, and is not, and should not be a substitute for the obstetrician; it should complement the obstetrician. It must not become an independent provider of obstetric care. I believe the obstetric and nurse-midwifery leadership should continue to emphasize and to reaffirm a joint statement made several years ago which indicates that nurse-midwifery is practice only in association with the obstetrician and under the direct supervision of professional medical care.

These physicians have been actively involved in the leadership of organized obstetrics, and they are associated with University Medical Schools and teaching hospitals which incorporate nurse-midwifery practices.

Hellman (1978: 925-6) reminded his colleagues at the eighty-eighth annual meeting of the American College of Obstetricians and Gynecologists that their lack of foresight had allowed them to miss a critical opportunity to gain control of nurse-midwifery, the result of which was a greater threat of competition.

> In the early 1960's...a committee of the College (ACOG) was formed to discuss and to recommend the relationship of nurse-midwifery to the practice of obstetrics and gynecology. This was the time of considerable agrument about nurse-midwifery.... (The committee's) first recommendation to the College was made because we feared many of the things that have happened. We feared a fragmentation of nursing, so that there would be nurse-assistants, nurse-associates, and what-not, with varying degrees of training and responsibility. I do not think we foresaw the rebirth of home deliveries. (The then president of the ACOG, two other Ob-Gyns and Hellman) at that time ran the only-university-affiliated school of nurse-midwifery that existed in the United States, and it was our recommendation...that the College assume accreditation of the schools of nurse-midwifery in the United States... but I think the recommendation, although it was turned down, would have made a significant difference in the organization of our specialty. I am sorry, but I believe that the refusal of that recommendation was a mistake.

For its part, the ACNM has formally acknowledged that nurse-midwifery "...practice is continually evolving...(and) (b)ecause of this the nurse-midwife may frequently be in a

position of having to evaluate a new function for possible inclusion in her practice" (ACNM, 1979). Such inclusion may represent expansion of function, or extension of function, running the risk or making the nurse-midwife an extension of the physician; this situation suggests that which concerned nurses considering the expanding role of the nurse. Toward enabling nurse-midwifery to accept the potential inclusion of new functions while retaining its identity and philosophy of care-giving, the ACNM developed initial guidelines for this process. Further, in its 1976 statement on home birth, the ACNM noted that "...the hospital or maternity home is the preferred site for childbirth...(but that) (w)here home births are indicated, the obstetric team must develop guidelines which will ensure the safety of mother and infant (emphasis mine)." Finally, the ACNM chooses to refer to nurse-midwifery as "...an interdependent health discipline...." (ACNM, 1972).

This potential competition has, however, been more than a contest of words. In its larger move to reassert hospital birth and obstetric hegemony, organized obstetrics, in tactics that suggest an effort to assert what Illich calls a "radical monopoly," has sought to eliminate or severely restrict nurse-midwifery practice where it has appeared threatening.

As early as 1966, a nurse-midwifery demonstration project in Madera County, California, which promptly and dramatically improved health outcomes for the patient

population, was shut down. Its continued existence necessitated a change in the state law enabling nurse-midwives to practice and the Council of California Medical Association blocked the change by refusing to support it. To the surprise of no one, the negative health outcomes reappeared (Levy, et al., 1971).

In several cases, obstetricians have sought (often successfully) to stifle nurse-midwifery practice, especially independent and/or home birth practice, by withdrawing hospital privileges and or bringing pressure on back-up physicians (NAPSAC NEWS, 6(1 and 2)1981). For their part, CNMS have in several cases responded with suits claiming restraint of trade, and on December 18, 1980 the Subcommittee on Oversight and Investigations of the U.S. House Committee on Interstate and Foreign Commerce convened a hearing to examine the issue of physicians' efforts to restrain trade by blocking nurse-midwifery practice. Dr. Pearse, the executive director of ACOG, was questioned extensively by committee members on the specific meaning of physician-direction of the team (as stated in the 1971 Joint Statement), (The Federal Monitor, 1981, cited in NAPSAC NEWS, 6(1)1981: 10, passim). By mid-1981, the American Medical Association, earlier enamoured with the concept of allied health workers sought to reverse its position. At the annual meeting of the AMA, delegates "...took steps to stifle competition to doctors.... (They) voted to seek elimination of federal

funds for training of physician assistants, nurse practitioners, and other midlevel practitioners. Some delegates specifically mentioned nurse midwives...for whom they would like to see federal aid for training eliminated" (Van, 1981, quoted in NAPSAC NEWS, 6(1)1981: 8).

What changes had occurred in nurse-midwifery practice to so alarm and arouse organized medicine?

The Location of a Market and the Collective Mobility Project

Nurse-midwives came out of marginal but relatively autonomous work structures. Functioning as adjuncts to the medical division of labor which was based on fee-for-service, nurse-midwives as public health nurses worked in structures funded through the state, private contributions, or churches.

As important change in the practice of nurse-midwifery took place during the late 1950's and early 1960's. Both the major nurse-midwifery practices, the Maternity Center Association and the Frontier Nursing Service, altered their home-birth service programs toward hospital or clinic birth services. The MCA undertook an affilitation with hospital practice in 1958 after its hospital referral rate rose to 18 percent. The MCA, concerned by these figures, examined them carefully and concluded the referrals were medically indicated; they were encouraged in their affilitation by the head of the Department of Obstetrics and Gynecology at Kings County Hospital. In Kentucky, the FNS attributed the change in its practice during the 1960's to the availability

of third-party payment for hospital birth. With the provision of state funding for hospital birth, the home birth service, even though considerably less expensive, represented an out-of-pocket expense to consumers (Browne, 1968: 77).

In the 1960's, nurse-midwives began to be drawn into hospital practice, along with other newly created medical workers, to meet projected "physician shortages." Their changing direction was reflected in a study conducted by the ACNM in 1962 (ACNM, 1965). Of the total number of respondents (213), three quarters were living in the United States--meaning fewer were leaving for foreign nursing services. Only one third of the respondents were trained in public health nursing indicating a shift away from the role of nurse-midwives as essentially specialized public health nurses whose function was primarily of exclusively to serve the "underserved."

While by 1976 the numbers of CNMs in the United States had increased dramatically, they retained a pattern of geographic concentration. This was particularly true for those NMs engaged in clinical practice. Of a study population of 1,200:

> Nearly 25% of the study participants in clinical practice work in the central Atlantic states around New York and especially in New York City itself. The second largest number of clinical nurse-midwives are located in the six south-eastern states (Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, comprising 13%) (Rooks, 1978: 14).

The nature of the work structures in which nurse-midwives were involved in clinical practice also indicated concentrations. Fully 45 percent worked in hospitals, the majority of which were located in cities with over 500,000 people. Less than 13 percent were in private practice with a physician (M.D.), and while their numbers were more evenly distributed among communities of different sizes, over half were located in those with populations under 50,000. Nurse-midwives in independent private practice were rare, comprising only 2.4 percent of the study population, and they were most likely to be found in cities of half a million or more people (Rooks, 1978: 18). Even though nurse-midwives were beginning to move into the mainstream of medical care-giving in 1976 they delivered only slightly over one percent of all the babies born in the United States. In fact, nurse-midwives were in short supply, a concern expressed by both nurse-midwives and sponsoring obstetricians since the early 1950's. Some areas had minimal nurse-midwife representation, for example, of the nurse-midwife study participants located in the five northeastern states (Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont) only seven managed deliveries with any regularity and these averaged 33 births a year, accounting for less than one percent of all births managed by nurse-midwife study participants. Thus, both the distribution and role of nurse-midwives was still quite restricted by 1976.

Meanwhile, the collective mobility project was succeeding.

Even as early as the 1950's, nurse-midwives were reporting greater satisfaction with their work (MCA, 1956: 47).

> Only a decade ago it was difficult to recruit nurses for the obstetric departments of hospitals: obstetric nursing had become so mechanized, so dissociated from human relationships, that the nurse spent her days in routine procedures bringing little personal or professional gratification. The nurse-midwife, on the other hand, finds obstetrics a highly satisfying work.

These Nurse-midwives attributed to their increased scope of autonomy and responsibility and greater personal involvement with patients. It was a sentiment echoed by nurse-midwives' writing in the late 1970's (Brennan and Heilman, 1977). In addition, salaries and incomes for nurse-midwives represented a substantial improvement over that of staff nurses (Judge, 1973: 104). Data from the 1976 ACNM study not only corroborated these findings, they also suggested that CNMs were making almost as much money through direct patient care as they were through administration and supervision, thus providing a way out of the old dilemma facing nurses interested in patient care. Interestingly, data indicated that the mean salary of CNMs whose income was based on patient fees ($21,600) was over $5,000 higher than CMS on fixed annual income ($16,111) (Rooks, 1978: 27).

In terms of the larger professionalization project, the transformations of the 1960's and 1970's suggest mixed interpretations. On the one hand, nurse-midwifery showed many signs of concrete improvement. Education was being

upgraded and CNMs were largely in control of it. Practitioners experienced higher salaries and increased satisfaction. Legislation facilitating nurse-midwifery practice was passed state-by-state during this period. By the end of 1977, enabling legislation had passed in every state except Michigan, Missouri and Wisconsin. Even in those states, CNMs were able to function in specific settings. By 1977, nurse-midwives worked in at least 42 states and Washington, D.C. (Rooks, 1978: 42).

On the other hand, nurse-midwives were still few in number and restricted both geographically and in terms of scope of practice. Obstetricians were working hard to harness nurse-midwifery firmly in the "team." And by the late 1970's, organized medicine began to take an active, obstructionist stance toward CNMs.

The major reason for medicine's concern is the fact that CNMs finally began to locate a market for their services which had previously been monopolized by obstetricians. Furthermore, neither the projected baby-boom nor the physician-shortage materialized and some were even predicting an obstetrician surplus (NAPSAC NEWS, 6(1)1981).

While the ideology of scientism had been dominant when allopaths were consolidating their power, competing ideologies emphasizing "natural," "humanistic" social relationships and "appropriate technology" were emerging and being taken up by large segments of the middle class. Movements concerned

with health, particularly the women's movement, were raising the expectations of consumers and recipients of medical care. More and more women were openly challenging and criticizing obstetricians. Birth reform and childbirth education brought the message of "natural childbirth" to prospective parents across the country. The lay-referral network took on new meaning as informed consumers began to "shop" for care-givers, comparing information with one another. By the mid-1970's, informed consumers had discovered CNMs and were spreading the word through friendship networks. The later 1970's would provide mass access to this information through "women's magazines."

The clientele the CNNs were drawing were increasingly white, middle-class, educated and often professionals (Steinman, 1975). These people were often willing to travel considerable distances to have access to the nurse-midwifery services. Informed consumers liked nurse-midwives precisely because nurse-midwives delivered the kind of care they professed to in their claims of special contribution. The NMs had finally located a new clientele, much larger and more socially and economically powerful than the underserved populations which had previously been their exclusive province. Furthermore, this new clientele was a least somewhat activist and they were willing to demand and patronize nurse-midwifery services. The philosophy of practice of nurse-midwives typically allied them with birth reformers

and their client-centered orientation attracted consumers with raised expectations.

> There are still few of us, but we're in strategic positions in hospitals and in the community, and we have managed to influence maternity care to a remarkable degree just by being totally flexible ourselves, letting our patients have it their way whenever we can, persuading our tradition-bound hospitals to bend their rigid rules, and turning out beautiful, healthy babies for mothers who tell the world about their happy experiences (Brennan and Heilman, 1977: 52).

While the status of a profession in often claimed to be tied to its function in society (cf. David and Moore, 1945), in fact the status of the practitioner is frequently tied to the status of the clientele (Friedson, 1970a; Shaw, 1974). Thus, the higher status of the newly located clientele of nurse-midwifery will probably be linked to the rising status and visibility of nurse-midwives.

In her examination of the development of the pharmaceutical profession in England and the United States, Kronus concludes that the relationship with a clientele proved critical and that a supporting clientele proved a key resource in the professionalization project. On more than one occasion, when apothecaries or druggists were attempting to gain state sanction for their expanded task domain,

> When the occupation was able to demonstrate that it controlled a sizeable portion of the market--as indicated by the size, wealth and loyalty of its clientele--its task boundary efforts succeeded (Kronus, 1976: 35).

Certainly, nurse-midwives' claims that organized medicine's obstructionism represents restraint of trade are strenghtened by a supporting, or demanding and influential clientele.

The ability of an occupation to achieve professional status is, according to Larson, based on several major components. In her analysis of engineering, she examines elements which effectively inhibited professionalization. Several characteristics are unique to engineering, for example the power and knowledgeability of its clientele. However, the heteronomy of engineering is not unique. Larson observes that during a critical phase of development, engineers were salaried empolyees working in large-scale economic organizations. Their capacity to determine the quality of their product was frequently dependent upon economic considerations decided by their employers. Engineers' access to their market was not independent.

> No matter how vigorously or successfully the engineering profession might have organized to secure its market and face its employers, it could not have controlled its professional market because the market was inherently subordinate.... (T)he attempts to standardize the "production of producers" independently of industry's prodefinitions simply reveal again the inescapable stricture of subordination of the professional marked.... (T)he autonomy in defining the content of work--or control over new cognitive areas--does not by itself compensate for the structural subordination of the professional market (Larson, 1977: 29-30).

In terms of nurse-midwifery, the fact that the vast majority of nurse-midwives work as salaried employees of

hospitals or physicians in group or individual private practice assures structural heteronomy. The organized efforts of obstetricians to control access to hospital privileges and withhold them from NMs in independent practice indicate physician efforts to maintain the inherent subordination of the market. Physician strategies of withholding or eliminating physician back-up and third-party payment for independent CNMs serves a similar purpose. Insofar as obstetricians (experts in obstetric pathology and surgery) are able to define what constitutes "normalcy" in obstetrics, they are able to define the potential market for nurse-midwifery services. Where nurse-midwives function under physician-determined protocols (as suggested in the Joint Statement amended in 1975), subordination is structurally assured. The inherent subordination of the nurse-midwifery's market is a direct outgrowth of the hegemony of organized obstetrics and a change in the nature of that market requires fundamental changes in the relationship between nurse-midwifery and obstetricians. Nurse-midwifery is not in a position to struggle to alter that relationship fundamentally at this point. However, other elements outside nurse-midwifery, for example an organized clientele, may take up the cause. Meanwhile, some obstetricians have further strategic uses in mind for nurse-midwives. At a 1975 regional meeting of ACOG, Long (1975: 39), suggested that nurse-midwives could be employed to meet consumer demands without significantly

altering the practice of obstetrics and gynecology. Note how he construed patient discontent as an outgrowth of (mis) perceptions.

> (T)he insistence of women upon control of their bodies (emerged) as a social phenomenon of this decade. All of us in gynecology and obstetrics are quite aware of the discontent among women all over the country--not so much with the quality of gynecologic and obstetric care as with the manner in which the care is supplied.... The idea, whose time is now, seems to me to be establishing a system in which our patients can have their say in how their care is rendered, as well as maintaining excellence in quality of care.

At a 1977 national meeting of ACOG, Thiede (1977: 923) was more explicit about the kind of obstetrical care-giving he wanted to see and the role of nurse-midwifery in facilitating it.

> Couples anticipating childbirth have a responsibility to seek a labor-and-delivery setting that will ensure the greatest protection for the fetus. The medical profession has the responsibility to modify its approach to obstetric care to make it more acceptable and responsive to the perceived needs of the patients. Nurse-midwives have the responsibility to help prevent the creeping polarization of patients and physicians by working for this compromise, (emphasis mine).

Chapter V

The Early Development of Nurse-Midwifery in Vermont

Having considered national trends in birthing practices as well as interprofessional relationships in the obstetrical division of labor, we now turn to the early development of nurse-midwifery in Vermont. To begin, we need to consider major characteristics of the state and particularly the major settings around which the case study is organized.

Vermont is a small state both in population and geographic area. The state's population grew gradually over the period of study, from an estimated 446,500 in 1970 to 493,300 in 1979 (State of Vermont, Department of Health, 1981). Comprising an area of 9,609 square miles, Vermont ranks 42nd in size among the 48 contiguous states, and 47th in population. It is predominantly a rural state; two-thirds of its population lives in towns and villages of under 2500 people. I have confined my study to northern and central Vermont; this area includes the two major urban areas of the state, Burlington and the surrounding area on Lake Champlain and the Barre-Montpelier area in the northern center of the state. While Burlington is the most densely populated city, Montpelier is the state capitol.

The state is mountainous and geographic divisions, coupled with narrow, winding roads encourage localism. An

exception is a major four-lane highway, which connects Burlington and Montpelier and continues south connecting with another major highway, which runs most of the length of the Vermont-New Hampshire border. (Both highways were completed in the late 1970's.) East-west travel in most of the state is difficult. Traveling in and through Vermont, I had the feeling that the major highways served more to connect Vermont with the New York City and Boston areas, or to allow passage through to Montreal, than to facilitate travel within the state.

One of the state's major sources of revenue is tourism. In addition there are nine colleges, several of them private. Both the beautiful scenery and the excellent skiing draw visitors into the state. It is no wonder Robert Frost wrote so lovingly about the natural world and meaningful human interaction, his native Ripton is located in the heart of the Green Mountains and is the epitome of a quaint, remote New England village surrounded by natural beauty. However, while its geography attracts tourists and its winters attract skiiers, they discourage year round residence. Nonetheless, some who come as visitors devise ways of remaining in the state. Nearly all of the people I interviewed were not natives. Native Vermonters and those who choose to live in the state are perhaps best noted for their hardiness, independence and resourcefulness. A bit of Vermont's history may help to illustrate this point.

During the early 1800's the territory which became Vermont was disputed and claimed by both New Hampshire and New York long after much of the land was settled. One service provided by the "Green Mountain Boys" led by Ethan Allen, was protection of home-steaders' lands from rival claims. After the Revolutionary War, Vermonters sought to make theirs the fourteenth state in the union. Since the territory was still disputed their request was rejected. These plucky folks were, however, undeterred.

> Snubbed by Congress, Vermont announced itself an independent republic, establishing a postal service and issuing copper coins from the Harmon mint.... Meanwhile, Congress began to grow alarmed as information leaked out that the Allens were negotiating with the British in Canada (Dodge, 1977: 33).

Vermont subsequently became the 14th state, but not until certain of its conditions were met.

To some extent, the independence, self-sufficiecy and pluck of early Vermonters still characterize residents today. In interview, one subject offered the following, "In Vermont, people are taken on their own individual merits, not their background (including degrees, titles, etc.)." And while discussing diversity and deviance in the state (for example, home birth) another subject explained that one must understand that, "...there's a philosophy of 'mind your own business' in Vermont."

Vermont is not an affluent state. The median annual family income in 1969 was $8,929 and the per capital income

was $2,776. By 1979 the median annual family income was $17,206 and the per capita income was $6,179. Both of these figures were below national median annual incomes. A list of the top ten industries and the numbers of people employed in them will help to explain the situation. The top three employers are local government (18,500 workers), health services (14,750), and state government (13,700). These are followed by electrical machinery manufacturing (12,250), eating and drinking establishments (10,650), contract construction (10,650), non-electrical machinery manufacturing (7,300), educational services (6,650), hotels, motels, etc. (6,550), and retail food stores (6,150). The two largest private sector employers are International Business Machines and General Electric, both located in the Burlington area (information from the Vermont State Planning Department).

With health services constituting the second largest employer in the state, it might seem likely that Vermont residents' medical care needs were adequately met. Whether or not that is true, the distribution of medical services in Vermont is not even. Examining primarily 1969 data, Wennberg and Gittlesohn (1973) found considerable variation among hospital service areas of the state in terms of ratios of hospital beds and personnel to population, utilization rates and expenditures. For example, they found a range of 34 to 59 in numbers of hospital beds per 10,000 persons,

while the number of hospital personnel per 10,000 persons varied from 68 to 138. Calculating physician activity per 10,000 persons they found a range of .1 to 1.1 (full time equivalent) among physicians practicing obstetrics. Similar ranges were obtained for general surgeons and pediatricians, differences between low-service and high-service areas were even more pronounced in the distribution of general practitioners and Internists.

They emphasized that this considerable variation seemed only to be exacerbated by state and regional planners who tended to construe use as the outcome of patient need. Thus, hospitals with the highest ratio of beds per population were granted the largest percentage increases by planners. In addition, PSRO's (Professional Standards Review Organization) chose to ignore data indicating, for example, significant correlations between the numbers of surgeons in practice in areas of the state and the amount of surgical procedures being undertaken there. These problems are hardly unique to Vermont, inequitable distribution of medical services is a national problem and the relationship between numbers and kinds of physicians and the frequency of various treatments of procedures has been noted elsewhere (Bunker, 1970). Summarizing their findings Wennberg and Gittlesohn (1973:321) concluded that "physicians concentrate(d) their efforts in more populous service areas and in those with higher per capital incomes." This pattern is also typical of the United States as a whole.

More specifically related to the issue of the obstetrical division of labor, the Vermont birth rate, which closely paralleled the national white birth rate, declined from 25 per 1000 population in 1947 to a low of 14.3 in 1976. By 1979 it had risen to 15.2. In both Vermont, and the nation as a whole, the predicted baby-boom of the 1970's failed to materialize. In 1979, the average age for all Vermont women giving birth was 25.5 years, a figure which had remained fairly constant through the 1970's. Of birthing women, 81 percent had high school educations and 18 percent had completed four or more years of college.

The Settings

I have chose four settings for an examination of nurse and lay/independent midwifery in Vermont. These areas I have located around hospitals since they are either sites of practice for nurse-midwives, sites of practice for physicians creating in-hospital birthing alternatives and/or backing up lay/independent midwives or referral centers for home birth attendants. In each of these settings I am concerned with specific work relationships, birthing practices and reforms in those practices. This case study is undertaken in an effort to see how nurse-midwives and lay/independent midwives attempt to negotiate for turf in the obstetrical division of labor and reforms in birthing practices.

UH/RMC University Hospital/Regional Medical Center

UH/RMC is located in an urban county which contains over 20 percent of the state's population. It is also the economic and educational center of the state. The hospital (actually two separate units organizationally joined in the late 1960's) is associated with university medical and nursing schools and functions as a teaching hospital. It serves the area population and also functions as the referral and high risk medical center for the region. Forty percent of all the obstetrician-gynecologists in the state work in this area (this number includes subspecialists in ob/gyn, for example, gynecological oncologists). UH/RMC has the largest number of obstetrical beds in the state (32), and in 1979 was the site of approximately 27 percent of all births to Vermont residents and nearly 30 percent of all births which took place in the state (including those to out-of-state residents). These numbers vary little over the period of study, 1970-1980. The obstetrical service included 17 attending ob/gyns in 1979, fourteen of whom were in a group practice associated with the medical school. In addition, obstetrical residents worked as house staff in the hospital and helped to supervise interns from the medical school. A full nursing staff was complemented by nursing students from the nursing school who also participated in care-giving as part of their training.

UH/RMC constitutes the major and initial site of nurse-midwifery practice in the state and will receive the majority

of my attention.

SCCH/South Central Community Hospital

SCCH is a small community hospital centrally located in the state in a town of slightly over 2,000 persons. Throughout the period of study there were no obstetricians associated with the hospital, instead the population was served by several general practitioners and family practitioners who limited their practice to obstetrics. In 1979 it had 5 obstetrical beds and over the period of study accounted for approximately 2.5 percent of hospital births in the state. This area was the site of considerable home birth activity and important in-hospital birthing alternatives.

NERH/North East Regional Hospital

NERH is a relatively recently built hospital (completed in the 1970's) serving two towns with a joint population of 10,000 as well as the surrounding sparsely populated region. The people were served by a few general practitioners until an obstetrician began a practice there in 1978. He subsequently hired a nurse-midwife. In 1979 the hospital had 12 obstetrical beds, and over the period of study it accounted for approximately 5 percent of the hospital births in the state.

NCCH/North Central Community Hospital

NCCH serves two adjacent towns with a combined population of over 18,000 as well as the surrounding moderately

populated area. The population is served by four obstetricians in a group practice, a few general practitioners and, late in the study period, a family practitioner. The hospital had 20 obstetrical beds in 1979 or 11 percent of the obstetrical beds in the state. Over the period of study, NCCH accounted for an average of approximately 12 percent of hospital births in the state. Although NCCH is a large hospital by Vermont standards, it is only a minor site in this study. Only one nurse-midwife worked in the area during the study period and she was forced into an exclusive home birth practice after her hospital privileges were suspended at NCCH. The nurse-midwife's practice will be examined but the hospital will not figure importantly in the study.

Origins of Nurse-Midwifery Practice in Vermont

Nurse-midwives first entered the state in order to practice in 1968. Their presence was the result of initiatives taken by the head of the Department of Obstetrics and Gynecology at UH/RMC. He was a native of the state and had come to the conclusion that involving nurse-midwives in obstetrical practice would improve the quality of care to pregnant and birthing women in Vermont. As early as 1971, he spelled out in the medical literature his vision of a new kind of working relationship in the delivery of obstetrical care, one in which the nurse-midwife figured importantly (Maeck, 1971).

In his view, the then much discussed "crisis in health

care" was mistakenly laid at the doorstep of the "doctor shortage." As we have already noted, considerable discussion both among leaders of organized medicine and representatives of the federal government in the 1960's centered on questions of adequate labor power in medical care. The federal government focused its attention primarily on the creation of new medical schools in order to increase the supply of physicians but Maeck found this direction misplaced. Meanwhile, he became interested in allied health workers as his conviction grew that the highly trained obstetrical and gynecological specialists were using their time inefficiently and sometimes ineffectively in practice.

He agreed that the health care system was ineffective and inefficient; that many people received inadequate care while others received no care at all. There was inadequate access to quality prenatal care and many women genuinely at risk were not receiving adequate obstetric care. The situation existed, he felt, because obstetricians' work had broadened in scope and, instead of countering this trend by attempting to limit the scope of practice to the ob/gyn's special expertise, they had continued to attempt to be "all things to all people." Because of this, the limitations which did develop were in terms of the numbers of people who could obtain their services. The problem of obstetrical/gynecological health care delivery could then appear to be one of inadequate <u>numbers</u> of practitioners when in fact, he felt, it was more realistically viewed as ineffective and

inefficient use of physician's time and expertise. In interview, he expanded upon this point.

> I thought that most obstetricians practiced pretty routine obstetrics and it's pretty mundane (work) and we don't do mundane and routine things very well. (Ob/gyns) don't do much teaching of the patients. They just record certain data, spend three minutes with a prenatal patient and are off to the next one. Furthermore, I felt that we needed more professional care to pregnant women and that it was a terrible waste of highly-trained, highly-skilled surgeons/obstetricians (for example, physicians standing around waiting for essentially normal labors to progress). All of which could be better done by...midwives in attendance.

Maeck (1971) argued that if a new division of labor in obstetrical care were developed, goals such as improved prenatal and post-natal counseling for all women, improved family planning, provision of services effectively and at reansonable cost and reduction of infant morbidity--especially among the disadvantaged, could be realistically undertaken. His goal was to include nures-midwives in the care of all pregnant, birthing and interpartal women. He decided that the way to accomplish this was to train residents in obstetrics and gynecology to work with nurse-midwives in the delivery of obstetrical care to women. That is, he concluded that allowing nurse-midwives to perform some tasks previously monopolized by obstetricians would improve both patient care and obstetricians' work performance.

In 1967, with this conviction, he set about convincing his colleagues that the project of bringing in nurse-midwives

was worth trying. He subsequently traveled to England to secure the commitment of two English nurse-midwives to work with him at UH/RMC. The first nurse-midwife began work in Vermont in 1968 and remained for three years. While she engaged in some clinical practice, the bulk of her work consisted of familiarizing the staff and patients with the potential contributions of nurse-midwifery. In addition, the possibility of establishing a school of nurse-midwifery at UH/RMC was considered, but was subsequently dropped for a variety of reasons, including prohibitive expense.

Interestingly, English nurse-midwifery, so important in the initial development of nurse-midwifery in the United States in the 1920's and 1930's appears again in the beginnings of nurse-midwifery in Vermont in the 1960's. This is not particulary surprising. Nurse-midwives in England had located a niche in the medical division of labor (Bayes, 1968) and had the support of British physicians, some of whom voiced strong support for nurse-midwifery to their American counterparts (Tompkins, 1977). Furthermore, as we have already observed, nurse-midwives in the U.S. were in short supply. Nonetheless, Maeck's willingness to travel to England to locate nurse-midwives to practice in Vermont and help to win the support of skeptical medical personnel clearly indicates his commitment to his vision of a new division of labor in obstetrical care. It should also indicate his leadership in this area.

In 1970, the second English-trained nurse-midwife arrived. At this point, a growing acceptance of nurse-midwives by both physicians and patients enabled her to begin some clinical work in labor and delivery. When, in 1971, the first English nurse-midwife departed, an American-trained NM was hired and attention was focused on further development of clinical practice as well as on the instruction of medical and nursing students.

As we have seen, the American College of Nurse Midwives has worked to define the special contribution of nurse-midwifery in practice and guarantee it through standardization in education and licensure requirements. However, it has often been the obstetrician/gynecologists who have been more capable of both making their views of NM's special contribution heard and translating them into the actual division of labor and the delivery of care. Here in Vermont, we find an obstetrician whose view of nurse-midwifery is central to the creation of a new niche in the state's medical division of labor. In this case, however, he appears to be more closely attuned to the nurse-midwives' own claims.

> In my belief, (the CNM) has an extremely important role to play in newly developing systems of maternal and child health care. Because of her training, she is qualified to manage the uncomplicated pregnancy and labor and to recognize the abnormal. Her motivation and background bring to this professional care an important aspect of psychologic and educational support which is often neglected by the busy obstetrician.... Her qualifications permit her to share responsibility and much of the routine obstetric care with the obstetrician who could then afford to devote more

> of his effort to the patient at risk. Such a real professional partnership should deliver optimal obstetric care to a much larger number of patients at no extra cost (Maeck, 1971: 317).

In Larson's (1977) terms, Maeck was attempting to rationalize the production and delivery of professional services by reorganizing the division of labor. His goal of returning the obstetrician/gynecologists' turf to complicated and abnormal aspects of obstetrical and gynecological care contrasts sharply with the trend in obstetrics and gynecology to monopolize the primary care of women (cf. Burkons and Willson, 1975).

That such a project was conceived and undertaken at a University hospital served primarily by ob/gyns employed in a group practice and engaged in teaching and research is understandable. Countervailing market forces are not keenly felt by practitioners in such contexts. Experiments in the development and employment of ancillary workers could serve to improve obstetrical care thus enhancing the prestige and power of obstetrician/gynecologists. It is worth noting, for example, that neither Maeck nor other leaders of ACOG were calling for expansion of production of general practitioners to meet the needs of birthing women. General practitioners would probably prove to be much more difficult potential competitors to contain.

Partnership was the major component of Maeck's vision of a new obstetrical division of labor. He described the emerging work relationship at UH/RMC in some detail.

> A model of total maternal care based on (partnership) is being developed at our Medical Center. The midwife (CNM) and obstetrician are both involved in the care of each patient throughout pregnancy, labor and delivery and the puerperium. The midwife is responsible primarily for patient education by conducting mothercraft classes, demonstrations and regularly scheduled interviews at routine prenatal visits. After the initial interview and evaluation by the obstetrician, the midwife may well alternate with him at follow-up examinations during which she must make value judgements as to the course of the pregnancy. In our experience, potential problems have been detected which might otherwise have been overlooked. Because the midwife establishes rapport with the patient early in pregnancy, she has an unparalleled opportunity to discuss future family planning and related problems.... In our experience, the obstetrician has had limited opportunity to instruct the patient about nutrition, personal hygeine and general activities. These aspects of obstetric care have never been accomplished so effectively as when the midwife functions as a member of the team.
>
> ...The program also includes the midwife in the conduct of the labor and delivery of the uncomplicated pregnancy. She acts in association with a member of the obstetric staff who serves as a consultant and is available for operative procedures or the management of complex problems demanding his particular skills. It is my firm belief that this type of team approach can and does render superior obstetric care with optimum patient rapport and satisfaction (Maeck, 1971: 317).

Maeck was seeking a CNM to help design and participate in research on nurse-midwifery practice in the state. In 1973, he was joined by a CNM who took a leave of absence from her teaching position in a masters nurse-midwifery program. While by that time nurse-midwives had worked in the state for nearly five years, they had practiced solely through

UH/RMC and under its auspices. The nurse-midwifery educator and Maeck designed a research project aimed at extending nurse-midwifery practice beyond UH/RMC. As Maeck explained in interview,

> I felt that we didn't need Nurse-midwives here because we have more residents than we know what to do with, more students, more obstetricians than we know what to do with...but, I felt that out in the rural areas that isn't true. We could develop a model here which might be replicated in our rural Vermont as well as nationally. And I think it has had some impact.

The unequal distribution of generalists and specialists in the state has already been noted. In an effort to counterbalance this trend, the research project aimed to place a CNM in a small town south of UH/RMC. The project's goal was stated in a mimeo issued from the Department of Obstetrics and Gynecology at UH/RMC (January, 1979). "The purpose of the project was to improve and expand obstetrical care in rural communities with the (UH/RMC) obstetricians as consultants."

The nurse-midwife was to work under the auspices of a general practitioner in the town within carefully constructed protocols. The G.P. was supportive of the project and after six months of preparation the project appeared to be realizable. However, when it reached the point of getting hospital privileges for the CNM at the local hospital, the project was snagged. The hospital's legal advisor recommended against granting privileges since the state had no clear laws regarding nurse-midwifery practice and the hospital might have to

assume liability. The project was effectively stopped, and the originators decided to put their energy into changing the law. This proposed project was interesting for several reasons. First, it demonstrated a concern on the part of at least some obstetricians at UH/RMC with the general nature of the delivery of obstetrical care throughout the largely rural state. Secondly, it coupled the traditional use of nurse-midwives as specialists with a public health orientation serving the "underserved" with a new kind of team concept in which nurse-midwives and obstetricians alternated prenatal patient visits. Finally, it sought to employ non-medical workers in an undertaking aimed at extending the influence of the University hospital, a trend some have criticized (Ehrenreich and Ehrenreich, 1971).

Efforts to develop enabling legislation became the new focus of the CNM and interested ob/gyns. The state nurses association was interested in and supportive of the proposed legislative changes. Furthermore, UH/RMC was interested in bringing in other nurse-practitioners. So the decision was made to develop broad-based state legislation to create a legal framework for nurses practicing in "expanded roles." National nursing organizations were unable to provide guidance since they had themselves only begun to set up legal guidelines for expanded roles in nursing practice. Furthermore, states which had legislation facilitating nurse-practitioner and nurse-midwifery practice varied considerably in the

nature of the legal framework created.

Interested actors in Vermont concluded that their best chance for fruitful change was an expansion of the existing Nurse Practice Act rather than the creation of a totally new law. An interview subject involved in this undertaking explained that it would have the effect of avoiding a CNM separation from nursing and at the same time keeping other disciplines out of the realms of practice being delineated in the legislation.

The CNM and representatives of both obstetric and gynecology at UH/RMC and the State Nurses' Association spoke before the board of nursing practice in support of the legislation. In 1974, the revision was granted. It stated that nurses with appropriate training were allowed to practice in expanded roles under the auspices of licensed physicians and working under protocols and guidelines for practice. It did not specify that CNMs had to work under the auspices of obstetrician/gynecologists or the particular settings in which CNMs could work.

While proponents of the expanded role of the nurse sought to broaden the Nursing Practice Acts, the state was encouraging licensure under the Physician's Assistant Act. The several actors involved resisted this more. The P.A. act required considerably less training than nurses in expanded roles had obtained. Secondly, as one CNM pointed out, "CNMs are <u>not</u> assistants to physicians." To emphasize

this point, the CNMs drafted a document stating their opposition to the state's suggestion.

After seeing the completion of the legislative project, if not the research project, the CNM educator was prepared to return to her post. However, by early 1974, the other two nurse-midwives at UH/RMC had left and the future of nurse-midwifery in the state was unclear. But the Department of Obstetrics and Gynecology reaffirmed its commitment to nurse-midwifery and the CNM was persuaded to stay on.

That was a critical decision for she subsequently brought her considerable skills and energy to the development of nurse-midwifery at UH/RMC. Several interview subjects suggested that she was politically sophisticated and thus able to provide valuable leadership and direction in this critical phase of development. Her previous experience in nurse-midwifery education at a major graduate school probably helped considerably.

As the only CNM at UH/RMC her work was varied. She taught in the medical school, and did some teaching to obstetrical residents and fourth year nursing students. In addition she did clinical work, mostly prenatal care in the office, although she did take labor and delivery call for a physician who had not yet relented to the inclusion of husbands/fathers in the labor and delivery room. However, one CNM at a large teaching hospital was not enough. Shortly after she decided to stay, she and Maeck began to seek funding to expand the

nurse-midwifery practice at UH/RMC.

By 1976, funding from the Private Foundation was obtained. The head of the foundation, located in Vermont, had been a practicing nurse and midwife in China for 30 years and was a gynecologic patient at UH/RMC. She agreed to provide initial funding for the development of a nurse-midwifery practice over a five-year period (1977-1981). The money provided for the salary of the CNM already on staff and enabled the department to hire two more CNMs over the following two years.

Meanwhile, an instructor at the nursing school associated with UH/RMC had acquired a certificate in nurse-midwifery and a new instructor with a masters degree in nurse-midwifery was hired. While these two CNMs were engaged primarily in teaching rather than clinical practice, they did create increased CNM representation at UH/RMC and engaged in a function widely performed by nurse-midwives.

A second CNM was hired in early 1977 and another in mid-year. In 1978 the acquisition of federal Maternal and Infant Care (MIC) monies made it possible for the department to hire another CNM. While the bulk of her work involved the delivery of prenatal and postnatal care in an outreach clinic, a portion of her time was devoted to the UH/RMC CNM service.

With four CNMs in practice the senior CNM arranged for the nurse-midwives to divide their time among the twelve physicians in group practice so that all patients were seen prenatally by a CNM. This model was consistent with Maeck's vision of partnership in obstetric care. And it is a fairly

unique structure among the various manifestations of "teams" throughout the U.S.

Little by little, nurse-midwives were able to be on call for the labors and births of patients who requested their presence. However, the physicians "didn't want us to advertise" that is, actively compete for patients as more than one CNM put it. So the idea had to occur to the prenatal patient. As we shall see later, the idea did occur to several women and it began to filter through the lay-referral network.

However, as the nurse-midwife involvement in obstetric care increased so did the obstetrician-gynecologists' control of the program. For example, the senior nurse-midwife was never formally given a budget for the program, instead money was doled out through the department of obstetrics and gynecology. As one respondent explained, "...physicians were keen on maintaining some kind of control of the whole thing (the CNM program)." In mid 1978, an obstetrician was appointed Medical Director of the nurse-midwifery service.

By 1979, nurse-midwives were working in or around each of the four study sites in the state. At UH/RMC, four CNMs were on staff engaged in clinical practice and two were instructors in the nursing school. In the NCCH area a CNM had set up an independent practice. Both the new obstetrician-gynecologist at NERH and the family practitioner at SCCH had hired a CNM. The manner in which their work relationships

were negotiated as well as the nature of the work they performed will be taken up in chapters seven and eight.

Chapter VI

Out-Of-Hospital Birth Reform: The Home Birth Movement

Introduction

While nurse-midwives were being drawn into the medical division of labor in Vermont and elsewhere, alternative philosophies of childbirth were emerging and being disseminated throughout the United States by a growing birth reform movement. The diffusion of these ideas and practices into Vermont occurred primarily through immigration into the state. Both "hippies" and more mainstream, middle-class couples brough with them raised expectations about childbirth experiences and new orientations to birth, including an interest in home birth. Some of these philosophies were to find fertile soil among the independent-minded Vermont natives.

The home birth movement, by advocating and practicing alternatives in childbirth, altered the birthing environment in the state. An examination of the movement will indicate the ideological and practical changes it created as well as the strategies by which these changes were brought about. In addition, it highlights the importance and complexity of a profession's relationship with its clientele.

The home birth movement is an increasingly active component of the birth reform movement, and it is its most radical element. The larger birth reform movement is quite

diverse and components of it differ considerably in both their short-term goals and strategies. However, both in-hospital and out-of-hospital birth reformers share the larger goals of better birth outcomes and better birth experiences. It is plausible that these different strategies and loci of change constitute a division of labor in the movement. Whether their paths diverge dramatically or ultimately converge, their overall goals were initially the same.

The Birth Reform Movement and the Revolt of the Client

The birth reform movement has had a significant impact upon orientations to childbirth among both the lay public and providers of obstetric services. However, some care-providers, such as nurse-midwives and some nurses, actively embrace birth reform while obstetricians and more traditional nurses have been more cool toward the idea. This may be explained in part by the fact that the movement changes the context in which nurse-midwives negotiate for both turf in the division of labor and a market for their services. The movement may work to their benefit while challenging obstetricians' autonomy and the functions of nurses accustomed to traditional hospital practices. While the professionalizing occupation of nurse-midwifery navigates a cautious course and is ever-attentive to the turf claimed by physicians, the birth reform movement has been somewhat less constrained and more able to seek changes using a variety of tactics.

These include persuasion of both physicians and nurses to incorporate desired changes into their routine practices and education and activation of the lay clientele. A brief examination of the ideology and strategies of this larger movement will aid in understanding and locating the home birth movement.

The incipient birth reform movement arose as a reaction and/or adaptation to what were regarded as problematic obstetrical practices. Interestingly, it came from among physicians themselves. In 1944, Grantly Dick Read, an English physician, published Childbirth Without Fear. The title neatly summed up his goal. After many years of practicing obstetrics, he became convinced that the bulk of the pain suffered by women in labor was the result of culturally-induced fear of childbirth, enhanced by ignorance of the normal process of birth. Rather than attempting to suppress the pain with anesthetics, as was the common practice, Read felt that with proper education and preparation provided by physicians, birthing women would be able to experience "the personal triumph of motherhood."

Subsequently, in the 1950's, a French physician, Ferdiannd Lamaze, developed another philosophy aimed at inhibiting the pain of childbirth. Drawing on the experiments of Ivan Pavlov, whose work indicated that the experience of pain could be inhibited through conditioning, Lamaze applied the principles (called psychoprophylaxis) to human

experience.

> (I)n the psychoprophylaxis method, the laboring woman responds to uterine contractions with specific breathing techniques which she has learned and practiced; this focuses her concentration in a way that does not permit the sensation of pain to register.... Lamaze preparation for childbirth is a precise and rigorous system. Beginning in the seventh month of pregnancy the woman (and her coach, typically her husband, are) trained.... (Parfitt, 1977: 47).

Interestingly, while Read's work initially had a limited impact in the United States, the program suggested by Lamaze was quickly picked up and disseminated. In 1960, Elizabeth Bing and Marjorie Karmel co-founded the American Society for Psychoprophylaxis in Obstetrics (ASPO) in New York City. Perhaps the scientism and the specific program of the Lamaze method provided a more attractive basis on which to pursue birth reform. ASPO has chosen the strategies of cooperation with obstetricians (who are included in its board of directors) and professionalization in order to institute its desired reforms. For example, it requires standardized and rigorous training for its instructors whom it certifies. And, having acquired some legitimacy among obstetricians and hospitals, some childbirth educators are able to make at least a part-time career out of what was previously an avocation.

Other organizations which prepare birthing women and their partners are more eclectic in their approaches and tend to draw upon both Read and Lamaze while adding new components.

These include the International Childbirth Education Association (ICEA) which was also begun in the early 1960's, and the Bradley method of the American Academy of Husband-Coached Childbirth, popularized in the mid-1960's. While these organizations have also provided training programs for instructors and promoted standardization, they appear less committed to the twin strategies of professionalization and cooperation with obstetricians.

Whether or not such training programs enable women to experience what they have called "natural childbirth" is questionable. As Margaret Mead observed,

> It should be pointed out that natural childbirth, the very inappropriate name for forms of delivery in which women undergo extensive training so that they can cooperate consciously with the delivery of the child, is a male invention, meant to counteract practices of complete anesthesia, which were also male inventions. Contemporary forms of natural childbirth are an attempt to restore to women what women among many peoples once had (Mead, quoted in Parfitt, 1977: 37).

Echoing her sentiments, Rothman (1982) suggests that childbirth education has largely been coopted by medical interests. It has become a vehicle to socialize patients into hospital-oriented births by training them in self-control which enables them to better cooperate with physician and staff demands. It suggests to patients that they are in control and freely making choices while in fact they are adjusting to the hospital organization of labor and childbirth (e.g.,

"don't push now, we're going to the delivery room!").

Still, even at its most conservative, the birth reform movement has encouraged the patient to shun the passive role and it has raised both the patients' and the providers' expectations about the acceptable level of quality of the prenatal care and birth experience. In so doing, childbirth education has largely accepted the medical segmentalization of childbirth and its conception of the separation of the body and the mind/psyche. While management of labor and birth is left to the physician, childbirth educators attend to the patient's experience. Nonetheless, increased lay involvement in childbirth practices has produced a movement which medicine finds difficult to contain.

The growth of the birth reform movement, and the home birth movement in particular, is indicative of a growing rift between obstetricians and at least some portion of their clientele. Since medicine is a consulting profession, its continued success rests upon the willingness of its clientele to seek its service and regard its authority as legitimate (Freidson, 1970a). However, among the laity, growing concern with and criticism of hospital and physician practices have given rise to movements aimed at reforming medical care or offering alternatives to it. Haug and Sussman (1969) refer to this phenomenon as "the revolt of the client."

These lay challenges to the profession's authority and its claims to both trustworthiness and the reliability of

producers of professional services have taken several forms. Informally, clients activate and alter the function of the lay-referral network by exchanging information about care-givers in order to "shop" for the right practitioner. They also have more ready access to knowledge about health and medical care via both the mass-media and patient-education organizations such as childbirth education. Armed with this information and knowledge, many clients seek to manage their interactions with professionals (Lopata, 1976: 443). In so doing, they attempt to alter the asymmetrical relationship by, "us(ing) the expert as consultant, not as authority figure," (Haug and Sussman, 1969: 158).

The client revolt thus poses a fundamental challenge to the medical profession which counts as one of its benefits, freedom from lay control and intervention, particularly in the delivery of its services. What was previously construed as a question of individual patient compliance has increasingly become a question of collective challenge. The profession's ability to "exercise power over subordinates, the clients...." is eroded as more patients seek to participate in decision-making (Haug, 1975: 207).

While Haug (1975) views this trend as heralding a societal move toward deprofessionalization, Lopata (1976) anticipates instead greater variation within the clientele (some in revolt, others more inclined to compliance) resulting in greater variation in client-expert relations. In

either case, the collective revolt of even a portion of the clientele may have a far-reaching impact on the medical profession and the division of labor, particularly if that portion of the clientele is educated, articulate and vocal. The revolt of the clientele presents a fundamental challenge to both the profession's claims and its status.

Within the birth reform movement, the early 1970's was a period in which some elements became radicalized, and the strategy of cooperation with the medical profession was superceded by overt challenges to its autonomy. In 1972, Doris Haire, who was then president of the ICEA, wrote an essay which was widely cited in birth reform literature. In it she charged that obstetrical practices has "warped" childbirth and had failed to significantly improve infant mortality and morbidity rates. This essay set the tone of the argument which was continued by Suzanne Arms (1975) who scathingly critiqued what she called the "new, improved, quick-and-easy, all-American hospital birth." She challenged virtually every component of hospital obstetrical delivery, particularly the phenomenon she described as "birth's machine age." The impact of the work was enhanced by the fact that it was accompanied by a photo-essay and a plethora of quotes from the women-in-the-stirrups.

In addition, Arms examined alternatives to the hospitalized and medicalized obstetrical services, including American nurse-midwives and lay midwives as well as

maternity practices in Denmark and the United Kingdom, both of which included professional midwives. This work is still widely read and is regularly stocked in the health sections of many bookstores I have visited in several states. Many women with whom I have spoken both in this study and more casually have pointed to Arms' book as making a turning point in their views about childbirth.

Thus, where previously the profession had enjoyed freedom from fundamental and antagonistic lay intervention, it now faced an activated clientele which demanded accountability and change. The medical profession itself is not of one mind on the issue of birth reform. As Bucher and Strauss (1961) observe, professions include segments which may move in different directions. Some physicians have been won-over by birth reformers' critiques and proposals for change. This is especially true of physicians who are more client-centered. But other physicians oppose the movement, as Lopata (1976: 443) explains,

> (T)raditional experts see these moves as an erosion of professional authority. In fact, they are shocked at the behavior not only of the client, but also of the younger members of their own profession.

Among the clientele, the more radical critiques of hospital birth and physician practices had a varied impact on the movement's strategy. While for some the effect was a renewed commitment to further in-hospital birth reform,

for others it was an impetus to consider home birth.

The Home Birth Movement

Reviewing the diffusion of the ideology and practice of birth reform during the 1960's and early 1970's, Hazell (1976: 8) noted that home birth continued to be regarded as deviant.

> Newman (1965) defined the population interested in natural childbirth, home birth and breast-feeding as a part of the 'Back-to-Nature-Ethos' also noting that they were concerned with ecology and the survival of mankind (sic) as a whole. In the years since Newman's work, it has been my observation that natural childbirth, breast-feeding and ecological concern have become adopted much more in the wider cultural ethos, while home birth remains by and large culturally unacceptable.

I would argue that Hazell's assessment is still accurate today. In large part this is because home birth involves a more complete cessation of faith in the medical profession and its claims. In addition, it requires the willingness to assume personal responsibility for an area of life which the profession has claimed as its legitimate responsiblity. Particularly in the face of professional charges of negligence, home birth parents must assume a posture of greater willingness to take risks along with their assumption of responsibility. However, this situation assumes that clients have access to professional medical care which

they choose not to utilize.[1]

During the 1970's, several home birth organizations were formed. The hospital-oriented childbirth preparation organizations had been unwilling to align themselves with home birth advocates for fear of losing physician cooperation. Thus, people planning home births found themselves with many needs and few resources. In response to those needs, organizations designed to aid those planning home births were created. In the early 1970's, the Association of Childbirth at Home, International (ACHI, formerly ACAH) and Home Oriented Birth Experience (HOME) were begun independently, to educate home birth parents. As in other movements,

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[1]While the Home Birth Movement is overwhelmingly white and middle-class that does not mean that only white and middle class Americans are having home births. Rather, it is these people who have recently "discovered" home birth and who vocally champion it. As the history of both lay and nurse-midwifery indicates, minorities and the poor have engaged in the practice of home-birth both before and after allopaths achieved dominance. Lee and Glasser (1974) found that Black and Mexican-American midwives in the Houston area served a population 80 percent of which was Black or Mexican-American. In 1974, at the time it was closed down over the active protests of supporters and clients, the Chicago Maternity Center's patient population was 40 percent Latina, 45 percent Black and 15 percent white (Parfitt, 1977: 168). These populations have fewer resources, are less vocal, and are probably not as used to having their concerns taken seriously as are white, middle-class Americans.

The fact that physicians have rarely sought to attend this potential clientele is illuminating and suggests fundamental questions about the profession's commitment to responsibility for childbirth. Apparently, it feels greater responsibility for the births of white and middle class patients while it considers alternative care-providers acceptable for less attractive clients. The home birth movement has only begun to develop this critique of professional interests.

small newsletters were begun and information was disseminated. In addition, ACHI trained childbirth educators to aid prospective parents in preparing themselves for home births. While prospective home birth parents clearly represented a need for home birth oriented childbirth preparation, childbirth education also represented a vehicle by which advocates could legally support its practice. In addition, it provided an avenue through which those planning home births might gain access to a lay-midwife and meet one another. A childbirth education class for home birth parents, which I attended in Michigan for several weeks, was marked by a strong sense of camaraderie and mutual support.

In the mid-1970's, the National Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC) was formed. It held its first national conference in 1976 and attracted over 500 participants. While it chose not to support home birth exclusively, NAPSAC became a strong advocate for the practice and it facilitated the interaction of many smaller groups championing home birth. During this period, associations of providers of care to home birth parents were also formed, including the American College of Home Obstetrics (ACHO, these physicians were generalists, not obstetricians), and the American Midwives Association (AMA).

In 1976, Ina Mae Gaskin, a midwife at The Farm (an intentional community in Tennessee in which midwife-attended

births predominated), published her book, Spiritual Midwifery. In it she also announced the Farm's newsletter, The Practicing Midwife. Both the book and the newsletter contained not only her counterculture philosophy of birth but also considerable technical information typically unavailable to lay-midwives and people planning home births. On the whole, these strategies of disseminating information were efforts to end the profession's monopolization of knowledge about pregnancy, labor and childbirth.

Characteristics of Movement Participants

While movement participants share a desire for home birth, both their commitment to the movement and their other interests may diverge markedly. Speaking to a conference organized by ACHI, Suzanne Arms (1980: 3) acknowledged their considerable differences.

> I think there is a basic fallacy in thinking today when we come to conferences, particularly when there are a lot of people from divergent backgrounds and the going line is something like, 'Well, we all want the same thing, don't we?' This is a fallacy; we don't all want the same thing. Many of us want many different things. Some people are willing to accept far more risks in their lives than others. Some people are willing to tolerate far more potential problems and take far more courageous steps than others. Some people are very product oriented, others are process oriented.

My own experience attending a 1981 NAPSAC conference bears out Arms' claim. While the participants were all white and

predominantly middle-class, some were clearly professionals (there were many advanced degrees) while others dressed and presented themselves more as members of the counterculture suggesting downward social mobility. Another indication of the diversity of the movement is the fact that, until the recent past, NAPSAC has avoided the topic of abortion, recognizing that its membership would split over the issue. Levin and Idler (1981: 84) spell out the differences more explicitly.

> Although the enthusiasm for the home birth experience is common to all members of the movement, their interests differ considerably, as do their perspectives on the problem of hospital obstetrics. Feminists see childbirth practices preempted from women by a male-dominated medical profession; counterculture members see the human body as a prisoner of technology; midwives see the professional issues in the takeover of normal childbirth by medical obstetrics.

In addition, other perspectives can be described; conservatives see the traditional family as harmed by professional intervention (Teasley, 1981), while others, including health care workers, stress the negative health outcomes of hospital birth. Certainly most of these positions are not mutually exclusive, but this multiplicity of interests indicates the potential fragility of the movement. In addition, as Arms (1980) noted, there is considerable variation in participants' willingness to take risks and their commitment to broader social change. This spectrum of interests among home birth supporters suggests that physician efforts

to reassert hospital birth may be met with greater acceptance from some elements than from others.

Other differences also exist. In Hazell's (1976) study of over 300 home births in the San Francisco Bay area from 1969 through 1974, she found only 10 percent of the population were involved in the "hip" subculture. Fully 90 percent of the home birth parents she studied were middle-class whites who fit the dominant expectations about appropriate life-style. They lived in single-family dwellings, owned one or two cars, and the husband was employed. The majority of the subjects had attended college but few had graduated. Examining a population in the same area, Mehl (1976), found class and cultural differences among home birth parents in choice of attendant. Participants in the counter-culture were more likely to engage midwives while professionals were more likely to opt for physicians.

Whatever the differences among participants in the home birth movement, the movement as a whole is in agreement on the larger goal of freedom from professional control of childbirth. It seeks to rearrange both the occupational turf and the power relations in the provision of care to pregnant and birthing women and their families. This anti-professional-hegemony movement challenges the medical monopoly on care-giving and for many participants this takes the form of deprofessionalization and support for lay midwifery.

The Home Birth Movement in Vermont

The home birth movement has been active in Vermont since the early 1970's and both the numbers of home births and home birth activism grew throughout the period of study. The movement has been successful in creating awareness of its chosen birthing option and engaging the medical profession in public debate. Whatever else, it has brought the issue to the fore. In addition, the home birth movement has facilitated the development of "new" birth practitioners, the lay midwives. (See Table 6.1)

The home birth movement and the rise of midwifery in Vermont are continually ascribed to a grass-roots demand for a new kind of childbirth. The people desiring such birthing alternatives are often characteristized by those interviewed as seeking self-sufficiency through alternative life-styles involving a back-to-nature orientation. These people are typically described as having originated from outside the state. One lay midwife said of her clientele, "(they) are interested in an alternative life-style. They want to build their own homes....They've gone to college, most of them... they're also somewhat free spirits." A midwife working in a different section of the state echoed this characterization, adding, "(Their involvement in home birth is) part of their larger move away from medicine (and toward) taking more responsibility for themselves, not blindly trusting the opinions of 'experts.'" While the theme of self-sufficiency

Table 6.1

VERMONT BIRTHS BY LOCATION AND YEAR[1]

	Total Hospital	(Out-of-state hospital)	%	Home	%	Other	%	TOTAL	%
1975	7031	(628)	99.2	47	.7	9	.1	7087	100
1976	7037	(681)	98.6	83	1.2	20	.2	7140	100
1977	7037	(692)	98.2	121	1.6	10	.1	7438	100
1978	7456	(675)	98.3	116	1.5	15	.2	7587	100
1979	7914	(770)	98.1	148	1.8	5	.1	8067	100

1. Vermont resident births and out-of-state resident births in Vermont.

and independence is hardly new to Vermont, this particular manifestation of it seems to have been brought into the state from outside, having grown out of other social movements. As one physician explained his involvement in home birth,

> In 1974 the hippie movement was still fairly strong in Vermont, even though it was dying out elsewhere. I guess that's because a lot of hippies had moved to Vermont. They picked up on the fact that I was (not the ordinary physician) and I had a lot of requests for unusual things: herb medicines and so forth. A request which was continuing, though not in great numbers, was birth at home.

However central the counter-culture movement of the 1960's was to the inception of the home birth movement in Vermont, it was not only the causal factor nor the sole source of home birth clientele. The larger birth reform and childbirth education movements continued to raise expectations of birthing parents. In the face of hospital recalcitrance and disinclination to meet their demands, some birthing parents were radicalized. In interview, a home birth couple indicated that part of the impetus for their home birth came from a growing frustration with the standard hospital birth.

> I think that around 1976 (in the UH/RMC area) there was a middle-class upheaval. The more educated person was saying, 'Look, we don't want to be pushed around in the hospital. We do want to have (the birth naturally).... Especially with second babies, like us, we've tried it, we've been through it.

Many people I spoke with distinguished the home birth population from the "native Vermonter," who they often

characterized as "traditional." As one home birth parent pointed out, parents who have home births are typically more-educated and older than Vermont natives. Data from the Vermont Health Department bear out these assertions. For example, in 1977, forty percent of the 117 women recorded as giving birth at home were college-educated and ninety-five percent were high-school graduates. In contrast, of the women giving birth in hospitals, only seventeen percent were college-educated and eighty-one percent completed high school. In addition, fully sixty-five percent of the women who chose birth at home were between the ages of twenty-five and thirty-four. This compares to only forty-eight percent for women giving birth in hospitals (Burlington Free Press, November 24, 1978). (See Table 6.2).

In addition, other differences between home birth parents and the surrounding population also exist. A nurse-midwife observed that at the opposite end of the spectrum from the home-birth clientele was a component of Vermont population which is a "...rigidly traditional lower socioeconomic group; their main source of information is Mom (who probably experienced a traditional hospital birth). Some people are still angry they didn't get a spinal." An independent midwife noted that many native Vermonters are, "...people who have been brought up all their lives on a farm, they are very conservative and they totally believe in the system. Going to the hospital is part of being involved in the system.

Table 6.2

COMPARISON OF EDUCATION OF WOMEN GIVING BIRTH AT HOME WITH GENERAL POPULATION OF BIRTHING WOMEN IN VERMONT BY YEAR

		EDUCATIONAL ATTAINMENT									
	TOTAL	9 YRS	1 YR HS	2 YRS HS	3 YRS HS	4 YRS HS	1 YR COL	2 YRS COL	3 YRS COL	4 YRS+ COL	UNKNOWN
1979											
Total	8067	193	252	413	492	3565	652	651	249	1409	191
At Home	148	1	0	2	4	24	21	21	9	59	11
Row %											
Total	100	2.39	3.12	5.12	6.1	44.19	8.08	8.07	3.09	17.47	2.37
At Home	100	.68	0.0	1.35	2.7	16.22	14.19	11.49	6.08	39.86	7.43
1978											
Total	7587	203	265	441	407	3337	598	615	230	1270	221
At Home	116	0	0	1	2	28	10	10	9	35	11
Row %											
Total	100	2.68	3.49	5.81	5.36	43.98	7.88	8.11	3.03	16.74	2.91
At Home	100	.00	.00	.86	1.72	24.14	8.62	17.24	7.76	30.17	9.48

In contrast, other interview subjects point to similarities between rural native Vermonters and alternative-oriented newcomers. A nurse-midwife working in a reformed hospital explained.

> (The people here are) a lot of loggers, farmers, salt-of-the-earth type folks. There are also homesteader types.... It seems like there is an incredible number of people from (an east coast city). We like the life up here and we're transfers. Really, it's a very good population to work with. The old-timers who have been here are not into the high-technology birth experience; they've never been exposed to it. Half of them work with cows all the time and can't see what the big deal is anyhow. (We) transplants and homesteaders, of course, are not into the high-technology scene anyway--that's one of the reasons we're here.

Another interview subject, a birth attendant, observed that, as a countervailing force to the authority of expertise, "...in New England, people are taken on their own merits."

Whatever points of similarity or difference exist between the home birth advocates and the rest of the Vermont population, this larger population plays a critical role in determining the fate of the small minority of movement participants. Whether it is legislators considering lay-midwifery legislation or jurors deciding whether to convict a lay-midwife of practicing medicine without a license, the home birth movement must attempt to persuade the larger population to shield it from medical efforts to curtail or eliminate it.

The central ideological factors which distinguish

home birth practitioners from the broader population are: a skepticism about the authority of experts, the desire to be more in control of their lives and, perhaps most importantly, the willingness to undertake preparations for a birth that is an autonomous, intimate, family experience. A home birth parent, writing in a local paper stated the position clearly,

> ...we recognized that for us home birth provided the details and atmosphere that had become important to our concept of family-centered birth. We found little support from the medical staff and our only alternative was Birthwork, a group of women experienced in home births and associated with the People's Free Clinic. We knew our decision was not without risk but we found the women knowledgeable, competent and supportive. Although they try to attend all births, they insist that parents accept total responsibility for home delivery. For us this meant an in-depth knowledge of what to do when, as well as learning danger signals. It was important to them that we know when the risk becomes too great and the hospital became a necessary friend. This meant that the months before the births were spent reading, studying, learning and rehearsing, but it also gave us a sense of total involvement; a commitment that brought us infinitely close to each other as well as to our child (Osher, 1976).

The Ideology of the Home Birth Movement in Vermont

During the late 1970's in particular, newspapers paid considerable attention to the question of birth reform, home birth and lay/independent midwifery. At least one newspaper supported home birth and birth reform in an editorial (The Times Argus, December 12, 1977). (Some in-hospital care-

providers explained in interview that they were rankled by what they saw as lopsided reporting).

Statements of the home birth movement's ideology appeared in newspapers in various forms, including interviews with lay/independent midwives and home birth parents and letters to the editor (of which there were many). In addition, newspapers provided accounts of collective meetings of home birth supporters, including those surrounding trials and public legislative hearings at which lay-midwifery legislation was being considered. Other statements of ideology are drawn from interviews.

The movement for home birth and lay midwifery is explicitly striving for independence from medical control. In addition, it is seeking to rearrange both the occupational turf and the expert-client relationship in the care of pregnant and birthing women. This is a grass-roots movement whose goal is primarily the creation and maintenance of viable options in birthing in order to meet the needs of its advocates. It thus seeks to enable people to make meaningful choices in childbirth.

Medicalized and hospitalized childbirth has become normative and physicians have claimed the care of birthing women as their domain. Thus, in order to make their desired birthing options available, this lay movement is forced to challenge the medical profession's authority and its claims to both a monopoly on expertise and commitment to a service

ideal. The very existence and visibility of the home birth movement highlights the fact that birthing practices are socially organized and thus subject to change; it undermines the medical monopoly on defining this reality. Perhaps the central issue on which the ideology of the home birth movement is constructed is personal autonomy and concomitant responsibility. Home birth parents typically refer to their birthing experience as a crucial point at which they took control of their lives and assumed responsibility for making hard choices, recognizing the risks they faced in the undertaking. However, it is important to note that they do not celebrate the risk-taking in and of itself; they do not see themselves as reckless. Additionally, many are quick to point out, as some national pro-choice birthing organizations have done (NAPSAC, 1977; 1979), that it is naive to think that people do not face significant risks within the hospital, some of which are unique to the hospital.

Thus, rather than advocating a new norm in childbirth (e.g., midwife-attended home birth for all but high-risk women), the movement embarked on the strategy of advocating freedom of choice in childbirth. However, even though some of its spokespeople suggest that as many as ninety percent of all births could safely take place at home with properly trained attendants and adequate medical back-up, most will specify that nowhere near that percentage of birthing women is currently adequately prepared for such an undertaking.

In this regard, phrases sometimes used are "prepared," "responsible," or "informed" homebirth. Each of these terms emerges in part out of debates with the medical establishment. "Prepared homebirth is used to distinguish planned home births from births which occur at home but are accidental, unanticipated and undesired. This distinction is made necessary in part because organized obstetrics, in its efforts to delegitimize home birth, has analyzed as "home birth" outcomes data which included accidental births, miscarriages and unplanned home births (NAPSAC News, 1981:6(1): 10).

"Responsible" or "informed" homebirth are terms used to counter physician criticism asserting that home birth parents are ignorant and cavalier about their choices. For example, the physician in charge of the neonatal intensive care unit at UH/RMC publicly charged that people who chose home births were "crazies who go off to caves and log cabins to deliver the newborn who has no say in the process;" he went on to say that home births were a "selfish fad" (Calta, 1977). From the point of view of the dominant medical profession, the laity's choice not to consult it represents irresponsibility. Physicians make such charges (which they may sincerely believe) as a way of restating their claim to authority and a monopoly on appropriate expertise. In contrast, lay people's use of the terms "prepared," "responsible" and "informed," suggest that those who practice home birth

have access to expertise, are reasonable and ethical and both desire and deserve legitimacy.

Central components of the concept "responsible home-birth" include self-selection by participants augmented by screening by midwives.

A home birth mother, writing in support of home birth in a local paper, emphasized the importance of both midwife screening and self-selection in responsible home birth.

> No person will be attended at a home birth who hasn't been screened as thoroughly as possible for complications. Because of the risks involved in home births, the women are usually far better informed and prepared than those destined for the hospital. We, who are for home births or alternative birthing feel ourselves not irresponsible but more responsible for our actions instead of putting ourselves in others' hands totally. If we had assumed any potential danger we would have used the available medical facilities (Brown, 1977).

Other supporters of home birth pointed out in interview that screening and self-selection included consideration of psychological factors as well as geographic location and weather conditions. As one subject noted,

> People who (successfully) do home births have to be super together....(Some likely home birth candidates choose to give birth in the hospital) because they're together enought to realize that two miles up a dirt road in January...(it) is the better part of valor to come in.

Finally, a lay-independent midwife explained, "We're not against hospitals and would recommend, whenever there's a question, that the birth be in the hospital. We're not

trying to take on a role we're not capable of" (Reilly, 1977: 3A).

The Critique of Hospital Birth

Most home birth advocates present their position as one supportive of the option of home birth. As I have suggested, this enables them to take the more defensible strategy of advocating freedom of choice rather than championing a new birthing norm. However, throughout their statements, runs the thread of a critique of physicians, hospital birthing practices and professional power.

Some general criticisms seem to apply to most hospital births in the area of the state under study, while others point to particular hospitals or medical practices. I located several related components of the critique. First, physicians are criticized for placing professional interests ahead of the provision of health care. Many physicians, especially obstetricians, appear to be disinclined to knowingly provide prenatal care for women planning home births. The home birth friendship networks and lay midwives typically provide referrals to the few sympathetic medical personnel who do knowingly provide prenatal care to prospective home birth parents. However, some people planning home births don't have access to these sorting devices of the "lay-referral network" or they must utilize the available medical prenatal care in the area, despite warnings against it.

These people often relate stories of physician harassment.

Home birth supporters frequently criticized physicians for their unwillingness to provide back-up medical care for home births, for example, few physicians were willing to discuss cases with midwives over the phone. In addition, certain hospitals were notorious among the home birth clientele for harassment and brow-beating of midwives and birthing parents who came into the hospital when complications had arisen at home. In interview, a midwife explained that one hospital in particular (NCCH), was so opposed to midwifery and home birth that she could not accompany her clients into the hospital, assuring an abrupt break in the continuity of care.

One of the home birth movements central critiques of typical hospital birth turns on the hospital and physician usurpation of birthing parents' decision-making and ability to have their needs met. They charge that, even when physicians are practicing responsibly, they are colleague-centered and committed to particular methods of practice. Closely related to this is the assertion that hospital birthing is not "family-centered," that people become "patients" and are treated insensitively, receiving standardized hospital care rather than personal care. Particularly at UH/RMC, the charge is frequently made that physicians practice "cook-book obstetrics," as one interview subject characterized it. This was a reference to the standards of practice agreed

upon by the 14 obstetricians comprising the ob/gyn group practice. A related concern is the lack of continuity of care; often patients in group practice see different caregivers throughout pregnancy and have to take as the primary caregiver whoever is on call at the time of birth.

Other home birth advocates challenge physician's control of the event of birth. One woman, writing in a local paper asked "Whose children are they?" She suggested to readers, "It is not necessary to submit yourself both physically and mentally to a standardized medical procedure.... It is most important to know your rights as a patient upon entering the hospital" (Cram, 1976). Many home birth advocates balked at the arrogance of some physicians opposed to them, as one critic wrote,

> When the arrogant 'experts' can stoop to bring infant souls into this world with the same humility, spiritual sense and loving touch that I have observed in the people who attend local home births, then, and only then, will I consider having anyone but our local independent midwives help birth a child of mine anywhere but in my own home (Hawes, 1977).

Finally, a comparison of the costs of home and hospital births indicated that midwife fees ranged from approximately $200 to $450 (for a two-person team) while normal hospital births averaged $1500 (complicated births were considerably more expensive). Some critics implied that physicians were charging higher fees than were necessary. As one home birth supported said, "midwives fees are more in line with

(the income of) the people they serve." In all these critiques, SCCH is excepted since its orientation to birth, as well as its fees are relatively unique. Its role in birth reform will be discussed in detail below.

Lay Midwifery

While home birth parents stress their own responsibility for birth, in Vermont they also typically support and promote lay midwifery. Thus, out of this eminently anarchistic movement arose a number of birth attendants and midwives, incipient leaders and certainly the foci of the movement. While many of the home births were planned and carried out by the family involved, the vast majority included prenatal consultations and birth attendance by lay midwives. Several respondents pointed out that the Vermont Health Department records indicating father as birth attendant include a substantial number of midwife-attended births. Sometimes parents do this to protect the midwives. (See Table 6.3)

The birth attendants (a term for beginning midwives) and midwives perceive themselves as having arisen to fill a need in the community. Each of them stressed to me that they do not seek out home birth clients; rather, they are sought out. Apparently, the information that they are willing to attend home births spreads rapidly by word-of-mouth through friendship networks and via some parent-oriented structures such as day-care centers. Not surprisingly, many midwives cast their choice as a kind of calling. Certainly they emerge

Table 6.3

VERMONT BIRTHS BY ATTENDANT AND YEAR[1]

	M.D.	(%)	D.O.	(%)	CNM	(%)	LM	(%)	Father	(%)	Other	(%)	TOTAL	(%)
1975	6540	(97.4)	127	(1.9)	12	(.2)	1	(0.0)	29	(.4)	5	(.1)	6714[3]	(100.0)
1976	6544	(96.9)	134	(2.0)	0	(0.0)	11	(.2)	47	(.7)	17	(.3)	6753[3]	(100.0)
1977	6729	(96.4)	138	(2.0)	10	(.1)	29	(.4)	49	(.7)	25	(.4)	6980[3]	(100.0)
1978	7411	(97.7)[2]			54	(.7)	46	(.6)	51	(.7)	25[6]	(.3)	7587[4]	(100.0)
1979	7803	(96.7)[2]			115	(1.4)	57	(.7)	39[5]	(.5)	53[6]	(.7)	8067[4]	(100.0)
1980	8055	(96.3)[2]			171	(2.1)	58	(.7)	44[5]	(.5)	39[6]	(.5)	8367[4]	(100.0)

1. Information derived from Vermont State Department of Health Publications.
2. MD & DO data combined.
3. Vermont resident births only (includes out-of-state hospital births by residents).
4. Vermont resident births plus out-of-state residents' births in Vermont.
5. Includes other family members.
6. Includes nurses and emergency medical technicians.

as the key risk-takers in terms of the movement as a whole and they generally indicate a very strong commitment to both their home-birth clientele and to the viability of home birth as a birthing option.

For many of the midwives, attending the home birth of a friend as an observer/support person marked a turning point for them. They typically referred to this experience as transformative. For others, planning and having their own birth at home was crucial in their decision to become a midwife. Most of the midwives had had a least one home birth. Finally, some women came to an inclination to midwifery through a larger concern for health care, often women's health care in particular. Here the influence of the feminist movement is more clearly felt and mentioned by these respondents. Of course the stories are varied and intertwined, but it is worth noting that there are several related routes into midwifery.

Once the self-selected birth attendants embark on the calling of midwifery, their path is far from clear. For example, one respondent recalled confiding to a friend her desire to be a midwife, but admitted knowing neither what it actually was nor how to go about becoming one. There were virtually no structured avenues to midwifery training and socialization, so, like the New Age/counter-culture people form which many of them came, the midwives gathered information where they could and made the rest up as they

went along. As one lay midwife explained, "...lay midwives got responsibility and then scrambled (to learn adequate skills)." After the virtual obliteration of midwifery by the rising medical profession early in this century, there is little known tradition on which to build the work of midwifery. Thus, midwives find themselves re-inventing what is probably the oldest form of health care. However, in Vermont, there were some variations on this theme. Midwives were aided in acquiring training by a physician who broke ranks with the medical establishment. In addition, a midwife in the southern portion of the state, (to which I never gained entree') was trained and worked for some time as a nurse-practitioner in Canada. She referred to herself as a domiciliary midwife and, having attended approximately 500 births by 1977, could hardly be called an amateur (Calta, 1977b: 8).

Most beginners seem to have referred to themselves as birth attendants, emphasizing the centrality of the parents' responsibility for the birth. Given their level of skill, they were simply unable to take responsibility for the birth; they came to assist the parents in carrying out a home birth. The point at which the birth attendants began to call themselves midwives was problematic for them. One birth attendant explained that people typically called her asking for a midwife, she responded with the caveat, "...well, I have assisted at a number of births but I am not a professional

midwife...." Becoming a midwife does seem to suggest a higher level of skill and thus, perhaps, a somewhat altered relationship with the birthing parents. A woman wo did consider herself a midwife described the point at which she made the transformation,

> Other people started calling me a midwife long before I was calling myself a midwife. (Meanwhile) the more births I attended the more comfortable I felt. I was doing an enormous amount of self-studying and going to conferences. Then one day it sort of fell into place. They'd say 'Are you a midwife?' and I'd say, 'Yes.' Instead of saying, 'Well, no...' and go into a long explanation of what a midwife was...it got to be a hassle. And before I knew it, I knew in my heart that I was competent at attending births. I did know what I was doing...it was a couple of years before I felt comfortable. About forty births.

Most birth attendants charge little or no money for their services while midwives, often working in pairs, may charge up to $450 for prenatal and postnatal care and attendance throughout labor and birth.

The process of becoming a midwife is not clearly marked, and neither is the label used to indicate having completed that training. The medical establishment, and often the public, refer to the midwives, as "lay midwives," emphasizing that they are not professionals. However, the midwives themselves don't use this term. As one explained to a reporter, "We prefer the term 'independent' to 'lay' because 'lay' means unskilled, and we're not" (Reilly, 1977). This label is taken at least in part to distinguish these midwives

from nurse-midwives who, almost without exception, work in the hospital in the health care team, and thus structurally under the supervision and control of the obstetrician. Thus it is linked to both their claims to turf and special expertise. Writing in response to a nurse-midwives' statements about midwifery legislation, an independent midwife stated,

> The nurse-midwives...write...that they are qualified to practice independent management of labor 'within a health care system which provides for medical consultation, collaborative management or referral.' Independent domiciliary midwives have the same responsibilities, only our practice is in the home which the medical profession has defined to be outside the system. We must challenge the health care system to provide consultation and collaborative management for homebirth couples (Nolfi, 1979).

Independent midwives also point out that physicians and the vast majority of nurse-midwives currently graduating are trained for hospital births, not home births. They argue that midwifery skills are largely different from medical skills, though they do overlap. This position would help to explain physician's fears about home birth. Since physicians are trained for treatment of the abnormal in a high technology setting, home births leave them stripped of skills and resources. Independent midwives, in contrast, are trained to pay closer attention to prenatal care, screening and preparation of birthing parents. They travel light and treat birth as a natural event.

They also sometimes refer to themselves as "empirical midwives" indicating that while they may have extensive training, it is not a formal, theoretical/(medical) education. Consistent with their philosophy of freedom of choice and inclination to question authority, these "independent midwives" emphasize that they are answerable only to their clientele and one another.

The position of midwife in this movement is complex. She differentiates herself from her clientele as a skilled, independent practitioner, but at the same time she is, as least ideologically, firmly client-centered. The midwives characterize their role as that of helper: providing information on birthing options and responsible birth (in any setting), and making viable the option of prepared/responsible home birth and thus facilitating careful choice in childbirth.

Even the issue of screening out people who are "at risk" becomes difficult. Since most independent midwives view individual decision-making as virtually sacrosanct, most are loathe to deny care to women who might otherwise be categorically characterized as "at risk." One midwife pointed out that independent midwives, nurse-midwives and physicians could agree on risk factors, but they would probably not agree on how to deal with them, that is, how to practice. The assumption here is that nursing and medical personnel, would be more inclined to "go by the book"

and treat people categorically. This treatment would occur in part because it is within the model and structure of medical practice that the data and prescribed practice for risk factors were developed. The midwives explain that every pregnancy and labor is different and they resist categorical treatment.

Constructing a hypothetical situation of a woman apparently "at risk" (multigravida, over 35) but determined to have a home birth, a midwife explained,

> I, as an independent midwife, am committed to that woman out of my own ethics. I can explain to her why I think that she is "at risk" but I cannot refuse to give her care. I think a lot of midwives feel that really strongly. Because it's her decision. You share your knowledge but you don't make decisions for people. If you start making decisions for people, you're professional; you're turning people away, you're medical. Because the medical profession has turned away home birth people, all the time; that's partly why lay midwives started....

However, some evidence suggests that midwives may take a more active role in screening and management of labor and delivery than this statement indicates. At least some midwives do actively screen and are unwilling to take on clients who smoke, for example. Also, an obstetrician described having been contacted by a midwife who requested aid in convincing birthing parents that a complication requiring hospital care had arisen.

Several of the midwives noted that their role was sometimes problematic. For example, a few birthing parents,

who the midwives had helped to inform and train through prenatal classes, gave up responsibility during the birth. This effectively forced the midwife to assume a physician-like decision-making role. The more skilled midwives are able to do it, but greatly dislike it.

Even if everything goes as planned, midwifing is described as exhilirating but also demanding physically, mentally and emotionally. What midwives are doing is facilitating an often lengthy intense, intimate, emotional and physical experience for the birthing family. Upon completion, the midwives return home to their own lives, exhausted. One midwife discussed the irony of the romanticization of the midwife,

> There's a mystique about being a midwife, there's an awe about it. It really is an incredible thing to be doing and I love it.... At the same time it's an enormous amount of work. It can be so draining. You're on call all the time. You can go crazy. People just don't know what a heavy deal it is to be somewhat responsible for someone's life and death.

Training and Organization of Midwives

The viability of home birth as a birthing option may be indicated by the success or failure of the midwives. They become the foci of the movement because the struggle to assure the viability of the movement often means struggles to locate, sustain and support home-based birth attendants. As long as medical personnel are essentially absent from the

practice of home birth, these attendants will be lay/independent midwives. Also, it is typically the midwives who bear the brunt of harassment from the medical community and state medical examiners. Thus, as the primary risk-takers, they become symbolic leaders and often function as spokespeople for the movement.

The first organized activities of home birth attendants/midwives in the sections of Vermont studied, began around 1973. There appear to be two primary sites of origin with growing connections between them as well as dispersion of activity over time. The first site is the UH/RMC area, in an urban country. The second site surrounds the SCCH and is a rural area.

The Free People's Clinic, apparently begun in 1972 in the UH/RMC area, attracted progressive physicians and paramedic staff. A number of staff were women, many of whom were interested on women's health care. Included in the early staff was one of the independent midwives with whom I spoke. She had previously received training as a "barefoot doctor" from an area physician who had set out to train health care workers from among the communards, she had gone as a representative of her commune.

From among the staff involved in the clinic, a group of six women interested in birthing emerged in late 1972 or early 1973. They embarked on a group study of pregnancy and birth. During the next few years, several of the women

had home births. The staff at the clinic had been doing prenatal care and their clientele included women planning home births. Apparently they did not begin actively attending home births themselves until 1974; at this time they were joined by a physician also interested in home birth.

Two years later, after attending many home births with the women, the physician left the group. At this point, internal conflicts emerged within the group. Some members felt that their training was not yet adequate to enable them to safely attend home births without a physician. Other disagreements centered around feminist issues and group process. By 1977, four of the members had left the group, three of whom apparently did not continue their involvement in birthing care. The two members remaining reformed the group naming it Birthwork. Subsequently another physician, a family practitioner, attended several home births with these midwives and helped to train them.

The newly formed group began teaching a series of evening classes several times a year on choices in childbirth. The classes covered topics including prenatal care, normal pregnancy, labor and birth as well as some complications and common hospital procedures. The classes were primarily geared toward training clients for midwife-attended home births; while some additional group members seem to have been added, the core members continued to be the midwives who were still attending home births as of 1980.

It was at the second site of midwifery activism, the SCCH area, that organized midwifery in the state received its major stimulus. Here the involvement of a family practice physician was central; his willingness to provide textbook training, and subsequently, apprenticeships at both hospital and home births provided the midwives-in-training with crucial resources. In 1974, this physician left the group practice in which he was involved in the SCCH area. He had become frustrated with his first practice, feeling rushed and unable to practice as he wanted to. He decided to "retire" from medicine, but planned to complete the care of his last birthing patients. At this point, he began to be drawn into the practice of home birth at the initiation of some of his patients and interested home birth parents in the area. He was reticent until he attended the home birth of a friend, as an observer. Describing the experience as transformative, he embarked upon serious consideration and study of home birth. Shortly thereafter, he began teaching classes on basic obstetrics and prenatal care to birthing parents and birth attendants. Beginning with informal sessions at his home, he was by mid-winter 1975 teaching a more formal course to a group of about fifteen women. By this time he was actively attending home births himself and learning first-hand about its special considerations. Describing the class, he explained,

> We worked on basics. They needed training. They'd only been to four or five births

> and they didn't know a lot. They'd read books, they were dying for experience. And they were doing births out there in the back-woods. God, I made it very clear that this was a big responsibility, and that you had to carry certain equipment. So we went into it pretty well... as it turned out, about three of them became midwives, (and continue to practice).

During the year and one half that he attended home births, he took on a few apprentices. One apprentice-partner who worked with him for several months was a co-founder of the first and only state-wide organization of lay midwives: the Independent Midwives of Vermont, begun in 1976. The impetus for the organization came in large part from the collective interaction made possible by the training sessions which the birth attendants had regularly attended. The organization was formed for "mutual support and education (as well as) the formulation of political strategy," the co-founder explained.

Physician willingness to train and support midwives did not give rise to the movement for home birth and lay midwifery in Vermont. However, physician involvement was important and sometimes pivotal. Obstetricians seem never to have been involved in overt attendance or support of out-of-hospital births. The physician involvement I discovered came almost exclusively from general practitioners and family practitioners, some physicians in residency programs were also involved at points.

This division among physicians is not surprising since

historically general practitioners have been cut out of the practice of birth attendance in hospitals by obstetricians. In Stevens' (1976) discussion of the process of specialization in the American medical profession, she observed that training for general practice came to be construed as preliminary to specialist training. This characterization was then employed by organized specialists as a rationale for their usurpation of work previously performed by generalists. This process continued into the 1950's nationally, and, in more rural areas initially less attractive to specialists, perhaps into the 1970's. In at least one area of Vermont, obstetric specialists were still quite new at the time of this study.

In larger competition between generalists and specialists, generalists have attempted to counteract their lower status, income and declining numbers by creating residency programs (thus "specialization") in family practice. However, the specialist usurpation continues relatively unabated. The family practitioner with whom I spoke related a case at a nearby hospital in which a generalist, in practice successfully for over twenty-five years, was being severely restricted in his ability to practice by recently arrived obstetric specialists. The obstetricians had decided, for example, that all twin births or breech presentations required their attendance.

The ongoing competition for obstetric patients has

clearly had the effect of undercutting unity among physicians as obstetricians continue to attempt to marginalize general and family practitioners. Nationally, the leadership of the American College of Obstetricians and Gynecologists has attempted to woo and placate generalists by suggesting a future more equitable division of labor in the care of pregnant and birthing women (Pearse, 1980). The ACOG leadership no doubt senses that disaffection by generalists may spoil organized obstetricians' desire to reassert full monopoly. Or worse, that some generalists/family practitioners would engage, as this one did, in sponsorship of client revolts and new care-providers which further challenge specialist hegemony.

Strategies of the Home Birth Movement

Several of the people that I interviewed pointed to the years of 1976-77 as marking a watershed or peak in the Vermont home birth movement. This period does not constitute a peak in the actual numbers of home births in the state, those continued to rise at least through 1978. However, it may be the point at which home birth advocates became most vocal and visible. A collection of news clippings on home birth from the UH/RMC and NCCH areas spanning the years 1976-1980 was made available to me by an independent midwife. A perusal of it would certainly suggest that 1976 marked the turning point at which home birth parents and

lay midwives "went public." Also, many women receiving prenatal care began "coming out" to their physicians about their planned home births. Meanwhile, in the area surrounding SCCH, the family practitioner engaged in home birth practice was under fire by area physicians. A war of words ensued in the local paper between his supporters and detractors.

This effort by home birth movement participants to win support for their cause by activating the public was met with an intensely negative medical response. Moreover, the net effect of physician efforts to publicly discredit both home birth and its advocates appeared to back-fire. The inflammatory rhetoric of some physicians in particular seemed only to galvanize home birth advocates and strengthen their resolve. Apparently, this activism on the part of home birth parents was wholly spontaneous and constituted a self-mobilization--a strategic necessity in an anarchistic movement.

The Legislation

In 1979, a state representative from the NERH region submitted to the Vermont House Health and Welfare Committee a bill designed to license lay midwives, H302 (See Appendix F). While the Independent Midwives of Vermont had considered initiating legislation, it seems this was begun independently of them. Apparently the impetus came from the legislator's own interest in the home birth movement. Nevertheless, independent midwives quickly picked up the

legislation as a key strategy. The purpose of the bill was to set minimum standards in the practice of midwifery and to license and thus regulate midwifery. Two hearings on the legislation took place during the period of study, 1979 and 1980. The first was a public hearing and at the second 8 witnesses selected by the chair of the subcommittee were called.

Supporters of the home birth movement argue that people have a free choice about when and where to have their babies, and that home birth is a viable alternative. They assert that physicians cannot and should not dictate where people choose to have their births, and further, that there are good reasons for not choosing hospital birth, including insensitive and overly standardized hospital treatment. Many advocates of home birth assert that there are more, perhaps substantially more, home births in the state than state health department data would indicate. This is not charged to inaccurate record-keeping on the part of the health department, but to either non-registration of births or births misrepresented as, "on-the-way-to-hospital" etc. These techniques are sometimes used to obscure midwife-attendance and keep out medical intervention. Apparently, some people do not record their children's births in an attempt to resist mandatory schooling or, for sons, the military draft. In making the claim that there are more home births than appear on the face of the data, the advocates are countering the

medical charge that it is a handful of extraordinary people who are irresponsible and should not be taken seriously.

People desiring home births charge that medical personnel will not attend home births (many also assert they do not possess the appropriate skills). This necessitates either the use of alternative care-givers, or birthing without the assistance of trained attendants. The latter option is a situation almost all agree is highly undesirable. Supporters of the legislation want the state to license lay midwives so that consumers choosing this birthing option can be guaranteed a minimum of expertise. Also, this would, they hope, facilitate the medical acknowledgement of lay midwives, thus making for more inter-occupational interaction and less hostility, harassment and discontinuity of care. Supporters claim that in opposing the legislation, the medical establishment is only assuring that lay midwives will have no minimum required skills, or in their absence, that people desiring home births will have to do it themselves, thus greatly increasing the risks. Surely, they continue, the medical establishment, so very interested in medical outcomes would not seek to maintain the status quo or a degradation of it, thereby assuring increasing risks.

The medical response to the midwifery legislation was mixed. The overwhelming response from obstetricians and nurses was that home birth is irresponsible and under no circumstances to be condoned, it is retrogressive. The

claim was made several times that better birth outcomes are the result of improvements in technology and obstetrical skills and that to turn away from this superior medical care is a dangerous mistake. It may also be particularly galling to the physicians in the ob/gyn group practices at the two largest hospitals, UH/RMC and NCCH, that residents in their areas account for the largest percentages (in some years) of people choosing home births. While this may be due to the fact that the populations are considerably higher in these areas and may be proportional, it nonetheless indicates that the hospitals' and obstetricians' presence is not dramatically inhibiting home birth. (See Table 6.4 and note particularly the years 1977 and 1978.) Physicians claimed that support of the licensure of lay midwives is tatamount to supporting home births and was thus repugnant. The physicians bemoan the fact that the "botched jobs" end up at their doorsteps anyway, that they have to clean up the messes, take on the data from the bad birth outcomes which enter the hospital for care and thus they are in any case responsible. Most physician spokesmen believe and assert that they are responsible for birthing women and infants and they have a direct interest in birthing outcomes; they "know" that at home there are greater risks and in the interest of good birth outcomes they cannot bring themselves to support home birth. One physician compared giving prenatal care to women planning home births to

Table 6.4

HOME BIRTHS BY AREA OF RESIDENCE AND YEAR[1]

	1974		1975		1976		1977		1978		1979	
	#	(%)	#	(%)	#	(%)	#	(%)	#	(%)	#	(%)
NORTHWEST[2]	10	(27)	7	(15)	13	(16)	34	(28)	30	(26)	21	(14)
NORTH CENTRAL[3]	8	(22)	6	(13)	19	(23)	22	(18)	21	(18)	21	(14)
NORTHEAST[4]	6	(16)	4	(8)	8	(10)	7	(6)	11	(9)	9	(6)
CENTRAL[5]	5	(14)	13	(28)	13	(16)	24	(20)	15	(13)	22	(15)
SOUTH CENTRAL	2	(5)	5	(11)	16	(19)	16	(13)	16	(14)	16	(11)
SOUTH	6	(16)	12	(25)	12	(14)	14	(12)	20	(17)	43	(29)
Out of State	0	(0)	0	(0)	2	(2)	4	(3)	3	(3)	16	(11)
TOTAL	37	(100)	47	(100)	83	(100)	121	(100)	116	(100)	148	(100)

1. Data from State Department of Health. Regions obtained by combining county data.
2. Region contains UH/MC.
3. Region contains NCCH.
4. Region contains NERH.
5. Region contains SCCH.

jumping off a bridge with someone in the hopes of helping them at the bottom. Physicians assert that they have standards of practice which would be compromised by the midwifery legislation and they would be unwilling to comply with legislation which facilitated the continuation of home birth. A discussion from the 1980 legislative hearing indicates this position as well as one physician's style of presentation, obviously disturbing to the legislature.

> Dr. Anderson: The perinatal mortality is four times lower than it was in 1940. These things do not happen by themselves; but because of these (medical) technical advances. These are some of the things that the home birth advocates cry out against. They are anti-science, anti-intellectual and anti-interference. (Similar movements) were rebuked and are fading away as will this one, if properly handled.... Perhaps the most important point I would like to make today is that if the law is passed as it is presently written the University of Vermont and the Medical Center Hospital of Vermont will have no part of it. We cannot support in any way a retrogressive fad put forward by (interrupted)...
>
> Representative May: Excuse me, if we pass the law, are you saying the University of Vermont and you will not adhere to the law? You would violate the law?...
>
> Dr. Anderson: We are saying that we cannot be a part of a law that you will pass that would require us to support functions that we do not believe in. In other words, we are dedicated to life. We are dedicated to the lowest possible perinatal mortality. If you pass a law which we know will increase that, there is no way we can aid and abet it.... The mother and fetus at time of delivery are my responsibility.
>
> Representative Regan: Do you--I may say this awkwardly--but nothing in this legislation that we have got, could prevent a mother from having a child at home. Is that right?

Dr. Anderson: That is correct.

Representative Regan: Would it not help, if she did decide to have her child at home, have the best possible midwife, if she wants that? There is nothing you can do to stop it.

Dr. Anderson: Well, first of all, I think that if you are going to aid and abet, as I say--it is her decision--but, then, if you are going to supply people, then the number of home deliveries are going to go up and by definition we can say that they are not as safe for anyone concerned.

Representative Regan: That is not my question. She still can have the baby at home?

Dr. Anderson: Yes. That is true.

Representative Regan: That is all.

Representative May: Are you saying, that if a mother who was having a baby and having any kind of trouble, that U.V.M. would not take her in?

Dr. Anderson: Oh! Absolutely not! We take any patient at any time for any reason and we will always do that. What I am saying is we will not be part of a home delivery service. It is not safe...

Representative Wright: When you speak of--I would rather not use the term--not co-operating with the law--are you speaking just for yourself, you are not speaking for all the doctors at the University of Vermont?

Dr. Anderson: Yes. I am.

Representative Wright: You are speaking for them?

Dr. Anderson: I think I can safely say that I am speaking for all the doctors at the University of Vermont and the Department of Obstetrics and Gynecology.

Representative Wright: How did you arrive at that doctor?

Dr. Anderson: I talked to all of them.

Representative Wright: Did they vote? Did they sign something saying you may make that statement?

Dr. Anderson: No. I say that I think I can safely say that I represent the University of Vermont, the Medical Center Hospital of Vermont, and the state medical society.

Representative Wright: ....Are you speaking for every doctor at the University of Vermont that they would not participate as a supervising physician for a midwife?

Dr. Anderson: As best as I can determine, yes, that is true...

Representative Wright: Well, that is the question I asked you doctor is how you determined that. It is important to me, it may not...

Dr. Anderson: My answer was that I talked to all the doctors in our department.

Representative Wright: But, that is not all the doctors that participate in the medical facility at the University of Vermont?

Dr. Anderson: Well, they are the only obstetricians, now if you want an opthalmologist to support a home delivery, that might be possible. I have not talked to everyone in the hospital....

In a letter to a newspaper, an independent midwife discussed the medical establishment's response to the proposed legislation.

> I am not hopeful that fair "lay" midwifery legislation will receive support from the medical experts who have no vested interest in the continued practice of independent domiciliary midwifery. It was from the people that the interest and encouragement must

> come to see that a fair midwifery licensing bill is passed into law in the state of Vermont (Nolfi, 1979).

And legislative hearings and support meetings did draw substantial crowds of supporters who brough their babies and children with them (Seidman, 1980). Their very presence, as well as that of their healthy home birth offspring became a statement in support of home birth and responsible, committed parenting. It also indicated their cohesiveness and sense of community. I observed a variation of this theme at the trial of an independent midwife who had been charged with administering a drug without a license. (She was later found "not guilty" under the state's "good Samaritan" law.) In my field notes of June 11, 1981, I wrote,

> What is remarkable (about this trial) is the support here for her. When I came in, the lobby was filled with nursing mothers discussing the case. The courtroom itself is filled with her supporters, the home birth parents--young adults with many babies. Many of the men have long hair and/or beards. The women wear long print skirts and their babies are everywhere, cooing, laughing, crying. The poor guard keeps telling them they'll have to be quiet or leave; people in the seats look at one another and smile when he says this. The courtroom is transformed. The jurors are taking this all in.

Conclusion

Home birth advocates were able to make their presence and their desires known; newspapers seemed sympathetic and reported the movement actively. Since birthing parents and lay midwives adopted the strategy of seeking only to

continue to have and attend home births legally without physician harassment, many observers, including the legislature were inclined to support them. For their part, physicians were typically outraged at the existence of the movement and went to great lengths to portray participants as a handful of irresponsible or, at best, misguided people. However, the incoming data on the characteristics of birthing parents did not bear them out, instead they indicated that those who chose home births were typically older and better educated than their counterparts who opted for hospital births. Physicians were forced to take the position of demanding a "radical monopoly," that is, demanding that their potential clientele be forced to consult them. As Freidson (1979a) noted, this is not a position destined for success. Here, in particular, the independence and self-sufficiency ethos of New England seems to have come face to face with the demands and pronouncements of sometimes arrogant authority figures. The fact that a profession has achieved state sanction for its work does not mean that it has a timeless guarantee. In this case, lay midwifery legislation initiative came from a state legislator whose commitment to his constituents' freedom of choice took priority over maintenance of professional hegemony. Thus, while during the period of study, legislation aimed at licensing lay midwives was not enacted into law, it did have supporters among the legislators. And it was clear from the testimony

at legislative hearings, that some legislators were becoming disenchanted with the presentation of some leading members of the medical profession in the state.

The independent midwives, who espoused an ideology of deprofessionalization, were increasingly emerging as a distinctive occupational group with a collective sense, emerging standards of practice and occupational turf. These transformations culminated in an effort to obtain state sanction to practice. Committed to their clientele, these midwives whose expertise was marked only by local reputation, sought state supplied credentials to legitimate their skills and indicate that they had achieved minimum qualifications. In this way, they would not only obtain a recognized symbol of their status and level of skill, they would also be able to protect their clientele from unskilled imitators. At the same time, most independent midwives I spoke with, sought to avoid being drawn into the medical division of labor. They saw their turf as normal births outside the hospital and regarded the medical establishment as useful for consultation and back-up in emergencies. Thus, they sought formal status, not a niche in the medical division of labor. At least one physician who defected from the medical establishment, openly supported home birth and lay/independent midwifery. That crack in the physician's armor was to widen considerably. For their part, nurse-midwives kept a low profile during this debate. Some

acknowledged in interview that they sympathized with home birth parents but for the most part they sought to put considerable social distance between themselves and their "unprofessional competitors" (Larson, 1977: 75). They did not make any public statements calling for an end to independent midwifery but instead suggested that the legislation aimed at licensure required too little training. One independent midwife suggested that they wanted to make lay-midwifery training into nurse-midwifery training. A sympathetic physician described nurse-midwives' mixed responses to the legislation as largely a question of "turf." "It's understandable," he said, "they've gone to school all these years, and here come these lay midwives claiming similar skills..."

After the legislation was tabled, advocates of home birth embarked on another strategy, a joint study with the Department of Public Health and UH/RMC to examine outcomes from home and hospital births. This study was in process as my study was being completed.

Chapter VII

In-Hospital Birth Reform: The Provider-Oriented Movement To Reassert Hospital Birth

Introduction

The medical establishment in Vermont is faced with the thorny problem of avoiding the defection of its clientele while maintaining control of the institution of reforms aimed at placating that clientele. Since freedom from lay control and intervention is a hallmark of professional status, that freedom is jealously guarded. At the same time, medicine is a consulting profession and will have a very difficult time coercing its clientele to consume, or establishing a "radical monopoly," especially in Vermont with its countervailing values of independence and self-help.

While the movement for home birth and lay midwifery clearly represents the interests of a minority among the birthing population in the state, it is vocal. It serves to raise birthing parents', and some care-providers', expectations for birth. At the same time, it challenges hospital, medically-supervised births which do not meet these expectations. The success of the home birth movement is measured in part by the fact that obstetricians in Vermont have been forced to come to grips with at least some of the arguments and practices of the movement.

Complicating the issues, the medical profession is having trouble closing ranks in order to facilitate a unified response. As I have noted earlier, a system which is so physician-centered in the organization and delivery of care enables defecting physicians to have considerable impact unless or until organized medicine can stop them.

Non-defecting physicians have undertaken two major strategies in response to the home birth movement. The first is to strongly attack and attempt to delegitimize the movement with the stated goal of improving health outcomes. This is couched in terms of the profession's commitment to and responsibility for the well-being of the birthing population. Part of this responsibility, it is argued, involves protecting that population from the impact of both quackery and its own well-intentioned ignorance. The second strategy, related to the first, is the institution of physician-controlled reforms in hospital birthing organization and practices. Ultimately, I will pay special attention to the manner in which nurse-midwives will be employed in the use and institution of these reforms.

The Medical Response to the Home Birth Movement

It is important to note that the response to the home birth movement by physicians in the state is mixed. Condemnation of the movement is not universal, several general or family practitioners seem to support the option of home birth and/or lay midwifery, either overtly or covertly.

However, the obstetrician, with very few exceptions, seem to close ranks on the issue and strongly oppose it. My impression from interviews and committee testimony is that many seem to take the existence of the movement as a personal affront. Certainly the movement challenges obstetricians' claims to being the best qualified person to deal with the phenomena they claim as their special turf. In addition, their claims of univeralistic orientation in care-giving and special concern for the patient's well-being are challenged.

The strategies of those opposed to the movement for home birth and lay midwifery are several. Physicians have used many vehicles to curtail or eliminate it. As we have seen, physicians have worked through the state, often successfully, urging medical examiners to critically review bad home birth outcomes toward indicting the midwife in attendance. (To my knowledge, no comparable peer surveillance occurs within hospital practice. NAPSAC and the newly formed Alternative Birth Crisis Coalition have stressed this point and suggested a counter strategy of focused attention on bad outcomes from in-hospital births. In study after study, researchers have found peer review and other forms of professional self-regulation simply do not work and where there is concern, it tends to be financially motivated, [Freidson, 1970b; Jones, 1980]). In an effort to assure that practicing physicians in the state are disinclined to aid and abet lay midwifery, the state board of medical practice sent out a

letter warning about potential problems inherent in such an undertaking (Appendix D). This is perhaps the most overt example of what seems to be strong peer pressure to bring defecting physicians, especially obstetricians, into line.

The legislative initiative to license lay midwives provided another forum for anti-midwifery physicians; while they were under-represented at the public hearing (which was largely pro-midwifery), they did appear, when called by the house subcommittee chair, at the second hearing. At this point they made very strong statements about the unacceptability of the proposed legislation. In their private practices, consumer witnesses claimed, some physicians took it upon themselves to discourage their patients from considering home births and some went so far as to harass patients planning home births.

Meanwhile, some physicians have taken a different tack moving in the direction of seeking to placate potential home-birth parents by bringing them into newly developed in-hospital birthing alternatives. Physicians and hospital administrators may be attempting to reassert monopoly by revitalizing normative hospital birth. At least some of them are willing to create birthing alternatives themselves or allow hospital birth reformers to do so in order to facilitate this goal. However, the involvement of physicians who actively defect from organized medicine's position may transform such initially cynical reforms into substantial alterations and

vehicles for further client-centered changes. An example of this phenomen on is provided at SCCH.

By the end of 1977, the Family practitioner who had attended home births in the SCCH area for approximately one and one-half years, decided to bring his practice into the community hospital; that is, to cease home birth practice. Midwives, who had been former partners/apprentices carried on the home birth work and they maintained their cooperation and friendship. Since this physician was, insofar as I could ascertain, the only physician to have a primarily home-birth practice during the period of study, his decision to return to an exclusive hospital practice is significant. It is therefore important to examine the factors which facilitated this decision.

First, efforts by physicians nearby to inhibit or eliminate the practice of lay midwifery eventually reached him. During an inquiry by the state medical examiner, he was called into a court hearing to testify about the midwife's training, as she had been one of the women who had studied with him informally. He was, as he told me, "grilled for two hours in front of a court reporter and a judge by the state's attorney." The case, involving a midwife-attended still-birth at home, was subsequently dropped, but not before both he and the midwife had paid lawyer's fees, and been alerted to the fact that two physicians were pushing the case in an effort to stop midwifery practice in the area.

Shortly therafter, he became the object of public attacks in the newspaper, by a local physician. Although these attacks initiated a debate in which he was championed by his supporting clientele, he understood the relative power of each and began to fear that his license might be revoked. "I was sort of thrown into the arena of politics, and I would have preferred to avoid that. But it didn't take me long to figure out that everything was politics," he told me.

Meanwhile, as it happened, there was a spate of complications in the home births he attended necessitating hospitalization for several of his patients. During this period he had maintained his hospital admitting privileges in a special or limited capacity. This had exempted him from more extensive involvement in the hospital. But his increased presence necessitated by the complications was enough to cause other physicians, some of whom were already hostile to him, to demand that he resume active staff participation in order to retain his hospital admitting privileges. In the midst of this increasingly politicized and conflict-ridden environment, he was not earning enough to "survive and pay a small mortgage." His home birth practice was not lucrative and he was supplementing that income by working several health-related odd jobs around the area. He increasingly felt, as he said, "tired of that harum-scarum way (of making) a living." Describing the factors which made the decision to go into the hospital with his practice seem more viable

and necessary, he explained:

> Well, one night it came to me. But this was after the hospital administrator came and said that the birthing room that I had been lobbying for almost a year was a distinct possibility if I would agree to it. So, all these things came together in about two months time. And I said to my wife one night, when I woke up in a cold sweat, "I think somebody's trying to tell me something.... I've got to make a decision." So, I decided to stop doing home births. Support midwives and train midwives, but myself, personally, open the birthing room, put all my eggs in that basket and work toward a good birthing room, a good environment. And that's what we did. It worked out very, very well. Very much to my liking. I was able to see more patients, I was able to make a living without running around, and things just sort of fell together. All the peer pressure and legal pressure dropped away. My life was a whole lot easier. I didn't have to lay awake at night with insomnia. But the home birth, it was the most beautiful time of my life. But the life-style I had to assume was just too radical for me. Too much pressure.

As his explanation suggests, physicians who deviate significantly from standards of medical practice at least outside the hospital are subjected to intense scrutiny and harassment. Physicians, seeking to maintain the hegemony of their hospital-based practices and opposed to the deviants' activities, can create a social environment which makes the continuation of their deviation/innovation extremely costly to them personally. The issue then may appear to be one of personal choice--of course, for lay/independent midwives, no comparable choice exists since organized medicine refuses them a niche in the medical division of labor. Thus, pressure such as this is calculated to bring the erring peer back

into the fold while the pressure on the midwives is toward their elimination. In this case, the choice faced by this client-oriented physician was not the repugnant decision faced most in his position: standard hospital practice or deviant out-of-hospital practice. He helped create a middle option of an in-hospital birthing alternative.

There were several factors which facilitated the development of the birthing room at SCCH. As with his involvement with home birth, the family practitioner became interested in alternative in-hospital birth at the initiation of his clients. During the period of his home birth practice, he received several requests from clients for hospital births which allowed the women to labor and give birth in the same bed, with the aid of a support-person, thus avoiding the delivery room. From individual requests, an organized effort emerged to reform hospital birthing--or at least provide in-hospital birthing alternatives for those who requested them. A community group met to discuss these requests with the hospital administrator, interested physicians and labor and delivery nurses. However, this initial effort at reform, begun in 1976, was tabled pending further information about the safety of birthing outside the delivery room.

There are several changes implied in this reform which may not be immediately apparent. For example, since there are not stirrups on hospital labor beds, women can, with adequate staff and physician support, labor and birth in

any position they find comfortable and effective. This requires that the physician attending the birth arrange hirself in a physically complementary position, rather than standing center-stage and expecting others to adjust. Friends and family who have supported the woman through labor need not be rushed away from the activity and shunted into a waiting room, but instead may remain actively involved and supporting throughout the birth.

Reformers made other related requests for changes in post-partum arrangements, for example, continual "rooming in," that is, the cessation of the practice of mother-infant separation and rigid feeding schedules. Obviously, such innovations require substantial changes in hospital procedures and care-giving by both physicians, and labor and delivery and nursery nurses. Considering the breadth of the changes proposed, it is not surprising that SCCH denied initial efforts to reform hospital birth in this manner. What is more interesting is that the hospital later embraced such reforms.

By the end of 1977, a birthing room opened at SCCH. Several elements coalesced to facilitate its realization. Information was beginning to appear in the medical literature suggesting the viability of in-hospital birthing alternatives. Mid-year, the family practitioner found an article in the medical literature describing a birthing center in the south staffed by a physician and a CNM. They provided

Table 7.1

Numbers of births for selected hospitals and at home by year[1]

	1976			1977			1978			1979		
	# of births	%[2]	%[3]	# of births	%[2]	%[3]	# of births	%[2]	%[3]	# of births	%[2]	%[3]
UVH/RMC	1827	28.7	28.3	1940	29.3	28.8	1908	28.1	27.6	2171	30.4	29.8
NCCH	785	12.4	12.2	811	12.3	12.0	777	11.5	11.2	776	10.9	10.6
NERH	314	4.9	4.9	307	4.6	4.5	317	4.7	4.6	435	6.1	6.0
SCCH	150	2.4	2.3	140	2.1	2.1	200	2.9	2.9	262	3.7	3.6
At Home	83	---	1.3	121	---	1.8	113	---	1.6	132	---	1.8
Total in-state hospital births	6350	100.0	98.3	6611	100.0	97.9	6781	100.0	98.1	7131	100.0	97.7
Total in-state births	6459	----	100.0	6746	----	100.0	6912	----	100.0	7297	----	100.0

[1]Data from State of Vermont Department of Health.

[2]Percentage of total in-state hospital births.

[3]Percentage of total in-state births.

family-centered, minimal interventive care at low cost with good outcomes. He showed the article to interested physicians at the hospital and he and others supportive of the idea subsequently presented it to the administrator.

Meanwhile, the physician's home birth practice drew consumers away from the hospital, lowering hospital births, (see Table 7.1).

> There's no question that since I took my obstetrical practice out of the hospital I had taken something like fifty births a year away from the hospital. And they were only doing something like 150 to begin with...there would be weeks at a time when the OB unit would be closed; there were just no births.

Of course, the hospital continues to pay for the overhead, even when the space is not generating revenues. Therefore, overbedding (an excessive number of hospital beds per population served) is of necessity an issue of concern to hospital administrators. During this period, however, the concern was intensified by the threat of regionalization--a term for the plan by the federal office of Health, Education and Welfare plan to cut costs and centralize resources. Implementation of the plan threatened the closure of the obstetric units in small and some mid-sized hospitals in the state and throughout the country. While the plan was never realistic and major exceptions were eventually made for rural areas, it did intensify the pressure on small hospitals to avoid overbedding in their obstetrical units and it made the loss of patients more keenly felt.

Impact of the Birthing Rooms at SCCH on Birthing Reform

The birthing rooms at SCCH were so typically regarded by respondents as "real birthing rooms" that many told me only of SCCH when I asked them where birthing rooms were located in the state. In fact, several hospitals have at least nominal birthing rooms on the premesis. Respondents who had opinions about birthing rooms all stressed that making the rooms "home-like" was nice but not nearly sufficient. The essence of a "real birthing room" was the philosophy and practice of supportive, non-interventive care-giving. The birth experience was client-oriented rather than physician-centered. At least a partial transfer of power, authority and decision-making to the family/couple was necessary. It is frequently characterized as a much more egalitarian, friendly and uninhibited interaction. As one respondent said fondly, "...at SCCH, they'll get down and roll around on the floor with you." As in the rest of the world, birth in a birthing room is a more earthy undertaking than in the delivery rooms of hospitals.

When the family-practitioner brought his practice into the hospital birthing rooms, he retained his commitment not only to non-interventive birth but also to keeping costs low. The first year (1978) of his birthing room practice the total cost for the birth was $300, (the cheapest birth anywhere in the country at that time, he told me). It subsequently rose, but even at an estimated $450 to $500, costs

compared very favorably with UH/RMC where a typical delivery cost $1700 to $1800.

Once in the hospital, his practice quadrupled (see Table 7.1). By 1980 the two full-time family practitioners and one part-time CNM at SCCH were attending around 325 births per year, doubling the 1976-1977 figures.

Where were the patients coming from? The birthing rooms at SCCH drew patients away from other area hospitals, including NCCH and even a few from UH/RMC. This diversion was not by design, the family practitioner explained to me, and he sought to counter it by persuading physicians in the other hospitals to consider birthing rooms.

> People were coming here because they had choices they had nowhere else. They'd drive an hour, and a half to get here for a birth. I think that is definitely not ideal, I'm not in favor of people having to come long distances to get anyplace to give birth. And so, the pediatrician and I who were so behind the birthing room began to go to all these other places and show them what we had done and to enlighten them as to birthing rooms. Show them our statistics, which were very good.

They made presentations at UH/RMC on pediatric grand rounds (interestingly not on ob/gyn grand rounds). A trip to NCCH drew only one interested physician, a family practitioner. The ob/gyns stayed away, as they did at another conservative hospital southwest of SCCH where a lone pediatrician attended their presentation. The family practitioner at SCCH expressed to me the opinion that the absence of ob/gyns was less the result of passive disinterest than a strategy of active

opposition, especially at NCCH and the south-western hospital. However, because of the financial pressures exerted by SCCH on nearby hospitals, hospital administrators in each opened birthing rooms. Not surprisingly, these are rarely used by the obstetricians who so adamently opposed them, and some respondents construed them as "window dressing" strategies to compete for clientele.

Along with nearly every other respondent with whom I spoke, the family practitioner described NCCH as "a bastion of conservatism." While he described the south-western hospital as "even worse" he explained that he drew more clients from the NCCH area simply because it was closer and the south western hospital was on the other side of the mountains.

To dramatize the impact his practice and the reforms at SCCH continued to have on area hospitals, he pointed out that fully 75% of his practice came from out of town. And, not unlike home-birth, the birthing rooms at SCCH drew a clientele not representative of the general population. While cost was certainly a factor, he perceived that most people came for the different kind of birth experience available to them. Interestingly, among those people who sought out this alternative were many nurses. A respondent from UH/RMC conceded that several obstetrical nurses on staff had chosen to give birth at SCCH and that that information had given some members of the medical staff pause for thought. The family practitioner reflected on this self-selection.

> Over the last couple of years, I've had more nurses come through my practice, from (the southwestern) hospital, UH/RMC... and not just nurses from the Ob floor, nurses from all over the hospital. Particularly UH/RMC, they really didn't want to have a baby up there.

As if the alternatives offered at SCCH and their impact on even the nursing staffs of other hospitals was not irksome enough to obstetricians in the state, this former home birth physician continued to train lay-midwives, to whom he still felt a commitment, while in the hospital. He explained that both the hospital administrator and other physicians, though leery at first, allowed him the option and did not attempt to block it as long as he was prepared to take responsibility for which he was in any case legally bound. He subsequently supervised several midwives providing one of the few sites in the U.S. where lay midwives are trained under physician-supervision in non-interventive obstetrics. In addition, he trained medical and nursing students from the state and the northeast and continued to do so at the completion of the study.

One may question why obstetricians in particular were so resistant to the institution of substantial changes in birthing settings and birthing practices even when market forces impelled them to examine client demands. Their reluctance largely stifled the diffusion of the innovation. Why are some care-givers interested in change while others so actively attempt to inhibit it?

On the face of it, one could say that these new ways of organizing caregiving conflict with medical standards of practice. Those standards serve to unify the profession which claims they serve to guarantee a particular level of professional performance based on the latest knowledge. Larson (1977) has emphasized that standards of practice represent a vehicle by which claims to the reliability of the producer of services can be made. Standards of practice may or may not guarantee come collective unity among members of the profession. They are, in any case, an organized effort to unify the phenomena (the production of services) which constitute the commodity being produced and marketed. Maintenance of professional standards of practice through colleague-control of peer-surveillance has been noticeably absent in terms of quality control (Freidson, 1970a) sometimes even serving as a vehicle to rationalize mistakes (Millman, 1977). It also serves to restate the boundaries of the profession by enforcing particular ethical conceptions or levels of technical competence (Bosk, 1979). Frequently colleague control centers on concerns about market factors (Jones, 1981) or conceptions of the appropriate organization and delivery of care. For example, until the late 1960's the AMA denounced and stigmatized group practices by physicians and harassed physicians who engaged in them (Freidson, 1970a).

Insofar as the standards of practice are related to

the nature of care-giving they derive either from the pragmatic concern with the maintenance of professional power or from the paradigm (by which I refer to both knowledge and practice) upon which the profession built that status. I think one of the major reasons obstetrician-gynecologists are so resistant to the acceptance of fundamental reforms in birthing practices is that they instinctively understand that it constitutes a threat to their professional dominance. It does so because it represents the beginnings of a paradigmatic shift, which could be tied to a concomitant shift in the organization of care-givers. If birth is essentially normal and if it is organized around that concept in essentially non-medical settings (such as birthing rooms) then what is the justification for an expert in surgery and abnormal obstetrics to be in charge of the event?

As Rothman (1979) observes, the medical model characterizes pregnancy and birth as something which happen to women. And, viewing the body as machine, physicians perceive their function as management and intervention. Both the patriarchal (a term for the system of male-supremacy and male exploitation of women) and technological orientation of the medical model cast the physician as actor (in fact, benefactor) while the birthing women is viewed as the object of their actions. The midwifery model, in contrast, centers the social interaction on the woman who, with the aid of her supporters, is the actor giving birth. This, I believe,

is the critical distinction implied in the different characterizations of childbirth as a "delivery" implying medical management or "birth" indicating the woman was the central actor.

If a midwifery model of care-giving enters the locus of the physician's work (the hospital), a different organization of care may emerge. If birth is really the rightful province of parents and their loved ones, as some birth reformers charge, then why should the birth be physically, temporally and spatially organized around the physician? What happened to SCCH is at least the partial transfer of a home birth, lay-midwifery model of care-giving into an essentially non-restrictive hospital setting. It is little wonder that obstetricians elsewhere in the state, deeply invested in their world-view and orientation to care-giving from which their claims to pre-eminence derive, would actively resist such fundamental changes. Where the physicians at NCCH chose obstructionism as a response, the Department of Obstetrics and Gynecology at UH/RMC took a different, less reactionary tack. The source and model of the reform they instituted derived not from home birth and lay-midwifery but instead from the movement for in-hospital birth reform which were considerably less antagonistic to professional authority and pre-eminence. As we shall see, opting for this relatively comfortable compromise enabled them to successfully turn back the efforts of more radical birth reformers in their area.

In-hospital birth reform movements have historically upheld physician pre-eminence even as they have criticized and sought to alter hospital birth. This was possible because they aimed to change not so much the activities of physicians as those of patients and subordinate workers. Agreeing with "progressive obstetricians," birth reformers focused on the manner in which care was given (especially by subordinates) and received by patients (thus largely accepting of the active-passive model). The notion that the content of care was essentially acceptable was at the heart of in-hospital birth reform. In fact, Rothman (1979) has suggested that prepared childbirth classes may actually socialize the patient into a more cooperative and self-controlled patient role. They have, for example, come to construe as "natural childbirth" hospital births in which the woman is in lithotomy position (on her back with the legs up in stirrups), use of forceps for extraction of the baby, and use of local anesthesia.

As has been noted above, consumers and activists, often including childbirth educators, have sought hospital reform in birthing practices in the U.S. since the 1950's. Birth reformers have spent years educating prospective parents and attempting to establish rapport with obstetricians and hospital administrators in order to institute their desired in-hospital reforms. They have finally begun to experience some success (Forrest, 1979; Parfitt, 1977).

University Hospital/Regional Medical Center - (UH/RMC)

At UH/RMC, the first recent moves toward birth reform which I could document, appeared in 1970 when a patient-care committee was formed. It was composed of nursing instructors at the University, staff nurses, childbirth educators and at least one physician. This group investigated and considered in-hospital birth reforms across the country and generated information on their viability. This method parallels, in a more organized manner, the method used by the family practice physician at SCCH whose discovery of a precedent for his concept of a birthing room encouraged both other physicians supportive of the idea and the hospital administrator. This method of reform is clearly related to the medical profession's efforts to regulate practice through standards of practice, and once again indicates the hesitation to innovate, lest those standards appear to be breeched. In addition, as in any other organization, change requires energy, resources and the willingness on the part of those involved to overcome resistance.

After studying alternatives, the group presented their recommendations in a meeting with the obstetrical, medical and nursing staffs. Paralleling the national trend, the first reform sought was the acceptance by the hospital and attending and house-staff obstetricians of the (restricted) presence of the father/coach in first the labor room and

subsequently, the delivery room. As was the case in most hospitals, reforms came slowly and after much effort on the part of those seeking them. One member of the group recalled during interview that most of the physicians agreed to the changes, some reluctantly, while a few continued to bar fathers from the delivery room. Here the reformers encountered the difficulty of instituting reforms in a situation where the dominant profession demands and retains ultimate control over actual practice, and, where possible, the conditions of practice. Thus, since the delivery room is the primary site of physicians pre-eminence and control, reformers can only attempt to persuade each individual practitioner to institute the desired reform: the admission to this turf of a previous "outsider."

That some of the would-be reformers had in mind a larger agenda of changes is suggested by one of the participants who told me that these changes were, "...the start of something bigger...(the recognition) that this was a family affair...it was their baby and we were there to assist the process." I shall question the extent to which this view was widely shared by either the medical or the nursing staff. Nonetheless, at least some perceived that these early reforms laid the ground work for subsequent modifications; for example, if fathers/husbands were to be allowed entrance to the labor and delivery room then childbirth preparation for both parents became more desirable.

Following the lead of other hospitals, UH/RMC eventually allowed "rooming in," extended periods of mother-infant interaction and in some cases total cessation of separation. Other birthing reforms such as the creation of a labor lounge and the option to deliver in the labor room came at the end of the period of study and will be discussed later. These changes took place over a period of ten years brought about by interested staff, pressure from consumers and childbirth educators, forward-looking department leadership (a new ob/gyn department chair arrived in 1976) and, perhaps the critical element at UH/RMC, funding from the Private Foundation which enabled reformers to surmount financial barriers.

Consistent with the national trend, childbirth educators were central in the realization of birth reforms at UH/RMC. Childbirth educators themselves occupy a pivotal role in mediating the birthing parents' relationship with the hospital and care-provider. Childbirth education plays a central role in preparation of birthing women and their partners. It may be used to train people to critically examine hospital birth and consider and/or prepare for the option of home birth, as did some of the lay/independent midwife-led classes. In contrast, it may be a vehicle for socialization of potential parents into a more self-controlled, thus more cooperative patient status (Rothman, 1979). Or, it may play some other role in between these options.

In 1978, along with other changes instituted at UH/RMC, a new parent education coordinator was hired. An ASPO-

certified nurse and an active ASPO member (she subsequently became president of the national organization), she was also the wife of the physician who headed gynecology at UH/RMC. She characterized her task, as she perceived it portrayed to her by the chair of the overall ob/gyn department: "Can you satisfy the community (of patients) without shaking up the medical community?" Toward this end she sought to facilitate reforms in birthing practices through changes in the practices of the nursing staff, especially nurse involvement in childbirth education. From the outset, then, the parameters of her role in reform were set, excluding overt pressure on the medical staff.

Once at work, she promptly set about to update the childbirth education classes taught by the labor and delivery nurses. She set new requirements for teaching, including ASPO certification. The latter she viewed as a vehicle for standardizing childbirth education and thus assuring the quality of its performance. In interview, he indicated that she regarded herself as a change agent and saw ASPO as a good vehicle for the creation of progressive changes in hospital birthing practices. She pointed out that within the UH/RMC area, the only options available to women dissatisfied with UH/RMC-birth were home birth or a long drive to SCCH (obviously a problem with short labors). Since UH/RMC had a de facto monopoly on care of pregnant and birthing women she decided to work within the system, as

ASPO itself does, to gain the confidence of care-providers and to create changes.

Whether or not she gained the confidence of the nurses teaching the parent-education classes, she had (at least the tacit) support of the chair of the overall department of ob/gyn (not the position held by her husband). It was support she needed and she was instrumental in bringing sweeping changes in the nursing staff.

Meanwhile, a study of the attitudes of consumers of obstetrical services at UH/RMC was developed in 1978-9 by an anthropologist and a sociologist (at the initiation of the department chair). The study consisted of two parts: first, an ante-partum questionnnaire was given to women during their office visits in the eight or ninth month of pregnancy. They were asked for both personal data and their desires and expectations for labor and delivery. Of this apparently quite large population of respondents, a sample of approximately 250 women was chosen for post-partal interviews--the second portion of the study. Nearly 200 interviews were subsequently conducted in the hospital. During the hour-long interviews held after the birth, patients were asked to describe in detail their treatment during labor and delivery and their feelings about it. While the findings were not formally presented to the department during the period this work examines, the interviewer reported her informal findings to the administrative assistant to the chair who, as she said, "used them to make changes."

The interviewer explained that the information made clear which of the physicians were liked or disliked, however,

> ...in terms of physicians, there were no real surprises...physician satisfaction was quite high. Basically the labors and delivery were managed by the residents, most of whom (were) outstanding. (A feminist senior resident) probably handled close to 50% of the deliveries.

Incoming information was not inconsistent with hospital staff and community scuttle-butt; it was perphas more indicative of the practices of the current "house staff" than of the "attending" ob/gyns. In addition, the person who conducted the bulk of the interviews pointed out to me that the time at which the interviews were given may have colored the responses.

> At that point in time, just after the birth, everybody was very high from the birth and feeling good about whoever delivered the baby.

In any case, I could find no concrete evidence of change in obstetrical medical practices at UH/RMC as a result of the study.

In addition to generating information about the medical staff, the study inquired about the nursing staff and the nature of support they gave during labor. Whether or not this information was substantially more critical, it seems it was related to substantial changes in the composition and orientation of the obstetrical nursing staff.

As the new parent education director pushed for changes in the classes taught by the labor and delivery nurses, struggles emerged. Many of the nurses resented her hard line and resisted the changes she demanded. They had made their peace with the system of care-giving, had accepted customary work routines in which they had developed competence and probably some degree of independence from physicians. Now they faced a younger woman, a doctor's wife who was not even a physician, giving them orders and demanding that they comply. No doubt it was a bitter pill to swallow.

Almost all the informed subjects with whom I spoke felt that most of the labor and delivery nurses had resisted other changes in hospital birthing practices (e.g., consumers' desire for less use of medication) and appeared uneasy if not hostile to more active people who resisted the traditional passive-recipient patient role. The pressure from reformers is squarely on nurses, since it is their behavior and care-giving which most immediately needs to change in supporting labors of reform-minded consumers. In the medical division of labor, the labor support is construed as a nursing function.

The findings of Hofling, et al. (1960) suggest that at least some aspects of nurses' work performance are indicative of over-conformity. But this may tell more about the nature of the work structure than it does about the nurses themselves.

> Ritualism results not so much from over-identification with rules and strong habituation to established practices as from lack of security in important social relationships in the organization (Blau, 1963, quoted in Merton, 1968: 239).

Not in decision-making positions formally themselves, the nursing staff nonetheless forms the front ranks of the hospital staff in patient care and most immediately encounters the patients' demands and complaints. This double-bind situation has been pointed out by Shaw (1974) and is not at all uncommon for women comparably located in hierarchical structures who elsewhere, as in this case, come to be seen as the problem themselves (Kanter, 1977).

The outcome of the struggles between the parent-education coordinator and the resisting labor and delivery nurses was that several of the nurses either quit outright or were transferred to other floors. Both the head nurse on labor and delivery and the nursing supervisor resigned. It is likely that these blustery changes were kept in-house; none of the hospital "outsiders" with whom I spoke seemed to know exactly how and why the staff changes had come about, though they were all well aware of the changes. However, insiders' descriptions indicate conflict:

> All but one of the (labor and delivery) nurses are gone. What happened was an incredible change in the last just two years, (79-80). The head nurse on labor and delivery, the nursing supervisor, they were bastions of conservatism who knew that consumers were asking for more and were trying to accommodate them. But in their heart of hearts they really didn't believe in any of it...they really resented it and they really resented (the parent-ed coordinator) who was extremely vocal.... They actually resigned under real hostilities. There were some incidents that happened that just really blew up and got people furious.

While more orderly reform may have been hoped for by the department head the conflict within the nursing staff erupted before the data generated from the consumer-attitude study was complete and analyzed. As noted above, the data seem not to have been used to alter practices by residents and attendings. In retrospect, the parent-ed coordinator characterized the ob/gyns as basically apathetic about things outside their immediate sphere of practice. "Do what you want as long as it doesn't bother me. Don't structure or assist in patient activism and demands," she felt implicitly instructed by them. While she aimed to use her position to upgrade the childbirth education, and thus brought about changes in the nursing staff, she also brought an activist orientation to preparation of prospective parents. Concerning the apparently rising expectations of the incoming patients, the head of the department said to her, "I thought the classes would answer their questions." That is, he hoped that by changing those things which surrounded the practice of the ob/gyns, the consumers could be satisfied. She reflected, "(the physicians) didn't care about consumer satisfaction, apart from economics--do you break even (do these surrounding changes pay for themselves?)."

After the nursing staff changes, the task of childbirth education was turned over to full-time childbirth educators who were ASPO-certified, and were not on the nursing staff. Although they were in the employ of the group

ob/gyn practice, they were hired as consultants and as such were at least nominally independent. In so doing, the ob/gyn chair acknowledged the importance of childbirth education and facilitated its institution as part of the standard procedure for care within the practice. After facilitating the dramatic changes, the woman who headed parent education resigned and withdrew from the local childbirth education scene. When I spoke with her, she expressed concern that the department chair had recently dropped the prerequisite of ASPO-certification for childbirth educators. That outside tie to a childbirth education organization, she felt, would facilitate independence on the part of the teachers and loss of it might mean they would become handmaidens of the institutions.

The nature of the strategies attempted to reform hospital birth at UH/RMC may be indicative of the physicians' formulation of the problem, insofar as they acknowledged that a problem exists. The changes which did and did not take place make sense if one assumes that the core of the activity--medical practice by physicians--is sound and right-headed. If, in addition, one assumes that it is the manner in which the care is given which tends to make the hospital impersonal, it would seem reasonable to make changes in the nursing staff and childbirth education to meet what are perceived as consumers' desires for a better "birth experience." This might help to explain both physicians'

reluctance to make changes and their narrow range of interest. Behind this definition of the situation is acceptance of a medical model which assumes mind/body dualism and organ systems (potential pathology sites) conceptually separated from the social person (who is someone else's concern) (Berliner, 1975; Goffman, 1967). Maintaining their belief that their work is central and nothing is wrong at the center, they retain fundamental autonomy in practice and facilitate changes in surrounding activities and personnel to improve the "experience." As several authors have noted (Larson, 1977; Friedson, 1970a, 1970b), absence of lay control over both medical practice and the creation of medical standards has been critical in allopathic medicine's development and recreation of its monopoly. Thus, while lay-intervention in actual practice is shunned, particularly by the colleague-centered physicians who comprise the UH/RMC medical staff, responses to lay concerns about "non-medical" aspects of care giving may be entertained.

A nursing instructor at the University described the birthing options available at UH/RMC:

> The patient has the option of being in a labor lounge, up and about during labor, delivering the baby in bed with no anesthesia, no stirrups.... So right now, our criteria is: as long at it's safe for both the mother and the baby, it's OK with us... this is available to all who are "low risk/ normal."

By 1979-80 a labor lounge on the labor and delivery floor was created with funding from the Private Foundation.

It looks like a relatively small living room extracted from an upper-middle-class home or perhaps a hotel lobby. Thickly carpeted, it was expensively furnished including comforable stuffed chairs, a rocking chair and a TV. It could be called home-like; certainly it stood in sharp contrast to the hospital rooms in which women labor. There have been other efforts to temper the aesthetic sterility of the hospital labor rooms, for example, colorful curtains and/or wallpaper have been added. In spite of this, the too small rooms, dominated by a hospital bed with equipment attached to the wall, seemed to me relatively unchanged from the standard fare. As we shall see, most women still gave birth in the delivery room.

It was difficult for me to ascertain how much the labor lounge was actually used by laboring women--some respondents felt that it was underutilized, but I could get no concensus on this. During my brief visit to the labor and delivery floor, it seemed that the hallways were used primarily by the staff as they moved about in the course of their work. Patients who felt a bit tentative about using the labor lounge might be deterred by this. Some respondents pointed out to me that the most private space on the floor (though in fact it was hardly private with staff coming and going) were the labor rooms, both the hall and the labor lounge were much more public.

At the same time, the labor lounge provided a comfortable space created for patient use and it might well facilitate interaction between laboring women, breaking down the

separation and isolation which is common in hospitals of this sort (see Scully, 1980: 69-70). It was clearly a non-medical space.

One of the latest changes which occurred during the period of study was the patient's option to give birth in the labor room. (The labor room is the small room in which women labor before being taken into the delivery room in typical hospital births). The labor room birthing option was instituted in 1980 and was available for those patients whose labors and deliveries were "normal." Several respondents characterized it as a response to the competition from SCCH birthing rooms which was an embarassment. Again, we will see that there is a difference between the nominal availability of an in-hospital birthing alternative and its actual utilization. The data I was able to obtain suggests that women who actually give birth in the labor room constitute under 10% (some staff estimates ran as low as 3%) of all birthing women at UH/RMC. How can we explain this? We shall see that it is either not requested (it is an alternative, not standard fare), not demanded, or the patient previously characterized as "normal," nonetheless "risks out," that is, a "complication" arises such as meconium staining, which has been previously specified by the physicians as necessitating delivery room birth.

Again and again respondents at UH/RMC, particularly the nurse-midwives, stated that they felt that patients and

potential patients were not adequately informed about the various in-hospital birthing alternatives available at UH/RMC. Every reform-oriented person with whom I spoke (including independent midwives and childbirth educators), felt that the bulk of patients were still alarmingly docile and felt the need to educate potential patients/clients to available options. Some felt, in addition that the hospital had something of a bad reputation in the area among those interested in alternatives, "...some people still think we're gonna slip them a 'mickie,'" one reform-minded obstetrician told me. All the hospital insiders felt the reputation was undeserved. Some attributed it to critical child birth educators, others to some homebirth parents, still others regarded its source as outdated "talk over back fences." A lay/independent midwife with whom I spoke suggested that many alternative-oriented people would self-select out of UH/RMC; the low usage of birthing options could be explained in part by the fact that many people who desired them didn't think they can be realized at UH/RMC and traveled to SCCH or had a home birth.

As difficult as it may be to inform and activate birthing women and parents to desire and request in-hospital birthing alternatives, the reality is that simply requesting the options is often not sufficient. Bad reputation aside, birthing alternatives at UH/RMC often had to be continually renegotiated and not infrequently demanded.

The interviewer for the consumer-attitude survey

described to me her interpretation of the study's findings regarding the labor room delivery option and its minimal utilization even by those who indicated a desire to employ it.

> As long as physicians are delivering babies, it seems that their orientation is so much toward intervention and delivery tables that it is very hard for someone ahead of time to say, "I want to deliver in the labor room" and then be able to follow through with that. Because the physician could say, "Well, I would feel more comfortable in the delivery room, but if you <u>really</u> want to stay here, I'll do it." And then, predictably, the woman would say, "Oh, well, if <u>you</u> feel more comfortable in the delivery room...(then I'll go).

The decision-making ability appears to be negotiated, rather than explicitly demanded by the physician, nonetheless it occurs in a context loaded with symbols and staff interactions restating the centrality of the physician in the birthing process. The outcome of the negotiation is frequently the apparently concensual recreation of the physician's role as decision-maker in birth. A nurse-midwife told a similar story.

> We also have a percentage of physicians who, although they verbalize that (labor room birth) is a good idea, it is hard for them to really put it into practice. They don't encourage it.

And this disinclination on the part of many physicians taps into the patient's inhibited ability to define the situation in a manner contrary to that of the physician, the authority figure who is located in what he regards as his appropriate arena of work and expertise. The nurse-midwife continued.

> There are a lot of people who still think... if my doctor says so, then it's all right. If my doctor thinks it would be better for me to go to the delivery room, then that's what I'm going to do.

As in the case in other innovations in large bureaucratic institutions of this sort, standard operating procedures dominate and typically preclude alternatives, the latter, in order to be viable, require active support by at least some non-subordinate component staff. Even where there is no outright obstructionsim, passive acquiescence is no method of instituting changes. Furthermore, change cannot be created wholly from without. In the absence of active staff support, it is difficult if not impossible for activist patients to demand particular kinds of medical practice (cf. Danziger [1978] for a fuller discussion of potential range of physician-patient interactions in the care of pregnant women, and their outcomes in terms of the free flow of information and the recreation of the authority of expertise). In so doing they challenge the profession's claims to freedom from lay intervention while within the context of the physician's domain: the hospital; it is at best an unlikely proposition. As many feminist activists have stressed for years, concern with health and the provision of health care is a struggle best fought when one is well and on one's feet, not while one is flat on one's back with one's feet up in the air, as in a gynecological exam, or, more relevant to this discussion, while a woman is in labor. Laboring and birthing women can hardly be said to enter the hospital and thus the arena of

negotiation in a position of strength and firm resolve. The physically and emotionally arduous nature of labor and birth disincline them to struggle for power. A former lay-midwife, questioning the notion that birthing women can be autonomous during labor and birth, explained the quandry she had encountered in home birth practice.

> It's ingrained in you that there's somebody else who's going to have that power to make everything OK. And when a woman's in labor, no matter what she says prior to that about taking full responsibility, it changes. It's, "please help me," "I need some assistance," whatever.

And certainly, to the extent that the hospital operates in the mode of a total institution, where the woman is separated from the bulk of her props for her social personhood, the position becomes even more problematic (Shaw, 1974).

North East Regional Hospital - (NERH)

Considering birthing options available at NERH, two birth attendants from the area explained that there has been considerable changes in the recent past. Discussing the years immediately before the 1977 arrival of the obstetrician, they described conservative physicians and traditional birthing practices. Upon the arrival of the obstetrician, changes began to occur and word moved quickly through the lay-referral network that he was "liberal." This physician was the only obstetrical specialist in a 50-mile radius. Although the area outside the community is relatively sparsely populated the scarcity of obstetric personnel quickly created a

situation in which he had more work than he could realistically handle. This gave him considerable economic impact on the hospital. The reforms he sought to institute were welcomed as a condition of his presence. Immediately upon entering practice he set about to create a birthing room. At the time I conducted interviews, the hospital had one birthing room with comfortable lighting and furniture (including the ubiquitous rocking chair) colorful curtains and wallpaper. A fetal monitor was in a corner and other medical equipment was at the ready. However, both the nurse-midwife with whom he worked and the birth attendants emphasized that the equipment was not pushed. They explained that the equipment and delivery room birth are available but are not used unless requested by patients or strongly medically indicated.

All other rooms could function as birthing rooms if necessary. During their pregnancy all patients are given a checklist, by the CNM or the physician, of the available options among which they will have to decide. The CNM described the typical birth at NERH.

> A woman comes in (to the hospital) and is checked and put to bed. She showers. Rocking chairs are available and she will be encouraged to move around. There is a refrigerator for food storage (thus she can eat, instead of being given an IV drip). She receives no "prep." She can ssume any position in bed, except flat on her back.

At-Risk and Risking-Out: The Medical Rationale for an Obstetrician-Centered System

Several authors (Scully, 1980; Lorber, 1975; Shaw, 1974) have observed that physicians (obstetricians in the first two cases) found dealing with patients who displayed pathology more interesting and more gratifying than dealing with patients who did not. Lorber noted that this coincided with their ability to generate clear-cut diagnoses, for which they had been trained. Further, physicians are particularly trained to avoid the error of not detecting pathology (Scheff, 1963, cited in Oakley, 1980: 22). Thus, since obstetricians have claimed all of women's reproductive functions as their exclusive province, no birth can be regarded as wholly "normal" while it is underway. As Oakley (1980: 22-3) explains,

> (T)he doctor views reproduction as a potentially problematic condition, reserving the label 'normal' as a purely retrospective term. Every pregnancy and labour is treated as though it is, or could be, abnormal, and the weight of the obstetrician's medical education acts against his/her achievement of work satisfaction in the treatment of unproblematic reproduction.... The equation of 'normal' with 'unusual' (uncommon) illustrates the medical rationale, for if this equation did not hold, obstetricians would presumably have no valid role in managing reproduction.

A physician, responding to a discussion of a nurse-midwifery service at an AMA Conference cautioned his colleagues about the implications for the profession as a whole.

> (I)f we cannot have everything, we must make a decision as to whether we are going to give away 'normal' obstetrics. If we are, then I think the time will come that we must also

> decrease residency programs by a third or 50 percent (Zuspan, 1978: 924).

In order to avoid the potential loss of their centrality in the delivery of care to (and the control of the reproductive functions of) normal women, physicians make counter claims about the potential abnormality of all birthing women. For example, Dr. Louis Alfano, Chairman of the Committee on Legislation of the Massachusetts Medical Society, sought to explain the committee's opposition to granting nurse-midwives hospital privileges in the state with this statement from his testimony to the Committee on Health, Senate and House of Representatives, Massachusetts General Court:

> There is no way to predict with absolute accuracy that any woman about to deliver will have a normal delivery. There are many cases of sudden vaginal hemorrhage, prolapse of the umbilical cord, premature separation of the placenta, or immediate post-partum shock. These conditions can occur in a matter of seconds and the obstetrician must be present to recognize the problem of immediately and institute immediate surgery in order to save the life of the mother or new born or both (Alfano, 1977: 1126).

While Alfano's sentiments were stated to me by several subjects interviewed, several birth reformers disagreed with what had become for them an often heard argument for obstetrician pre-eminence. Writing in reply to his statements another physician challenged his argument (Hunter, 1977: 282).

> I do not share Dr. Alfano's belief that physicians are available at all times in labor and delivery rooms to recognize the problems of sudden vaginal hemorrhage, prolapse of the umbilical cord or premature separation of the placenta--problems that he rightly states

> could happen in seconds. Quite to the contrary, it is the nurse who first witnesses the events and it is usually her responsibility to institute immediate first aid and summon the physician.
>
> If a physician had his practice so organized that he could provide continuous coverage to patients in labor it would be ideal. In fact, he has so many other commitments to surgery and office that the major part of labor is supervised by nursing personnel.
>
> How is it that the intricacies and responsibilities of an unconscious patient during anesthesia may be delegated to a nurse-anesthetist...and yet the supervision of intra-partum care is something that only a physician can do?

In response to home birth participants' charge that over 90 percent of all births are normal (NAPSAC, 1979) physicians have countered with the argument that no "non-risk" population can be identified. That is, all women are potentially "at-risk." The family practitioner at SCCH disputed this claim.

> That's all (the people who come to me) have heard, "risk, risk, risk." I really dislike the terms and I do not use the terminology in my practice. You're putting a woman "at-risk" or "not at risk" that automatically spells trouble.

While not all physicians accept arguments for the centrality of obstetricians, those arguments appear again and again in both the medical literature and the responses of the subjects with whom I spoke. They are also typically used to justify the necessity of hospital births. These arguments are a critical component of the medical profession's ideological justification of its hegemony. In addition, it

appears to be not only a strategy but a strongly held belief--part of the world-view developed and accepted by most practitioners. Interestingly, in my research, it also appeared in statements by many nurse-midwives. The point here is not that childbirth is not a risky undertaking, indeed it may be. The question is whether or not that inherent risk necessitates obstetrician-attended hospital delivery. At this point, it is interesting to compare the outcomes generated by the Maternity Center Association and the Frontier Nursing Service (both home birth services serving higher risk clientele) with those generated by obstetricians. The reader will remember that the nurse-midwives' outcomes were significantly superior.

Risking out is also a way in which previously agreed-upon informal contracts with patients prescribing the nature of the care to be given (for example a labor-room birth) may be overridden. In this manner, the purported client-orientation may be legitimately pre-empted for colleague-oriented care-giving based on standards of practice. Furthermore, all this can be done in the best heroic medical tradition, enhancing the prestige and apparent power of the obstetrician. Certainly this explains in part why many women seeking to give birth in the labor room at UH/RMC end up in the delivery room. The pressures to locate and treat pathology are intensified in a large teaching hospital.

Summary

Birth reform came in very different ways to the hospitals examined in this study but many changes occurred during the period of 1970 to 1980. I have argued that the changes instituted at SCCH were fundamental and represented a paradigmatic shift. However, whether or not a midwifery orientation can coexist with a hospital, even one which is supportive, remains to be seen. Certainly the birthing practices and organization of birth there have had far-reaching effects in the state. The birthing rooms at SCCH both met and stimulated consumer need and raised the expectations of both birthing parents and care-givers who are reform-oriented. The fact that this birthing option is not characterized as an antidote to home birth and lay midwifery--as are the reforms at UH/RMC and NCCH--but is instead supportive of home birth as a viable option, is especially important in this regard.

In contrast, the reforms undertaken at UH/RMC were obstetrician-controlled and largely conservative. Several actors, including nurse-midwives, were required to bring about reform and they did so working from several starting points. While important changes were made, the essence of the obstetricians' practice was left untouched. Physicians who viewed patient's demands as something other than an unpleasant fad seemed to regard them as focused primarily on the manner in which care was given. In order to placate consumers, the nursing staff was changed as were the rooms

in which women labored. While these reforms were real enough, physicians continued to practice much as they had before, and that practice was interventive and delivery-room based. Furthermore, since UH/RMC had a large group practice, patients who were attended by obstetricians had to take whoever was on call when they came in. In this system, the least progressive physician was the potential birth attendant for any birthing woman and the development of pre-existing agreements was problematic.

The option to deliver in the labor room at UH/RMC was an effort to deal with consumers' interests and the SCCH competition in the realm of the "birthing room." The phenomenon of the development of the birthing room is interesting. It is a reformed location in the hospital repeatedly sought by reformers and often widely touted by participating hospitals. This variant hospital birth setting is described in newspaper accounts and hospital literature, both in Vermont and elsewhere, as "home-like;" it is portrayed as a comfortable place staffed by caring workers in which consumers will have a good birth <u>experience</u>. (Remember, many physicians regard consumer criticism as centered on the patient's <u>experience</u> of the care they receive). It is stated that, unlike the home, the birthing room provides readily available medical back-up should anything go wrong. Interestingly, the back-up at SCCH is provided not by obstetricians but by surgeons in the surgical wing of the hospital. It is sometimes explicitly

stated in literature describing the birthing room, as it was stated to me by several respondents about both the birthing room at NERH and UH/RMC that this alternative aims to bring those who had planned a home birth back into the hospital. In addition, the birthing room is often suggested as the antidote to the segmentalization and routinization of typical hospital delivery since both labor and birth take place in the same room.

However, nearly all the birth reformers and home birth supporters with whom I spoke emphasized that there are "real" birthing rooms and rooms which pretend to be birthing rooms. All agreed that what distinguishes the two is that the "real" one is based on a philosophy of woman-centered (or family centered), non-interventive, care-giving providing the woman and her supporters with the maximum amount of freedom and self-determination possible. They all recognized that there were many more birthing rooms that were false than were authentic. Thus, the birthing room is not merely a space, though the idea of extricating birth from the delivery room is important. It is a way of organizing care-giving and, as we have seen, one which some obstetricians avoid. However, it should be noted that the birthing room at NERH was instituted by the new obstetrician who proceeded to use it regularly. Observers attributed the nature of his practice and his willingness to work with a nurse-midwife to his training. Thus some obstetricians may be more willing to innovate than are others.

Chapter VIII

Nurse-midwives and Negotiations Toward Professionalization

Introduction

At the same time that the home birth movement was creating out-of-hospital birthing alternatives it served as a catalyst for in-hospital birth reform. Those who sought reforms in hospital birthing practices at places such as UH/RMC were able to translate consumer demands and criticism into changes in some hospital procedures and some aspects of the physical plant. A critical factor at UH/RMC in both birth reform and the related development of nurse midwifery was the financial assistance supplied by the Private Foundation.

Nurse-midwives were among those actively seeking reforms at UH/RMC. Nurse-midwives at NERH and SCCH entered practices and settings already largely reformed and their presence enhanced and sometimes broadened the reforms. The birth reform orientation of nurse-midwifery is consistent with the historical role of the occupation and is an outgrowth of its orientation to caregiving. At the same time, birth reform may be a vehicle for CNMs to attempt to redefine the turf in the care of pregnant and birthing women. Informed and active consumers with raised expectations for care-provision may well turn to nurse-mid-

wives. CNMs may be able to utilize rising market demand as a vehicle for expanding their scope of practice or at least establishing a firm foothold in the medical division of labor.

While birth reform may facilitate the development of nurse-midwifery, it is within the parameters of legal, institutional and economic structures that nurse-midwives have to endeavor to translate their resources into turf and autonomy. Within these structures, nurse-midwives are explicityly subordinate to physicians. Physicians in Vermont and elsewhere have created a structure in which the market for nurse-midwives' services is subordinate to and a component of that market controlled by physicians.

Locating a Niche in the Division of Labor

Nurse-midwives came into the state as subordinates to physicians. Their location in the medical division of labor had been devised for them at UH/RMC largely by obstetricians. The changes in the legislation which enabled them to practice had been facilitated by the support of leading obstetricians in the state. Nonetheless, while the early development was strongly influenced by physicians, nurse-midwives were also involved in shaping both the occupation's role and its location in the medical division of labor.

The initial involvement of nurse-midwives at UH/RMC, their first site of practice in the state, was construed

by the obstetrician heading the department as a demonstration project aimed at developing models for care in rural areas. The subsequent development of nurse-midwifery practice at UH/RMC was a transformation of that model, a process in which nurse-midwives were actively involved. CNMs also worked with the state nursing organization in the creation of new guidelines for nursing practice through the state Board of Nursing, assuring significant nursing input in the development of enabling legislation. Thus, the emerging role of nurse-midwifery in the state was the product of obstetrician initiation and oversight and nurse-midwife influence.

Several structural factors, some of which are codified in the laws, delineate the parameters of nurse-midwifery practice in the state. Nurse midwives worked under protocols[1] in all settings. That practice was consistent with the 1971 Joint Statement and the 1975 supplement which specified the role of nurse-midwives in the obstetrical division of labor. In addition, the relationship is mandated by state law. One respondent described the legal relationship between CNMs and physicians.

> Under the law--the nurse practice acts, state law--we all practice under medical protocols. It's spelled out under each physician so it just depends on the relationship with the physician. The physician

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[1]Protocols are written sheets listing what nurse-midwives should and should not, can and cannot do and the appropriate circumstances under which they may be undertaken.

> is still legally responsible, that's why (CNMs) have to involve them whenever we make decisions; whenever there are complications they have to be involved.

In addition, in all settings in which CNMs worked in hospitals, they had hospital admitting and discharging privileges as well as the ability to write orders for care and medication as specified by the protocols.

A critical factor in the nature of nurse-midwifery practice and its prospects for professionalization is the financial relationship with physicians. In Vermont, all but one of the CNMs was an empolyee of physicians. The lone exception was the CNM in the NCCH area who was embarking on an independent practice near the end of the study period. Even she was initially employed at a local clinic doing normal gynecological work. At UH/RMC, CNMs were formally employees of the ob/gyn group practice even though after 1976 they were funded by the Privat Foundation. It is worth noting that they were by far the highest paid nurse-midwives in the state. At both NERH and SCCH, nurse-midwives sought employment and were hired by physicians in solo or small group practice. Thus, all CNMs in the area studied entered into the medical division of labor as salaried employees of physicians. There were no associate practices, although CNM employees in NERH and SCCH functioned more like partners since the full range of their skills was needed in busy practices. An external factor

inhibiting the independence of CNMs was the inability of nurses, even those in "expanded roles" to receive direct third-party payment for their services. This component of the law governing nursing practice required that CNMs receive reimbursement through a physician. There was thus no financial competition between the CNMs and the physicians for whom they worked. On the contrary, the physicians in private practice whose incomes were tied to patient fees probably benefitted economically from the employment of nurse-midwives by expanding their practices. As one obstetrician explained,

> Obs, by and large, are threatened and oppose nurse-midwifery generally.... We have an abundance of ob/gyns around the country....If there are too many doctors, they don't have enough patients to pay them a big enough salary a year... they are not going to be very anxious to have nurse-midwives taking over. But they're not very smart because if they had two nurse-midwives in their office, their patient population would double or triple, because patients appreciate that.

Since nurse-midwives worked as employees of physicians in different locations and different kinds of practices, what CNMs actually did in practice varied by setting and, at UH/RMC in particular, changed over time. There was also variation in the extent to which the work they performed was consistent with the occupation's claims to special contribution in care-giving. While CNMs in partner-like relationships with individual physicians in busy practices

tended not to be significantly restricted in the scope of their practice, at UH/RMC nurse-midwifery practice had to be fitted into a large teaching hospital.

Nationally and at UH/RMC nurse-midwives were being drawn into the medical division of labor at a time when it was becoming more highly articulated. Their entrance thus coincided with that of the nurse-practitioners. At UH/RMC, where physicians were almost exclusively specialists, the expanded role of the nurse tended to be divided along medical specialist lines. For example, gynecological nurse-practitioners performed normal gynecological work such as pelvics and pap smears on non-pregnant women while CNMs focused their work on the care of pregnant and birthing women. Initially and for a substantial period of time that work was limited to pre-natal and post-partal care. One nurse-midwife explained that she felt somewhat limited by her inability to do normal gynecological care (or "well-woman care" as she called it) for which she had been trained. But she recognized that it was out of the question under the circumstances since NPs performed those tasks. Thus, nurse-midwives' ability to provide continuity of care to women throughout their child-bearing years was significantly curtailed at UH/RMC.

Another change which occurred as CNMs were being drawn into the hospital division of labor was the emergence of fetal monitoring as a normal part of obstetrical procedure

(Goodlin, 1979). Fetal monitoring was in itself an outgrowth of the trend toward active management of and technological intervention in labor and birth. At both UH/RMC and NERH external fetal monitors were available. (This device consists of a strap placed around the woman's abdomen leading to a machine which produces an electronic graphic read-out of the fetal heart beat.) UH/RMC also had available internal fetal monitors, in which the source of the electronic impulses is an electrode inserted into the scalp of the fetus after partial cervical dilation has occurred. While fetal monitors seemed to be rarely used at NERH, every woman in labor at UH/RMC received 20 minutes of external fetal monitoring upon admission. If no abnormalities appeared, the monitor was discontinued, otherwise it was continued. I could not discover the specific rationale for the length of monitoring suggested. The external monitors have been criticized by birth reformers for several reasons. While a woman is being monitored she cannot walk or move about, and extensive touching, such as massage, interferes with the monitoring. Furthermore, monitors are expensive and add to the cost of hospitalization. In many hospitals, improper interpretation of the read-out was linked to rising Cesarian section rates. That did not seem to be the case at UH/RMC which had a fairly conservative C-section rate. In terms of nurse-midwifery practice, extensive use of fetal monitors meant that CNMs' training in non-electri-

cal (that is, aural) assessment of fetal heart beat was neither fully trusted nor fully utilized.

As the obstetrician who brought the nurse-midwives into Vermont acknowledged, CNMs were not required at UH/RMC. A plethora of attending and resident obstetricians and interns were available to perform deliveries and/or monitor labors. One of the reasons the idea of a nurse-wifery school was not pursued was the relative scarcity of "clinical material." A nurse-midwifery school would have too greatly intensified competition for patients. Even with only four practicing nurse-midwives, competition for patients was potentially keen enough. As one CNM explained, "There are so many people who could catch that baby it's ridiculous."

While nurse-midwives' structural relationship with physicians was the primary determinant of the parameters of practice, CNMs' relationship with nursing was equally complex. As nurse-midwives attempt to locate turf somewhere between those task activities monopolized by physicians and nurses typically each of the other occupations may experience some incursion. However, while physicians have structural power and may choose to delegate tasks, nurses have few legitimate means of resistance. Every CNM with whom I spoke had strong feelings about nursing and most had anecdotes about their experience with nurses. It should be noted that within the national nurse-midwifery organization, ACNM, debates about the continued relationship with other

nursing organizations and the necessity for an RN prior to advanced training in midwifery had begun to emerge. Further, as nurse-midwifery became more visible, more women who had commitments to feminism or midwifery but not necessarily nursing, entered the occupation. The population of nurse-midwives in Vermont mirrored this trend. While many considered themselves primarily nurses and had strong ties to nursing, others felt less affinity with the occupation of nursing. Nonetheless, all had had some difficulties with nurses and all described these with regret. For some, the initial encounters with nursing created a "no-win" situation.

> (My work relationship with nursing) has been kind of mixed. Overall, it has been very positive. There was some confusion about, for example, how much nursing care am I going to give? Am I going to usurp their bedside care? Some people would say, 'You're a nurse, if you are going to be with a patient, why aren't you doing the vital signs?' and so forth. Why should I have to do that? There are some people you can't please. If I come in and do nursing care, they're mad because I'm usurping their job. If I don't do nursing care, they think I'm lazy.

For some nurse-midwives, particularly those who did not feel an affinity with nursing, their day-to-day work with nurses could be problematic and frustrating.

> It's very tough to get along with nurses because of their passive-aggressive behavior, especially if you're trying to raise people's consciousness or work <u>with</u> women and here you have women fighting each other. Nursing is very jealous of the power that they don't have and they take it out in all kinds of devious ways. In some ways (the nurses) see us as a greater threat than (female physicians) because

> we're nurses; we're 'super-nurses.'

Another nurse-midwife reluctantly admitted similar experience.

> There may be times and places where there is a lot of mutually destructive (behavior) going on. I guess I have seen it. Which is again, a lot of the same women back-biting each other. I see it more in straight nursing, staff nurses, people within the standard administrative structure of nursing than I do with clinical specialists. Because that's the standard female attitude. You see it an awful lot in nursing.

Of course such patterns of behavior are typical of subordinates whose fortunes rest with the pleasure or displeasure of their superordinates in other structures as well. Nurses accurately judge the power of nurse-midwives to be subordinate to that of physicians and understand that acting out displeasure at their competition may produce less direct consequences than similar behaviors directed toward physicians. By withholding their willingness to work supportively, nurses can make daily work for nurse-midwives extremely uncomfortable. One nurse-midwife described the initial tension which existed between the nurses and herself in task performance.

> I used to, when I was walking up (to labor and delivery) feel like I was going onto (a) battlefield. I used to literally shudder going (there). I used to dread it. Someone was going to get after me. Someone was going to come down (on me). But now there's nothing of that. I'm very confortable.

One of the most interesting and graphic examples of the inhibiting effects of nurse's resistance to both birth reform

and nurse-midwives came from another nurse-midwife who was describing her second birth. She was well into labor but was trying to hold out going to the hospital till a nurse she wanted to avoid was off-duty. As it turned out, the baby was born, at home, before her co-worker's shift ended.

On the whole, the nurse-midwives were extremely concerned about their working relationship with nurses and sought to avoid competition and, ultimately, establish rapport with them. In part, the establishment of a cooperative working relationship was a pragmatic necessity. But there were several other reasons CNMs avoided conflict with nurses. Some felt a strong sense of colleagueship with nurses; for others feminist concerns made them unwilling to engage in power struggles with other women. Several CNMs recognized that it was physicians who were calling the tune to which they all danced. Sometimes nurse-midwives themselves were discouraged about the emergence of a successful division of labor within nursing. More than one nurse-midwife occasionally wondered if, in the context of a reform-oriented nursing staff, much of their work wasn't redundant. But for most nurse-midwives, effective ties with the nursing staff were actively and hopefully sought and maintained. As a nurse-midwife noted,

> It just took time (to defuse the mistrust). It just took them getting used to seeing us there. Getting them to realize that we weren't trying to boss them around or take over their role. They still had a role there. We had a

role, but we could work together.

Of course, at UH/RMC the dramatic changes in the nursing staff both undermined the rapport nurse-midwives were trying to develop with the original nursing staff and brought in a new reform-oriented nursing staff. The progressive nurses were closer to the nurse-midwives in philosophy and that probably facilitated cooperation.

Thus, nurse-midwives in Vermont, found the location of turf in the obstetrical division of labor a lengthy and complex process. Many articles in the nurse-midwifery literature attest to the universality of this problem (Kimbro, 1978; McCormick, 1976; Monnig, 1976). Further, the nature and extent of the difficulty may very by both the setting and the philosophy and orientation to care-giving of surrounding workers, especially the structurally dominant physician.

Negotiating for Autonomy

The nurse-midwives' larger inter-occupational relationship with physicians is both played out and negotiated in the work setting. Bucher and Strauss (1961) suggest that this is one of the major arenas in which their respective positions are negotiated. The division of labor means the performance of different tasks by different care-givers or sometimes the performance of similar tasks on different kinds of patients, for example, those characterized as

"high risk" as opposed to those characterized as "low risk."

Nearly every CNM with whom I spoke expressed a desire for greater autonomy, although the nature and scope of that independence from external control was differently construed. Acknowledging the legal and structural parameters within which they worked, nurse-midwives recognized the centrality of a cooperative relationship with the physician(s) for whom they worked. They understood too that for the time being the nature of this relationship determined the nature of their practice.

Nurse-midwives worked under protocols in all settings, but what appeared to differ by setting was the extent and nature of nurse-midwife involvement in setting up the protocols. Although I did not explicitly ask respondents about the manner in which protocols were derived, several of their responses suggested that the physicians at NERH and SCCH worked more closely and less formally with the CNMs in this area than did the obstetricians in group practice at UH/RMC. Further, the protocols at UH/RMC seemed to be more restrictive than those at the other two sites. One nurse-midwife indicated that UH/RMC's protocols were currently being rewritten and that she hoped that "...it will get more liberal on some protocols that we constantly run into problems over, things that recurr and they're not that dangerous."

Thus the nature of the protocols may both structure the

physician-nurse-midwife division of labor and reflect the underlying nature of their relationship. One CNM suggested that,

> A lot of it seems to hinge on the personal philosophy of the doctor. If the physician seems to feel that someone other than a physician can practice medicine, what they see as the practice of medicine, without an M.D. license...that is, can take on some of the skills and do some of the things that have normally been restricted to doctors; if they believe (it) in their guts and you can demonstrate to them that you're good and you're competent, that you know what you're doing, that you're going to blow the whistle when it needs to be blown, (then) you're going to get along. You can do it and create your own sphere of autonomy. (But) if they don't believe that and it's kindof done grudgingly or done because it looks good or because consumers are demanding it, it doesn't work. Because that's when protocol sheets get drawn up. That's when somebody's practice gets curtailed to be 'exactly this' or 'exactly that,' and there's not much leeway to play with.

Another nurse-midwife suggested that "the ideal would be to have a small practice with a physician who is fairly liberal." Describing a practice in which she was basically satisfied, one CNM observed.

> This is a job where I can almost write my own ticket, as far as I am compatible with this physician. If either of us were different persons, it would be a different story. (But) like a marriage, as long as we're reasonably compatible in terms of philosophy (it works).

While philosophical complementarity is important, the structure of the practice may be equally critical in determining the scope of nurse-midwives' practice. CNMs were strongly supported and granted wide scope in practice by

their solo or small group physician employers. These physicians recognized that the nurse-midwives shouldered a substantial portion of the work-load in their busy practices at a wage well below that of another physician. In practices where obstetrician's incomes were tied to patient fees, the nurse-midwife's work in normal obstetrics enabled the obstetrician to focus his attention on the more lucrative specialist work. As one respondent explained, "Ob is not real profitable. What it mainly does is bring in gyn practice... Surgery is much more profitable than what (CNMs) do." Clearly, this division of labor does not obtain in a nurse-midwife-family practitioner team in which neither is trained as an obstetric specialist. In this structure, both practitioners would perform similar work.

At UH/RMC where all ob/gyns in the group practice were salaried and physicians and residents feared competition for patients for non-economic reasons, physicians were less inclined to embrace nurse-midwives. Some obstetricians were disinclined to give up the performance of certain tasks to nurse-midwives, perceiving it as a threat to their status. After the Private Foundation committed funds to nurse-midwifery practice and several CNMs were hired, the nurse-midwives began to expand their work from exclusively pre-natal and post-partal care to work with patients in labor and delivery (the turf of obstetricians and obstetrical nurses). Every week day one CNM worked on labor and

delivery attending those patients who sought their assistance. However, since CNMs didn't work on weekends, they were unable to make commitments to patients. Nonetheless, even this limited involvement on the labor and delivery floor was carefully watched by physicians and nurses and several respondants characterized it as a trial or proving period.

> At that point, some of the physicians were a little resistant to having (the CNMs) see their patients. It took a while before the physicians would use (the CNMs, whose) schedules weren't really busy at first, because (the physicians) wouldn't refer. Because it all depended on physician referral.

By 1978 the nurse-midwives at UH/RMC collectively decided to seek a CNM service in which they would take on a case-load of patients who, with periodic physician visits, they would care for through pregnancy, birth and the postpartum. They were able to make commitments to patients to attend their births by rotating call between the CNMs. The mid-year employment of another CNM via federal MIC (maternal and infant care) funding facilitated this undertaking.

The CNMs proposed the program to the ob/gyns in group practice and the physicians approved of the idea, though some reluctantly. The service began functioning on a small scale that year. Among other effects, the service served to further differentiate the CNMs from the nursing staff who worked 8-hour shifts. At least one influential

physician in the department disapproved of the service fearing that the goal of better obstetrical care for all would be subverted by differentiating the services.

> The Maternity Center Association is attempting to show that for properly selected women, the nurse-midwife is an adequate care-giver (with obstetrician back-up). That isn't what (UH/RMC) is trying to show. Rather, (UH/RMC) is attempting to demonstrate that an obstetrician-nurse-midwife team, alternating visits, provides the best obstetrical care.

For this reason and others, CNMs were not allowed to "advertise" their newly formed service. Nonetheless, patient demand continued to grow.

The willingness of the obstetricians to allow nurse-midwives to embark on even this restricted service is interesting. The head of the department seemed to understand the benefit of conservative reforms and may have viewed the development of this service as one of them. Since he refused an interview with me I cannot be sure. Certainly the CNMs posed no threat since they were salaried employees of the group practice, had no control of their budget and worked under physician determined protocols. The protocols were extended to describe the characteristics of patients who could choose the nurse-midwife service and the circumstances under which even those could be shifted to obstetrician management.

While obstetricians at UH/RMC had ongoing qualms about losing some patients to CNMs who would otherwise be available for teaching, other factors encouraged their acceptance

of the altered division of labor. One respondent pointed out that physicians accepted the plan for differing reasons. While some felt the CNMs "added something" to the care of birthing women, some others saw it merely as a vehicle for lightening their work load. The latter attitude is not unique, Keetel (1973) in his presidential address to ACOG suggested that the use of nurse-midwives could minimize obstetrician attendance at night-time deliveries. The fact that ob/gyns were neither trained in nor intrigued by normal childbirth and gynecological care was a facilitating factor suggested by several respondants. A lay-independent midwife offered, "Most obs. don't attend births anyway, they just arrive to catch babies." When I asked a CNM if she thought ob/gyns would be willing to give up or delegate normal ob/gyn work she responded,

> I think the answer is 'Yes.' Because they don't like it. The more sick you are, the more pathology you can demonstrate, the more interesting case you become. The whole medical model is pathology oriented. The physicians are not interested in normal.... They aren't interested in 'yearly check-up and pap smear' etc. They don't like it. They don't like to do it and they are delighted to have nurse-practitioner people involved. They're giving up or turning over something that they don't want to do anyway. Plus we do it better. That's what we're trained to do.

Insofar as physicians construed treatment of pathology as more important and more central to their practice than care for normal labor and birth, they could regard the new division of labor as one in which secondary and less difficult

tasks could be delegated to subordinate "team members." Thus, as one obstetrician asserted, "The nurse-midwife is more challenged by the whole process of (normal) labor and delivery than is the more highly trained obstetrician." And obstetricians' ability to define "normal" and make the definition stick in practice enabled them to retain ultimate control. As one CNM observed, "They could define us right out of existence."

It is also possible that some of the obstetricians understood that nurse-midwives could serve and satisfy those patients who had been vocally critical of the hospital, including some who had advocated or chosen home births. The nurse-midwives were able to advance their idea for a CNM service partly by citing strong consumer demand. As several CNMs explained, consumer demand for their services was their wedge to establish their turf in the obstetrical division of labor in a variety of settings.

Nurse-midwives in smaller practices serve obvious functions. For example, one physician with whom I spoke noted, "I wouldn't be able to take the time to talk with you if (the CNM) weren't covering for me." In contrast, at UH/RMC, consumer demand was the nurse-midwife service's raison d'etre. A CNM explained,

> We're here because patients want us. They want to have somebody they know there. They want to have a trusting relationship with somebody who's going to deliver their baby. And they believe that we're their advocates. We are.

As her statement suggests, for patients who chose the nurse-midwifery service, unless they "risked-out" they could be assured that one of four midwives, rather than one of fourteen obstetricians, would attend them. Further, the CNMs made sure that their patients saw each of them at least once during prenatal care. In this way, consumers were offered an alternative to the "take whoever is on call" problem many actively criticized. Further, many who opted for the nurse-midwife service intended to take a more active role in what they hoped were more natural births. Another CNM explained,

> A lot of people who choose us want all the options and trust us to root for them and make sure they get the options.

The CNM service (officially dubbed by physicians as the nurse-midwife-physician service) at UH/RMC provided a group of middle-level health practitioners who actively supported consumer desires for non-interventive births. Thus, the hospital birth reforms, which were minimal in the absence of sympathetic in-house supporters with some degree of autonomy, were championed by CNMs. Their patient advocacy and client-centered orientation served to increase the likelihood that the options formally instituted by birth reformers would be realized. As one nurse-midwife pointed out to me, the CNM works to keep the labor and birth normal since when significant pathology appears, she turns over management to an obstetrician. This is in sharp contrast

to the active-management orientation of pathology-oriented obstetricians.

By the end of the study period, the CNM service at UH/RMC was formally offered as an option to prenatal patients in a check-list of labor and delivery options. Nonetheless, people with whom I spoke credited lay-referral for most of the patients who chose nurse-midwife attendance. Consumer demand continued to grow and by 1980 the service was "booming" as one respondant put it. While at least some childbirth educators were busy attempting to both inform prospective patients and raise their expectations for birth, it seemed likely that nurse-midwives were also drawing their clientele from among those who had considered home birth. Many nurse-midwives agreed with that assessment.

> I think it's possible. Most of the people we deliver say after the birth, 'I thought about home delivery and I'm really glad I didn't do it. I hear that all the time. There are definately times when people feel very angry that because of complications they had to have intervention....I think there's one piece of data in (the consumer attitude survey) where they asked, 'Would you have preferred to have a home birth?' or 'Would you do it next time?' And they got an overwhelming 'No.' ....If we didn't exist, if what was available was traditional delivery, if you had to take whoever was on, both the home birth movement and consumer reform would be stronger.

Thus, a supporting clientele, constituting a significant and growing market demand enabled CNMs at UH/RMC to

enlarge their scope of practice. In so doing, they benefitted from the home birth movement and in-hospital birth reform efforts, both of which raised consumer expectations and altered the birthing environment in the state. Having formally expanded their task performance to include not only prenatal and post-partal care but also management of labor and birth within parameters delineated by protocols, CNMs had to translate their success into day-to-day practice. In this altered context, some of the nurse-midwives found the team structure facilitative of their autonomy since they had ready access to obstetrician consultation and back-up. One CNM emphasized that "Nurse-midwives are the ones who make the decision as to when to refer a patient." (Of course, that decision had to be consistent with the protocols). For others, the team structure in a teaching hospital continued to pose problems. In an effort to resolve the problem of competition for "clinical material" CNMs suggested that they should teach normal obstetrics in practice. Apparently the ob/gyn group was more or less persuaded by the argument. As one CNM describing her job quipped, "...and, we are unpaid faculty." While attendings may have been persuaded to grant nurse-midwives autonomy within their scope of practice, residents presented more problems. One CNM who officially had a faculty appointment said she was not unwilling to send out bothersome residents when necessary. The problem was less easily solved by

CNMs who were unable to pull rank. As one CNM explained,

> The residents, a lot of times, want to get their hands in there whether things are normal or not. It's wanting experience. Also, they're responsible. I have a problem with the number of people present at a delivery. People come to us because they don't want a cast of thousands....(But) what happens depends on who's on (duty). I can't just tell the resident to leave. I quite often do say, 'Would you like to help?' or 'Things are alright. I can handle it on my own.' And it's up to the resident at that point if they want to be there. (They don't interefere intentionally)...but they're used to getting in there and doing stuff.

CNMs found themselves resisting incursion into their task boundaries from competitors for their turf. Between the restrictions on their scope of practice imposed by the protocols and the attempts at intervention from the residents, a substantial number of their clients were transferred into medical management. Information I obtained from those involved in the CNM service indicated approximately a 50 percent "risk-out" rate during the period of study. That is, of those patients who, according to the protocols, "qualified" for the CNM service and labor-room birth, at least half ended up in the delivery room in lithotomy position. Of these, approximately 15 percent had C-sections and another 5 percent had low forceps deliveries. Assuming that this medical intervention was required, this left another 30 percent of patients who did not require this level of medical intervention who nonetheless gave birth in the delivery room and did not achieve their

desired in-hospital alternative birth.

Since, during the study period many of the labor room births were attended by physicians it is not surprising that many women who began in the labor room ended up in the delivery room where physicians felt more at ease. Even though during the study period only approximately one third of the labor room births were attended by nurse-midwives, this physician disinclination to perform deliveries in the labor room does not adequately explain the high rate of risking-out. There were several other intervening factors, one of which was the size of the room, more like a cell. There was simply not enough room for actors whose presence might have allowed the birth to continue unaltered, for example, a pediatrician needed to check babies who had indicated minor distress. In any case, the resulting figures indicated that access to substantial in-hospital birthing options was still severely limited. For the period July to December 1979, only 3.8 percent of all patients gave birth in the labor rooms. By the period of January to June 1980, the figure had risen to 4.7 percent. CNMs pointed out that in the post-study period, as the nurse-midwifery service continued to grow, nearly two-thirds of the labor room birth were attended by nurse-midwives and only one-third by physicians. They also suggested that less restrictive protocols might diminish the percentage of patients who "risked-out."

In spite of the high rate of traditional delivery room births among CNM patients during the study period, one obstetrician observed that patients were still more satisfied with the nurse-midwife service and felt they had a good birth experience. In light of previous discussions of the separation of the patient's birth experience from the medical management of the patient's body, this observation is especially intriguing. Nonetheless, a lay-independent midwife concurred with patients' assessment. She noted that the involvement of CNMs at UH/RMC had served to "humanize the hospital" and that the CNM service represented a qualitative improvement over traditional hospital birth.

Nurse-midwives with whom I spoke, described projected plans for an alternative birthing space in or near the hospital. Early in my interveiwing I was told about a committee of nurses, nurse-midwives, childbirth educators and obstetricians which was considering the development of a birthing center. Apparently this idea had originated, or the impetus derived from out-of-hospital birth reformers in the area, including lay-independent midwives and some childbirth educators who called a meeting to discuss the idea. Nurse-midwives attended as representatives of UH/RMC. The lay-independent midwife who related this story felt that the CNMs had been assigned this task by their department. By the next meeting, the head of the department of ob/gyn had developed an interest in the idea and the

hospital sent several representatives, including their lawyer. At least some of the lay-people at the meeting regarded this action as a rather indelicate take-over attempt. It did seem to undermine the group and reasserted UH/RMC's monopoly over childbirth in the area. UH/RMC considered the idea for some time and then abandoned it.

While some CNMs regarded a birthing center as an important and progressive step which would enhance hospital birth reform while it broadened their scope of practice, some others were more cautious. One CNM explained that she had,

> ...played it down. I didn't want the doctors to support it for the wrong reasons: to get CNMs out of their hair. I wanted it inside so that more patients had access to it. I wanted to create an (alternative) environment where patients didn't have to be 100 percent normal (to use it).

So she focused her energy on improving the physical plant as UH/RMC, including revamping the labor rooms, developing the Private Foundation-funded labor lounge and facilitating non-interventive labor-room births. Ultimately, however, the birth center concept appeared to be discarded by physicians, who were in any case the ultimate decision-makers along with the hospital administrator. The probable reasons were the expense of the project, increased competition for patients, inhibited control of nurse-midwives and significant modification of the particular team concept, "partnership," which had been the founding vision of the obstetric-

ians who most strongly supported nurse-midwifery at UH/RMC.

Nurse-midwives had thus, at least temporarily, hit the limits of their professionalization project at UH/RMC. However, the ideas for the birth center were modified and respondants assured me that in late 1982 or early 1983 a birthing room suite was to be constructed in the hospital. This would be a large space with facilities for food-storage and possibly cooking as well as space for supporters to sleep-over. If coupled with an appropriate philosophy of practice, it could function as a "real birthing room" for those patients who had access to it. Nurse-midwives seemed pleased at the prospect of it, anticipating, among other things, that it would be a physical manifestation of their turf.

Still, CNMs' turf was fragile at UH/RMC. Funding from the Private Foundation was renegotiated in 1980 and continued on a year-to-year basis. Nurse-midwives continued to be structurally and immediately subordinate to obstetricians and they recognized the parameters of their birth reform efforts. As one CNM noted, "We have to be careful not to become anti-physician." Several subjects had characterized the nurse-midwives at UH/RMC as unwilling to take risks or disinclined to push as hard as they might, parlaying their consumer support into greater autonomy and more profound birth reform. When I asked a knowledgable respondent what to make of these criticisms, she explained

that she thought their caution was realistic.

> CNMs are still cognizant of the fact that if they get too aggressive, they could get drummed out of the roll-call.

Independent Practice

While more than one nurse-midwife had considered independent practice, only one actually engaged in it in the northern two-thirds of the state during the study period. This CNM did not enter into independent practice entirely by choice. She had begun working as a salaried employee in a clinic in the NCCH-area and had been fired and lost her hospital privileges when she had not ceased attending home births. Instead of leaving the area, as she might have under other circumstances, she remained, in part because her husband, a physician (not an ob/gyn) had a practice in the area.

As previously noted, independent practice by CNMs in Vermont was inhibited by the restrictions on third-party payment and the necessity for physician back-up and practice under protocols. Given the conservatism of the overwhelming majority of obstetricians on the question of independent nurse-midwifery practice, I was not surprised to find that her back-up physician was the family-practitioner at SCCH. Of course, he, in turn, had to refer complicated cases to obstetricians or surgeons, further segmentalizing care. She pointed out that neither of them considered it an ideal situation.

She had not wanted an exclusive home birth practice but the cessation of her hospital privileges and the antagonistic relationships with the conservative obstetricians at NCCH allowed her no other choice. This placed her practically in a position similar to that of lay-midwives and the analogy was not lost on her. In fact, more than most other midwives, she maintained contact with lay-midwives and had entertained the idea of a joint practice.

Obstetricians fearing independent nurse-midwife practice, have made the option as unattractive as possible. As one CNM pointed out, in a situation where a nurse-midwife left employment by a solo or small group ob/gyn practice and embarked on an independent practice in the same area, her earning power might or might not be enhanced, she would have to carry the financial overhead for her practice and related small business concerns and she would be working with the same people in the same hospital in an antagonistic relationship. Another CNM described the case of a nurse-midwife in another state who left her independent home-birth practice after she found herself transferring 3 out of 5 of her patients to the hospital because of restrictive protocols.

While nationally, successful solo or group independent nurse-midwife practices do exist, they are often harassed by obstetricians who fear competition and attempt to subvert them. As I observed previously, the

struggle for nurse-midwifery autonomy has begun to take place in the courts and before Congress where nurse-midwives are charging obstetricians with restraint of trade. Describing the situation at the city in which she attended nurse-midwifery school, one CNM explained,

> As the consumer support for (nurse)midwifery goes up, (so does) its competition with the medical community. In an urban area, for instance, where there's a specialist under every rock and a given number of uteruses to be exploited, they can be at odds.... (Obstetricians then inhibit CNM access to hospital privileges). (Then) they have no choice but to deliver at home or sit on their skills. That is part of the radicalization of the nurse-midwife. You deliver at home or you don't deliver. That is the reality. Whereas ten years ago people were perhaps willing to say 'Yes. Dr.' and do paps for the rest of their life, they're not now.

The CNM in the NCCH area explained that she was considering a suit against the hospital and obstetrician group practice to restore her hospital privileges charging them with restraint of trade. However, she recognized that it would be expensive, time-consuming, unpleasant and arduous. Still, she wanted to be able to pursue both in-hospital and out-of-hospital birthing alternatives.

Interestingly, the other nurse-midwives supported her, pointing out to me that her attendance at home births was not illegal and that she should not have had her hospital privileges withdrawn. Had this incident had the effect of radicalizing the nurse-midwives at UH/RMC? I asked one CNM.

> No. They know what they want (to support in-hospital birth reform). They're getting a salary. They've got their nine-to-five job. They don't have to take call all the time....Compared to what they can get in the area...we've all chosen to live in this crazy place...and so we have to sort of carve out what we can get.

While other CNMs had considered independent practice, the example of the CNM in the NCCH area might have served to dissuade them. Still, CNMs throughout the study area hoped for and worked for greater autonomy. They were also developing a sense of unity; at the end of the study period, nurse-midwives at UH/RMC organized a state-wide chapter of ACNM and the nurse-midwives met several times a year to exchange information and support. Most of the CNMs were fairly new at the work and were still waiting to see how much autonomy they could achieve inside the hospital and the "team." For some, the inability to legitimately attend home births was felt as a significant constraint. If CNMs were able to successfully extend their practices to include home births, they might strengthen the home birth movement at the same time that they infringed on the task boundaries of lay-midwives.

Chapter IX

Summary and Conclusion

Introduction

This is a case study of the changing division of labor in an arena of health care, the care of pregnant and birthing women. I examined the process by which a dominant profession (obstetrics) emerged and ultimately achieved hegemony. The subsequent development of broadly-based client movements to reform professional practices and less widespread, but equally active and vocal, client revolts challenged both the profession's hegemony and its freedom from lay-intervention.

The significant alteration in the lay-professional relationship poses fundamental challenges to a consulting profession such as medicine. It also created the opportunity for other occupational collectivities (LMs, CNMs) to emerge and coalesce, and seek new markets for their services. Their strategies challenged the boundaries of existing occupations by either collecting delegated tasks or creating new turf in the larger division of labor among occupations.

I examined shifts and conflicts in the processes of collective challenges to obstetrician hegemony as well as the dominant profession's responses to these challenges. The profession is faced with the task of reasserting its claims to a mandate for the exclusive performance of its work

(cf. Hughes, 1964) while manipulating its resources, such as control of licensure and access to hospitals, in an effort to resist competition.

Obstetricians have attempted to retain their monopoly on their clientele and their dominance in the division of labor. While within medicine there are segments with different interests, the professional organization of obstetric specialists is conservative--actively resisting the erosion of their professional power. Competing occupations, meanwhile, have tried to undermine the hegemony of obstetricians by either acquiring a privileged position in the obstetrician-headed division of labor (the strategy of CNMs) or by freeing themselves from professional regulation (the strategy of lay-midwives). Competing groups have tried to locate and monopolize a market for their work while asserting a definition of the situation (for example, childbirth) which complements their claims to special expertise.

Professionalization and the Medical Division of Labor

I have previously discussed in some depth the manner in which allopathic medicine emerged as a profession. The occupation was able to unify (even as it stratified), and develop both a cognitive base[1] and minimum standards of training and practice. In an innovative reorganization of

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[1]Freidson refers to this as "expert knowledge."

work around the cash-nexus this and other emerging professions engaged in a "collective mobility project" translating one order of scarce resources, expertise, into another, status and money (Larson, 1977). The occupation did this by making claims of unique expertise, asserting a complementary definition of the phenomena toward which their skills were directed and asserting their trustworthiness. In the case of medicine, the occupation's successful bid for state mandate and license for the excluse performance of its work was facilitated by financial and political assistance from leading industrial capitalists (Berliner, 1975). Medicine's professionalization project consisted of the construction and monopolization of a market for its services, which involved the elimination of its competition, both lay and expert. The profession achieved freedom from lay intervention and the ability to regulate itself. In addition, it came to dominate an extensive medical division of labor (Freidson, 1970a). Its professional organizations continued to mold and control subordinate occupations, such as nursing, in a rapidly growing and increasingly institutionally-based labor-intensive industry (Brown, 1973). So successful was medicine at professionalization, that it has become the archetypal profession in sociological literature.

Certified nurse-midwifery was one of the new and subordinate occupations which developed in the emerging division of labor. It developed as an uneasy blend of elements of autonomy and heteronomy and combined subordination to an

allopathic paradigm with the infusion of an alternative paradigm from British midwifery. The occupation achieved a substantial scope of autonomy in practice (1930's) in some regions of the country since physicians granted it a de facto monopoly on a market of less desirable clientele attended outside medical insitutions (e.g., rural areas). Nurse-midwifery's special occupational jurisdiction accounts for the separation of its occupational trajectory from that of nursing. In the 1930's and 1940's, the market for other independent nursing services collapsed while the market physicians had constructed and monopolized expanded. The hospital was emerging as the central institution of modern medicine and as nurses were drawn into it their practice became immediately subordinate to that of physicians'.

However two decades later, nurse-midwifery's path changed and began to parallel that of nursing. As third-party payment became available for indigent patients, physicians began to compete with nurse-midwives for portions of their clientele. Concurrently, organized obstetrics began to reshape the occupation to meet anticipated needs in the delivery of hospital obstetricial care, specifically, the "physician-shortage" and the "baby-boom." The dominant profession renewed its effort to gain full control over nurse-midwifery and to mold the subordinate occupation to fit obstetricians' varied needs, seeking to determine the turf and function of nurse-midwifery in practice. Thus, nurse-midwifery's marginal

location in the obstetricial division of labor was re-evaluated by the leadership of organized obstetrics which sought to bring CNMs into hospital obstetrical care as subordinates to obstetricians. Meanwhile, segments within the medical profession competed for the market of obstetrical patients and obstetric specialists edged out generalists.

Nationally in the 1960's, nurse-midwifery shifted its turf from the care of marginal and high-risk underserved populations, where it had considerable autonomy in practice, to the care of paying hospital patients within the obstetrician-headed team. Where previously medical restrictions had applied primarily to whom CNMs served, they now applied to the tasks certified nurse-midwives performed. This was legally manifested in the development of physician-created protocols, ultimate physician responsibility for care of patients and physician supervision of nurse-midwife practice. Nurse-midwives first entered Vermont in the late 1960's as subordinates in the obstetrician-headed team.

During its thirty years of existence, nurse-midwifery had been attempting to professionalize. By the early 1960's the occupation claimed it had developed a cognitive base and had made significant progress toward upgrading and standardizing its education and training programs. The occupation had gained significant control over these programs; in Larson's (1977) terms, it had gained control of the critical "production of the producers of professional services." In addition, Nurse-midwives' claims to expertise and the reliability of the

professional producer were enhanced by their remarkably good birth outcomes. However, nurse-midwives were few in number and their status and incomes were low.

In some ways, the occupations' move into hospital obstetrical care enhanced the occupations' collective mobility project. During the period of the 1960's and 1970's, CNMs' incomes rose significantly along with the occupation's status, legitimacy and visibility. Substantial federal monies were made available to upgrade nurse-midwifery education, thus strengthening the basis of the occupation's claims to appropriate expertise and standardization in education.

However, in this rapidly changing context, the problem for nurse-midwifery became: How can the occupation radically and heteronomously (other directed) change its trajectory and market without suffering the fate of nursing, that is, having its aspirations for professional status short-circuited? The transition to hospital practice enhanced the collective mobility project at the apparent expense of the occupation's autonomy in actual practice.

It is possible for an occupation, such as nurse-midwifery, which poses a potential threat of competition to physicians, to successfully pursue professionalization within the institutional matrix of medicine's professional power? The case study examined this question. In obstetrician-headed teams, physicians delegated CNMs specific tasks and restricted their autonomy in practice. In most settings, CNMs functioned

as physician-extenders or physician substitutes, performing routine tasks. In this structure, nurse-midwives negotiated with the dominant profession in an attempt to locate turf, and by developing bundles of monopolized tasks, to delineate a new occupational jurisdiction.

Nurse-midwives thus reinitiated their professionalization project by making modified claims to special expertise and a special contribution to care-giving. They sought a mandate for their altered services, sometimes nudging out potential competitors such as maternity nurses, and, with physician acquiescence, they obtained state licensing for nurse-midwifery practice in most states, including Vermont. Having been drawn away from an independent market for nurse-midwifery services, the occupation was faced with the problem of locating another market which was distinguishable from that monopolized by physicians.

While in the late 1960's nurse-midwives were facing the prospect of rapid underdevelopment of their occupation, client movements aimed at reforming birthing practices and professional-lay relationships were emerging. Birth reformers undertook the strategy of cooperative lay-intervention in hospital birthing practices. They activated and raised "prepared parents'" expectations for their birth experience through childbirth education; however, they also socialized them into a more cooperative patient role (Rothman, 1978) and accepted the dominant profession's separation of birth experience from

physician practices, leaving the core of physician practices essentially uncriticized.

In contrast, the client revolt, embodied in the home birth movement, sought to deprofessionalize the work of birth attendance and to deinstitutionalize the event of birth in an attempt to circumvent physician hegemony and augment the laity's autonomy. They reconceptualized the process of pregnancy, labor and birth (seeing them as normal processes) and attempted to gain individual expertise to manage them, thus challenging physician's claims to cognitive exclusivity. The client revolt, if uncontained, presented the threat of market collapse, but more immediately, it presented challenges to the traditional professional-client relationship. Clients in revolt not only attempted to manage their interactions with professionals, but also gave rise to yet another competitor for physician's turf: the lay-midwife.

During the period of study (1970-1980) this new work, lay-midwifery, began to emerge in Vermont as a distinct occupational collectivity. While lay-midwives espoused the movement ideology of deprofessionalization, they simultaneously sought state acknowledgement of minimum standards of care and training via licensing. The state legislature pondered legitimizing a realm of practice outside that which medicine monopolized; this shows the extent to which medicine's claims were being questioned.

Lay-midwives' efforts to obtain licensure for their

practice was both a response to physician efforts to eliminate them and an outgrowth of the problem of a new occupation attempting to claim expertise but having only local reputation to indicate efficacy and reliability. Unless practitioners acquire some external vehicle for the indication of their capabilities, they are unable to distinguish themselves from inept competitors (Larson, 1977). In Vermont, since educational credentialing was unavailable, lay-midwives and their supporters sought state enforcement of minimum standards of training and skill.

Like early nurse-midwifery, lay-midwives had low-incomes and low occupational status. However, unlike early nurse-midwives, they were hounded by physicians who sought to eliminate them and their challenge to professional expertise. The dominant profession attempted to establish a "radical monopoly" (Illich, 1976) on its market by claiming as its domain each pregnancy and birth among its desired clientele and attempting to coerce that clientele to consult it.

While lay-midwives were attempting to acquire a state-sanctioned mandate for work in the newly developing market of home birth, the dominant profession began to respond to the movement for lay-intervention and the client revolt. Not surprisingly, the client revolt had the effect of making cooperative birth reform more attractive to many physicians and hospitals. However, segments within the dominant profession responded differently, suggesting their own different

and sometimes conflicting trajectories.

With some exceptions, two major segments of the medical profession could be distinguished in Vermont. Conservative physicians (the majority group) were those who most explicitly shunned lay-intervention. They were colleague-oriented physicians attentive to professional standards of practice, who worked in group practices associated with larger hospitals. Progressive physicians in contrast, were more client-centered in their practices, and thus more oriented to reform. Family practitioners in solo or small-group practices associated with smaller hospitals typified this minority segment.

Many conservative physicians spoke out against the home birth movement. However, the behavior of the state legislature soon indicated that professional efforts to eliminate the laity's right to self-care would serve only to further delegitimize the medical profession. Instead, these physicians attempted to use their professional power and authority to retain control of the entire obstetrical work terrain, delegitimizing self-care in the process.

Conservative physicians had difficulty maintaining control of the division of labor outside the hospital. However, they were able to exert some control by restricting access to the hospital, (for example, withdrawing hospital privileges from deviant medical workers or blocking lay-midwives from entering the hospital with their clients). Outside their institutional base, conservative professionals attemtped to use the state to inhibit competition. While they were instrumental

in bringing civil or criminal charges against lay-midwives for bad birth outcomes, they were unable to outlaw the practice of lay-midwifery while the client revolt was mobilized. Using the state professional association, conservative physicians inhibited progressive physicians' and other health workers' association with home birth. Potentially deviant health workers who were conservative physicians' or hospital employees were held in check by the threat of loss of employment. Here, as elsewhere (cf. Freidson, 1970a; Jones, 1981) professional regulation served the interests of dominant and conservative segments of the profession.

However, in a system centered around a dominant profession, these progressive segments are able to significantly augment lay-intervention, client-centered reforms and/or client revolts. The case of Vermont provided an example of the impact of progressive physicians and their varied strategies for support of fundamental birth reform and home birth.

While conservative physicians at UH/RMC embarked on the restricted institution of provider-oriented birth reform, obstetricians at NCCH avoided all but the most obligatory reforms necessitated by competition from other hospitals. At SCCH, a physician who had aligned himself with the client revolt and lay-midwifery eventually succumbed to the pressures associated with his deviance and returned to exclusive hospital practice. However, he continued his alliance with the client-revolt from within the institution. The hospital's

deteriorating market position had made the significant and relatively inexpensive reforms he advocated both more attractive and more necessary. They were successful; the hospital's market share increased considerably.

The mixed medical response to client-oriented reform movements and the client revolt had a significant impact on the development of both nurse-midwifery and lay-midwifery. While conservative physicians attempted to eliminate both lay-midwifery and an independent market for midwifery services, the communicated to nurse-midwives the fact that any overt involvement in this market would result in loss of employment. Nurse-midwives recognized that however attractive they found home birth, independent practice was fraught with problems and drawbacks. While independent nurse-midwifery practice was not illegal in the state and one CNM undertook it, it was inhibited by laws designed by and for the dominant profession, (for example, third-party payment structures). Nurse-midwives realized that outside the "team" they would face physician opposition similar to that faced by lay-midwives.

Furthermore, birth reform, both conservative and progressive, drew a significnat portion of the home birth movement into the hospital, substantially diminishing the potential growth of the market for independent midwifery services. Physician-sponsored hospital reform was much more effective at turning back the client-revolt than physician opposition had been. The client revolt was increasingly reduced to its

core membership--and in Vermont that core was more a counter or sub-culture than a social movement; this core clientele continued to be served by lay-midwives.

Meanwhile, nurse-midwifery began to locate a distinct market within their hospital practice. It consisted of a clientele seeking an altered client-professional relationship and was drawn from both the periphery of the home birth movement and prepared parents whose expectations were raised by childbirth educators. However, the primary vehicle for nurse-midwifery referrals was a system of friendship communication networks in the lay-referral system.

In small, partnership-like practices with progressive physicians, nurse-midwives were granted substantial autonomy almost from the outset, but in a large group practice such as that found in the university teaching hospital, they had to actively negotiate with physicians in an effort to locate and monopolize turf. In these negotiations, their supportive clientele was their key resource (Kronus, 1976). In this context, their monopolized tasks were either bundles of tasks passed down from physicians (and codified in the protocols) or newly created turf: the birthing room and reform-oriented births. Their claims to special contribution to care-giving began to emphasize their client-orientation (distinguishing them from physicians) and their training which enabled them to manage normal births (distinguishing them from nurses).

Conclusion

Nurse-midwifery's newly constructed market, which was largely created by external forces, remains inherently subordinate. As long as nurse-midwives are structurally subordinate to another profession which mediates the occupation's relationship with its clientele, nurse-midwives will never emerge as an autonomous profession.

There are several collective strategies available to nurse-midwifery, some of which are being undertaken nationally. Nurse-midwives may attempt to use this period to entrench in their hospital turf and consolidate the power and limited automony they have already achieved. The occupation may embark on an ambitious campaign to undermine professional hegemony by challenging physicians' restraint of trade in the courts and legislatures. This would involve competition with physicians on their own turf. Finally, nurse-midwives may ally themselves with client/revolt, and seek to expand the existing market for independent midwifery services. In this strategy, they may either attempt to edge out lay-midwives, or they may formally ally with them, altering once again the function of and market for nurse-midwifery. Both nationally and in Vermont the conservative strategy of entrenchment seems to predominate at this time, though the other strategies are also being pursued by segments of the occupation.

APPENDICES

Appendix A

Interview Schedule

I will ask you a series of questions about nurse-midwifery, lay-midwifery childbirth, obstetrical practices and the social, professional and "political" relationships among various groups. I will also ask you for some information about yourself and your opinions. If a question is unclear or off the mark, feel free to let me know.

What is your occupation?
If it is associated with childbirth, what is your education/training?
Degrees; Certification; License
Source of training
Length of training
Nature of training (classroom, clinical, apprenticeship, etc.)
Location of training (nursing graduate school, nursing school, physician's office, hospital, U.S., or foreign).
What did you do before you became a (Nurse/Lay Midwife, Ob/Gyn, Childbirth educator, etc.)?
Do you have any children?
Where were they born?
Any comments about their births?
How old are you?
Do you belong to any organizations associated with your work and/or associated with childbirth? Which ones?
Are you actively involved in these organizations and/or other actions having to do with childbirth? If so, why? If not, why not?

Birthing Practices and Birthing Options in Vermont

In your view, what birthing options are currently available to the average birthing woman in Vermont?
Are there more options available to the informed consumer?
Have these changed in the last 5-10 years? If so, how?
In your view, what birthing options <u>should</u> be available to women in Vermont? Why?
What are the current typical obstetrical practices in Vermont? (e.g., C-section rates, fetal monitor use, father/coach in delivery room, episiotomies).
Have there been noticeable changes in obstetrical practices in Vermont in the last ten years or so? Do these practices vary by physician, locale, income of the patient, etc.?
What is the typical cost of an obstetrician-attended hospital delivery?

continued -- Appendix A

What is a birthing room?
Who staffs them?
In what positions do women give birth in them?
In what settings do NMs (LMs) attend births in Vermont?
In what settings should NMs (LMs) attend births in Vermont?
(Do LMs and NMs have a de facto division of labor?)
How would you compare childbirth in birthing rooms with typical hospital births? (What makes it similar/different?)
How would you compare birthing rooms with birthing centers? (What makes it similar/different?)
How would you compare birthing rooms/birthing centers with home birth? (What makes it similar/different?)
Would you characterize Home Birth and Hospital Birth/Birthing Rooms as: Complementary; Competitive; Contradictory?
Would you characterize NMs and LMs as: Complementary; Competitive; Contradictory?
Is the setting of the birth a determining factor in the nature of the birth.
Is the birth attendant (and philosophy/training) a determining/key factor in the nature of the birth?
What percentage of the Vermont population is capable of having a successful home birth? Explain.
What percentage will probably choose a home birth?
How do you feel about the choice to have a home birth?
Some articles in the medical literature specifically suggest birthing rooms in hospitals as the safe and proper solution to the home birth movement. How do you feel about this? Do you hear this argument presented in Vermont?
Why do some people choose to give birth at home?
Why do some people choose to give birth in birthing rooms?
Why do some people choose (traditional) hospital deliveries?
Does the medical community's attitudes toward birth setting affect people's decisions in this regard? Media?

Nurse-Midwifery

Why do people choose to become nurse-midwives?
Has the status and practice of nurse-midwifery changed with its closer association with team practice in hospitals?
What are NMs' expectations for practice? Are they being met? Reality shock?
NMs are structurally placed in the middle of change in obstetrical practices and the contest about the future of childbirth practices. Do you feel the pressure of this?
(How) will changes in the practice and status of NMs affect their ability to professionalize (turf/autonomy/special contribution/etc.)?
In your view, what is the future of Nurse-Midwifery in Vermont? In the United States? What is the future of Lay-Midwifery? The home birth movement?

continued --Appendix A

Nurse-midwives and Lay (Independent) Midwives in Vermont

What is the legal status of the nurse-midwife in Vermont? (LMs)
How long have NMs (LMs) practiced in Vermont?
Has their status changed in the last 10-15 years?
What is the role of the Nurse-midwife (LM) in current practice in Vermont?
What is her relationship to obstetricians? To General Practitioners? (How) has this changed? (work organization and larger professional relations)?
In your view, what should be the role of the nurse-midwife (lay-midwife) in Vermont?
Do Nurse-midwives have a special or unique contribution to make to the care of pregnant and birthing women? (Lay-Midwives).
Where do nurse-midwives (LMs) work?
What do they do at work?
What percentage of their time is devoted to: attending births; prenatal care; post-natal care?
How does this compare with obstetricians; general practitioners; family nurse practitioners?
How is the nurse-midwife (lay midwife) compensated?
How much is she compensated?
Who does the nurse-midwife (LM) work for?
Do nurse-midwives work in teams with other health care providers? Explain. (LMs)?
If so, what is the structure of these teams and how do they operate (no pun)? e.g., physician-led; democratic; autonomous but cooperative, etc.
Is this a desirable structure?
Do nurse-midwives work or cooperate formally or informally with: other birth attendants? medical practitioners? childbirth educators? other health-promoting groups?
Is there a difference between nurse-midwives and Obs in their philosophy of childbirth? Explain. (e.g., their relationship with the pregnant or birthing woman, attendant's role in childbirth, in the coach/partner's role?)
How do you (NMs, LMs) feel about the critique sometimes made about hospital birth being too mechanistic and insensitive?
How do you (NMs, LMs) feel about the critique sometimes made about hospital birth that it produces unnecessary risk and intervention?
Do NMs and LMs serve different populations? (e.g., income, education, region)

Birth Setting

Are birthing rooms available in Vermont hospitals or clinics? (other reforms if not already mentioned, otherwise, restate, you said that....) What is the criteria for use/access to alternative?
Who instituted these reforms/options? How?

continued -- Appendix A

What is the relationship of NMs to nursing in general? Other nursing specialties?
In your view, what does the future hold for obstetrical practice in Vermont and the relationship of Nurse-Midwifery to obstetrics?
As a NM (LM) do you find your work (role) satisfying? What (if anything) would you change?
These are all my questions. Do you have any comments? Who else should I talk with?

Appendix B

AMERICAN COLLEGE OF NURSE-MIDWIVES

1012 Fourteenth Street, N.W., Suite 801, Washington, D. C. 20005 202/347-5445

PHILOSOPHY

AMERICAN COLLEGE OF NURSE-MIDWIVES

The Philosphy of the American College of Nurse-Midwives is based on the beliefs that:

Every childbearing family has a right to a safe, satisfying experience with respect for human dignity and worth; for variety in cultural forms; and for the parents' right to self determination.

Comprehensive maternity care, including educational and emotional support as well as management of physical care throughout the childbearing years, is a major means for intercession into, and improvement and maintenance of, the health of the nation's families. Comprehensive maternity care is most effectively and efficiently delivered by interdependent health disciplines.

Nurse-midwifery is an interdependent health discipline focusing on the family and exhibiting responsibility for insuring that its practitioners are provided with excellence in preparation and that those pratitioners demonstrate professional behavior in keeping with these stated beliefs.

Adopted, 1972

FUNCTIONS, STANDARDS AND QUALIFICATIONS

Qualifications for the Practice of Nurse-Midwifery

1. Certification by the American College of Nurse-Midwives

   a. Active licensure as a registered nurse in one of the 50 states or Territories including the District of Columbia

   b. Completion of a nurse-midwifery educational program approved by the American College of Nurse-Midwives

2. Compliance with legal requirements of the jurisdiction in which nurse-midwifery practice will occur

FUNCTIONS, STANDARDS AND QUALIFICATIONS

Standards for the Practice of Nurse-Midwifery

Nurse-Midwifery practice:

1. Strives to provide continuity of care to the woman and her family during the maternity cycle, continuing interconceptionally throughout the childbearing years.

2. Fosters the delivery of safe and satisfying care.

3. Recognizes that childbearing is a family experience and encourages the active involvement of family members in care.

4. Upholds the right to self-determination of consumers within the boundaries of safe care.

5. Focuses on health and growth as developmental processes during the reproductive years.

6. Stimulates community awareness and responsiveness to the needs for delivery of quality family-centered care.

7. Occurs interdependently within a health care delivery system.

8. Occurs within a formal written alliance with an obstetrician; or another physician, or a group of physicians, who has/have a formal consultative arrangement with an obstetrician-gynecologist.

9. Exists within a framework of medically approved protocols.

10. Occurs within the realm of professional competence.

11. Requires opportunities for continuing professional growth and development.

12. Includes an on-going process of evaluation.

Functions for the Practice of Nurse-Midwifery

The Nurse-Midwife:

1. Assumes responsibility for the management and complete care of the essentially healthy woman and newborn related to the childbearing processes.

2. Develops with the woman an appropriate plan of care attentive to her interrelated needs.

3. Participates in individual and group counseling and teaching throughout the childbearing processes.

4. Manages, through mutual agreement and collaboration with the physician, that part of care of medically complicated women which is appropriate to the skills and knowledge of nurse-midwives.

FUNCTIONS, STANDARDS AND QUALIFICATIONS

Functions for the Practice of Nurse-Midwifery - Continued

5. Collaborates with other health professionals in the delivery and evaluation of health care.

6. Assesses own professional abilities and functions within identified capabilities.

7. Assumes responsibility for own self-determination within the boundaries of professional practice.

8. Maintains and promotes professional practice in concert with current trends.

9. Refers to Guidelines for Evaluation of Nurse-Midwifery Procedural Functions in Development and evaluation of practice (Appendix A).

10. Promotes the preparation of nurse-midwifery students.

11. Assists with the education of other health care personnel.

12. Supports the philosophy and official policies of the American College of Nurse-Midwives.

Accepted, 1975

APPENDIX A

GUIDELINES FOR EVALUATION OF NURSE-MIDWIFERY PROCEDURAL FUNCTIONS

The following guidelines were adopted by the Executive Board of the American College of Nurse-Midwives as a way of approaching the clinical practice of the nurse-midwife. Practice is continually evolving and it varies depending upon the institution and the demands for service within each setting. Because of this, the nurse-midwife may frequently be in a position of having to evaluate a new function for possible inclusion into her practice. This need for evaluation may be stimulated by the obstetrician, the demands of the patient or community, pressure from other groups, or desires of the nurse-midwife herself. In any case, the answer as to the worth and safety of a new procedure for inclusion into nurse-midwifery may not be clear.

No one of these guidelines can stand alone. It is only be employing each of them and then surveying the whole that an accurate feeling for the safety and suitability of the procedure for nurse-midwifery practice can be obtained. Guidelines help to direct but they do not necessarily guarantee that the direction will be completely clear. Systematic review of new procedures will help to assure that the F.S. & Q. statements are up to date.

1. The procedure assists the nurse-midwife in managing the care of the normal childbearing woman and infant.

   a. It does not conflict with the basic philosophy of nurse-midwifery as out-

APPENDIX A - Continued

GUIDELINES FOR EVALUATION OF NURSE-MIDWIFERY PROCEDURAL FUNCTIONS - Continued

lined by the ACNM and with that outlined by the nurse-midwifery service.

b. The procedure can be done competently by the nurse-midwife, i.e., the practitioner has obtained sound theory and supervised clinical experience from qualified faculty.

c. The nurse-midwife is prepared to handle possible complications from the procedure until help arrives.

2. The procedure is within accepted obstetrical practice within the institution.

a. It is presently an established procedure.

b. It is a new procedure that is being instituted by the obstetric service.

3. The procedure fills a demonstrated need.

a. There is consumer demand.

b. Within the obstetric team it is appropriate that the nurse-midwife carry out the procedure.

c. The nurse-midwife feels the procedure will contribute to the provision of optimal care.

4. The procedure is evaluated in the literature and/or in practice.

a. The literature has been reviewed with both indications and contraindications identified.

b. There is consideration of what other institutions and other nurse-midwives are doing.

5. The procedure is within legal limits.

6. There is an on-going plan for the evaluation of the procedure.

a. The plan is filed with the Clinical Practice Committee at the time of initiation of the procedure.

b. Progress reports are periodically submitted to the Clinical Practice Committee.

The Committee requests that if a nurse-midwifery service or a nurse-midwife intends to initiate a new procedure, the Clinical Practice Committee be notified. This will enable the Committee to record changes in practice throughout the United States and will also facilitate the dissemination of information of nurse-midwifery practice. It is hoped that periodic reports to the Committee will be made which are evaluative and in summary form. The collection of this type of data is important to the development of nurse-midwifery and will provide a resource for other services which may be considering the initiation of the same procedures.

Accepted January 27, 1972
Revised, 11/77 and 2/79

AMERICAN COLLEGE OF NURSE - MIDWIVES

1000 Vermont Avenue, N.W., Washington, D.C. 20005 202/628-4642

ACNM STATEMENT ON HOME BIRTH

The American College of Nurse-Midwives considers the hospital or maternity home as the preferred site for childbirth because of the distinct advantage to the physical welfare of mother and infant. Where home births are indicated, the obstetric team must develop guidelines which will ensure the safety of mother and infant. We encourage the members of the obstetric team in all settings to meet the personal needs of childbearing families by combining a family centered atmosphere with the safety of readily available obstetrical resources, including the physician.

*Second Edition

*First Edition Adopted by the ACNM Executive Board 1973

*Second Edition Adopted by the ACNM Membership 1976

AMERICAN COLLEGE OF NURSE-MIDWIVES

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POSITION STATEMENT ON NURSE-MIDWIFERY LEGISLATION*

PREAMBLE

The patterns of health laws in the United States vary widely and are changing rapidly. The complexity of this situation presents a barrier to the optimal growth and development of nurse-midwifery due to serious ambiguities in the legal base for practice. The American College of Nurse-Midwives (ACNM) has received increasing demands from the public and from professional organizations for recommendations on legislation. The following position statement is a result of the desire of ACNM to respond to these demands.

BELIEFS

The ACNM believes that accessibility to comprehensive care is the right of all persons. Certified nurse-midwives have demonstrated that they are capable of making significant contributions in provision of this care. The ACNM believes that legislation which regulates the practice of the profession of nurse-midwifery should be so designed that it promotes and protects the health and welfare of the public. To achieve these objectives nurse-midwives must collaborate with other groups which share their primary concern of quality maternal and infant health care for all population groups.

STATEMENT

A nurse-midwife who is currently certified by ACNM is qualified to practice nurse-midwifery throughout the United Stated and its jurisdictions.

The American College of Nurse-Midwives, as the recognized authority governing nurse-midwifery practice is responsible for:

certification of nurse-midwives,

establishment of qualifications, standards, and functions for the practice of nurse-midwifery,

approval of nurse-midwifery educational programs,

development of guidelines for nurse-midwifery services, and

development of guidelines for continuing education of nurse-midwives.

Separate statutory recognition is recommended as the basis for nurse-midwifery practice. To the extent possible, this legislation should be uniform throughout the United States and its jurisdictions. Until such legislation is enacted, nurse-midwives may practice under a variety of legal arrangements.

Nurse-midwives should be involved in the policy making process of those regulatory bodies which administer and/or influence the practice of nurse-midwifery. Nurse-midwives who act in these capacities should be representative of and accountable to the practicing nurse-midwives within their respective areas.

Information and consultation on legislation pertaining to nurse-midwifery is available through the American College of Nurse-Midwives.

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*Prepared by the ACNM Legislation Committee based upon recommendations from participants in the ACNM Workshop on the Legal Status of Nurse-Midwifery, held in Cincinnati, Ohio, June 14-15, 1974.

Approved by Board of Directors, July 30, 1974.

Additional copies available upon request.

Appendix C

JOINT STATEMENT
ON
MATERNITY CARE (1971)
AND
SUPPLEMENTARY STATEMENT (1975)

The American College of Nurse-Midwives
The American College of Obstetricians and Gynecologists
The Nurses Association of The American College
of Obstetricians and Gynecologists

JOINT STATEMENT ON MATERNITY CARE (1971)

The American College of Obstetricians and Gynecologists, The Nurses Association of The American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives recognize the increasing needs for general health care and, more specifically, the deficits in availability and quality of maternity care. The latter, which are not confined to any social class, can best be corrected by the cooperative efforts of teams of physicians, nurse-midwives, obstetric registered nurses and other health personnel. The composition of such teams will vary and be determined by local needs and circumstances. The functions and responsibilities of team members should be clearly defined according to the education and training of the individuals concerned.

To achieve the aims of providing optimal maternity care for all women the following recommendations are made:

1. The health team organized to provide maternity care will be directed by a qualified obstetrician-gynecologist.

2. In such medically-directed teams, qualified nurse-midwives may assume responsibility for the complete care and management of uncomplicated maternity patients.

3. In such medically-directed teams, obstetric registered nurses may assume responsibility for patient care and management according to their education, training and experience.

4. In such medically-directed teams, other health personnel who have been trained in specific areas of maternity care may participate in the team functions according to their abilities and within the definitions of responsibility established by the team.

5. Written policies describing the specific functions of each of the team members should be prepared. They should be reviewed and revised periodically according to changing needs.

In endorsing the above statement, The American College of Obstetricians and Gynecologists, The Nurses Association of The American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives recognize as their common goal the need for improvement and expansion of health services now being provided for women.

In order to maintain a continuing evaluation of the health services being provided for women and to plan for needed improvements and expansion, a mechanism for continued communication between all the organizations responsible for their provision is being developed.

1-14-71

SUPPLEMENTARY STATEMENT (1975)

Many questions have arisen concerning the meaning of the recommendation in the Joint Statement on Maternity Care (1971) that the health care team be "directed by a qualified obstetrician-gynecologist." These questions are justified and are accentuated by other developments in the specialty of obstetrics-gynecology which include the changing birth rate, formalization of new roles for personnel, emphasis on preventive care, HMO's, plans for national health insurance, PSRO, and regionalization of health services.

It is recognized that the obstetrician-gynecologist cannot under all circumstances be physically present to direct the health team; therefore it is essential that mechanisms of communication be clearly established for him or her to provide direction. Thus, the nature of the direction of the health team indeed becomes crucial.

"The obstetrician-gynecologist working within a team giving health care to women has many responsibilities. These range from the direct provision of services to community health efforts and include:

a. The supervision of the medical care provided by all team members.

b. The direct provision of care for complications of pregnancy and for complex medical and surgical gynecological conditions.

c. The setting of medical care standards.

d. The provision of consultation to other team members.

e. The surveillance of task distribution within the team.

f. Participation in the ongoing educational activities of the team.

g. The introduction of new medical techniques as they become available.

h. The development of medical research."[1]

In view of the diversity of health care systems in which the obstetric-gynecologic health team currently functions, no universal systems model can be applied. Generally, however, the team is found in the following broad contexts:

1. Urban (intramural, on site, immediate referrals);

2. Rural (with institutional affiliation);

3. Rural (without institutional affiliation but with obstetric consultation available);

4. Private office (urban or rural).

The logistics of consultation and referral may vary with geographic and climatic conditions, but the following basic principles of team interaction are valid regardless of these conditions:

1. There must be a written agreement among members of the team clearly specifying consultation and referral policies and standing orders. The representatives of each practice discipline should participate in the development of and be signatory to the agreement.

2. The obstetrician-gynecologist, upon signing protocols, must accept full responsibility for direction of medical care rendered by the team in accordance with his or her orders.

3. In circumstances wherein the functions of the team leader are necessarily performed by physicians without specialty training in obstetrics-gynecology, medical direction should be provided through a formal consultative arrangement with a qualified obstetrician-gynecologist who is available to team members for continuing consultation and assurance of quality care.

[1]From "Medical Practice in the Obstetric-Gynecologic Health Care Team," Interorganizational Committee on Ob/Gyn Health Personnel, September, 1973.

8-1-75

Appendix D

SARAH W. FERRIS
Executive Director

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STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

POLICY STATEMENT OF THE BOARD OF MEDICAL PRACTICE

CONCERNING PHYSICIAN SUPERVISION OF MEDICAL CARE DELIVERY

The Board of Medical Practice is charged with the responsibility of regulating the practice of medicine in Vermont to ensure that the citizens of the state receive the best health care possible. Health care delivery has become complex, involving not only medical doctors and hospitals, but also a host of other health care providers and delivery systems. The Board recognizes the value of these other providers working with the physicians in the practice of medicine in this state.

"Medical practice" includes the diagnosis and treatment of disorders of health; curing or alleviating disease, bodily injuries, or physical or nervous ailments; prescribing, advising, or giving to any person any drug, medicine, or agent for the treatment of such infirmities; and the provision of certain preventive and well care services. Unless specifically assigned under the law to another regulatory authority, the performance of any medical acts which are the province of the professional practice of medicine shall come under the purview of the Board of Medical Practice.

Any non-physician offering medical services, except in emergencies, with or without fee, must be properly licensed or registered and practice in areas specifically delegated by a responsible supervising physician.

Medical acts may only be performed by, or at the direction of a licensed physician. Physicians' assistants must be employed in the practice of and supervised by licensed physicians who specifically delegate defined areas of medical practice to these individuals and supervise their performance. Any physician who agrees to a relationship with a physician extender without a formalized written agreement will be considered to be engaged in a practice of medicine which is not consistent with the standards of medical care established in this state.

There is no law at the present time which acknowledges or regulates midwifery. The Board considers the provision of pernatal care, conduct of labor and delivery and post partum services to mother and child to be the practice of medicine, the province of a specialty within the profess. practice of medical doctors for over a century.

Any non-physician offering such services, with or without fee, except in emergencies, must be properly registered or licensed as a physician's assistant or nurse practitioner and practicing in areas specifically delegated by a responsible supervising physician. This physician must have appropriate skills in obstetrics and must take full responsibility for all aspects of the midwifery practice.

In adopting this policy, the Board of Medical Practice hopes to ensure the very best quality of health care delivery for the people of the State of Vermont.

October, 1980
Montpelier

Appendix E

NO. 192. AN ACT TO ADD 26 V.S.A. CHAPTER 28 AND TO REPEAL 26 V.S.A. CHAPTER 27 RELATING TO NURSING.

CHAPTER 28. NURSING

§ 1571. PURPOSE AND EFFECT

In order to safeguard the life and health of the people of this state, no person shall practice, or offer to practice, professional or practical nursing unless registered and currently licensed under this chapter.

§ 1572. DEFINITIONS

As used in this chapter:

(1) "Board" means the Vermont state board of nursing.

(2) "Professional nursing" or the "practice of professional nursing" means the performance of services requiring substantial specialized knowledge, judgment and skill for carrying out the nursing regimen based upon the principles of the biological, physiological, behavioral and social sciences in the:

(A) Observation, assessment, problem identification, care or counsel, and health teaching of the ill, injured or infirm, or in the maintenance of health or prevention of illness of others;

(B) Administration, supervision, delegation and evaluation of nursing practice;

(C) Teaching of nursing;

(D) Execution of a medical regimen as delegated by a licensed physician or licensed dentist who need not be physically present; or

1

(E) Performance of such additional acts requiring education and training and which are recognized jointly by the medical and nursing professions as proper to be performed by registered and licensed professional nurses.

(3) "Practical nursing" or "the practice of practical nursing" means the performance of services requiring the specialized knowledge, skill and judgment necessary for carrying out selected aspects of the designated nursing regimen at the direction of a licensed registered professional nurse, licensed physician or licensed dentist in:

(A) Health teaching and health counselling;

(B) Provision of care which is supportive or restorative to life and well-being directly to the patient or through supervision of nursing assistants; or

(C) Execution of a medical regimen at the direction of a licensed physician or licensed dentist, who need not be physically present.

(4) "Nursing regimen" means, in the context of the practice of professional nursing, a systematic therapeutic plan to carry out nursing practice as defined in this chapter.

(5) "Medical regimen" means, in the context of the practice of professional or practical nursing, that aspect of care which implements the medical plan as prescribed or delegated or directed by a licensed physician or licensed dentist.

(6) "Registered" means having met all requirements for initial licensure to practice nursing in

this state. Once granted, a registration need not be renewed under this chapter.

(7) "Licensed" means holding a current authorization to practice nursing as a professional nurse or practical nurse in this state. A license shall be subject to renewal under this chapter.

(8) "Examination" means a licensing examination.

§ 1573. VERMONT STATE BOARD OF NURSING

(a) There is hereby created a Vermont state board of nursing consisting of four professional nurses, two practical nurses, and two public members all of whom shall be appointed by the governor. The present members of the board holding office under this chapter on July 1, 1980, shall serve until the expiration of their respective terms. Thereafter, all appointments shall be for terms of three years or until their successors have been duly appointed. No person shall be eligible for more than one reappointment.

(b) Appointments of professional and practical nurse members shall be made in a manner designed to be representative of the various types of nursing education programs and nursing services.

(c) Each member of the board shall be a citizen of the United States, and a resident of this state.

(1) The professional nurse members shall:

(A) Hold a license to practice professional nursing in Vermont;

(B) Have at least five years' experience in the practice of professional nursing. Three of these

five years shall have been immediately preceding appointment.

(2) The practical nurse members shall:

(A) Hold a license to practice practical nursing in Vermont;

(B) Have at least five years' experience in the practice of practical nursing. Three of these five years shall have been immediately preceding appointment.

(3) The public members shall not be members of any other health-related licensing boards, licensees of any health-occupation boards, or employees of any health agencies or facilities, and shall not derive primary livelihood from the provision of health services at any level of responsibility.

(d) Any vacancy occurring on the board shall be filled for the unexpired term by appointment to be made by the governor.

(e) Each member of the board shall be entitled to reimbursement for necessary and actual expenses incurred while engaged in the discharge of official duties and compensation in the amount of $30.00 for each day of official duties.

§ 1574. POWERS AND DUTIES

The board shall:

(1) Hold annual meetings at which it shall elect a chairperson, a vice-chairperson and a secretary-treasurer from its members; and hold such other meetings as may be deemed necessary to transact its business;

(2) Conduct business at any meeting only if five members are present to constitute a quorum; and keep a record of its proceedings which shall be a public record;

(3) Prescribe standards for educational programs preparing individuals for registration and licensure under this chapter and approve such nursing education programs in Vermont as meet the requirements of this chapter and board rules;

(4) Establish standards for registration and licensure of individuals for the practice of nursing, including nurse practitioners and those in special areas of nursing practice which require additional education and training;

(5) Examine, register, license and renew the licenses of duly qualified applicants and keep a record of all persons registered by this state, all persons currently licensed as professional nurses and practical nurses, and all persons meeting standards which may be established in defined special areas of nursing practice;

(6) Provide standards for and approve training programs for the benefit of nurses who are reentering practice following a lapse of five or more years;

(7) Investigate complaints and charges of unauthorized practice, unprofessional conduct or incompetency against any person and take proper action under sections 1582 or 1585 of this title, as the case may be;

(8) Adopt rules under the administrative procedures act which may be necessary for the implementation of this chapter.

§ 1575. EXECUTIVE OFFICER; STAFF

(a) The board may appoint a qualified person, who shall not be a member of the board, to serve at the pleasure of the board as an executive officer, and with the approval of the governor, fix the compensation of the executive officer. The executive officer shall be a graduate of an approved school of nursing and hold a master's degree with preparation in nursing administration and education; shall have at least five years experience in nursing administration, or teaching; and have been active in nursing for at least three years immediately preceeding appointment.

(b) With the approval of the secretary of state, the board may employ or contract for such other persons as may be necessary to carry on the work of the board. Such persons may be exempt from the classified service.

§ 1576. PROFESSIONAL NURSE AND PRACTICAL NURSE REGISTRATION AND LICENSURE

(a) Qualifications of applicants.

An applicant for registration and a license to practice professional or practical nursing shall submit to the board evidence deemed satisfactory to it that the applicant has completed all requirements in an approved nursing education program preparing individuals for the practice of either profess-

ional or practical nursing, or has received equivalent practical nursing education and training.

(b) Registration and licensure by examination.

(1) The applicant shall be required to pass a written examination in such subjects as the board considers necessary to determine the ability of the applicant to practice professional or practical nursing.

(2) Upon passing the required examination, the board shall register and issue to the applicant a current license to practice as a registerd nurse (R.N.) or a licensed practical nurse (L.P.N.).

(3) The board shall hold at least one examination annually for professional nurse candidates and one for practical nurse candidates at such place and at such time as the board shall determine.

(4) Any qualified applicant shall be entitled to re-examinations.

(c) Registration and licensure by endorsement.

The board shall register and issue a current license to practice professional or practical nursing to an applicant who has been duly licensed by examination as a registered nurse or a practical nurse under the laws of another state, territory, or foreign country if the applicant meets the qualifications required in this state and has previously achieved passing scores on the licensing examination required in this state or its equivalent as determined by the board, and has practiced nursing within the past five years.

§ 1577. FEES

(a) The board shall establish fees which shall not exceed:

(1) $40.00 for initial registration and licensure;

(2) $25.00 for renewal of licenses.

(b) Fees for examination shall be established under section 114(e) of Title 3.

§ 1578. EXISTING LICENSES

Any person registered or licensed to practice professional or practical nursing by the board on or before July 1, 1980 shall retain all rights and privileges granted thereunder as if registered or licensed under this chapter.

§ 1579. RENEWAL OF LICENSE

(a) Licenses shall be renewed by the board for periods of up to two years according to a schedule for renewal established under section 114(c)(5) of Title 3.

(b) Any registrant who has held a valid license and practiced nursing within the past five years may apply for renewal without further examination or qualifying requirements not otherwise imposed on current licensees.

(c) All applicants for renewal of a license to practice shall have practiced nursing within the last five years as defined in section 1572 of this title or comply with the requirements for updating knowledge and skills as defined by board rules.

§ 1580. DISPOSITION OF FUNDS

(a) All fees received by the board and monies collected under this chapter shall be paid into the general fund of the state.

(b) The board shall submit a proposed budget to the secretary of state who shall prepare a separate budget for the board. The secretary of state's budget for the board shall be submitted together with the board's proposed budget to the governor for review, amendment and submission to the general assembly.

§ 1581. NURSING EDUCATION PROGRAMS

(a) A post-secondary educational institution within the state of Vermont desiring to conduct a nursing education program to prepare professional or practical nurses shall apply to the board and submit evidence that:

(1) It is prepared to carry out a professional nursing curriculum or a curriculum for practical nursing;

(2) It is prepared to meet such other standards as shall be established by this chapter and by the board.

(b) Upon application, a survey of the institution and its entire nursing education program shall be made by the board and its executive officer. A written report of the survey shall be submitted to the board and the institution being surveyed. If, in the opinion of the board, the requirements for an approved nursing education program are met, it shall be approved.

(c) From time to time as deemed necessary by the board, it shall be the duty of the board to survey all nursing education programs in the state. If the board determines that any approved nursing education program is not maintaining the standards required by the statutes and by the board, notice thereof in writing specifying the defects shall be immediately given to the nursing education program and the controlling institution. If the controlling institution receiving the notice fails within a year after receipt of the notice to correct the specified defects, its authority to conduct a nursing education program may be revoked by the board. A controlling institution may, at any time before the expiration of one year from the date it receives the notice, demand and shall be granted a hearing before the board. In that case, the board shall not take action until after the hearing.

§ 1582. REGULATORY AUTHORITY

(a) The board may deny an application for registration, licensure or relicensure; revoke or suspend any license to practice nursing issued by it; discipline or in other ways condition the practice of a registrant, or licensee upon due notice and opportunity for hearing in compliance with the provisions of chapter 25 of Title 3, if the person:

(1) Has made or caused to be made false, fraudulent or forged statement or representation in procuring or attempting to procure registration or renew a license to practice nursing;

(2) Is convicted of a crime or felony relating to the practice of nursing as defined in this chapter;

(3) Is unable to practice nursing competently by reason of any cause;

(4) Has wilfully or repeatedly violated any of the provisions of this chapter;

(5) Is habitually intemperate or is addicted to the use of habit-forming drugs;

(6) Has a mental, emotional or physical disability, the nature of which interferes with ability to practice nursing competently; or

(7) Engages in conduct of a character likely to deceive, defraud or harm the public.

(b) Proceedings.

(1) Any person may prefer charges setting forth a violation of this chapter. The board may also on its own motion prefer charges based upon its investigation and reasonable belief that unprofessional conduct has occurred. Charges against a person shall be in writing and shall set forth the particulars of the claimed misconduct and shall be filed with the executive officer of the board;

(2) The board may dismiss the charges without hearing by a majority vote of its members but shall retain a written record of its reasons;

(3) The time and place of a hearing shall be fixed by the executive officer of the board and a copy of the charges, together with a notice of the time and place of hearing, shall be served by certified mail, return receipt requested, and addressed to the last-known address of the person complained against and to the complainant at least 14 days prior to the hearing;

(4) The attendance of witnesses and the furnishing of evidentiary material in connection with a

hearing may be compelled by subpoenas issued by the executive officer of the board with the approval of the board and which shall be served in accordance with law;

(5) At any hearing, witnesses may be sworn and any member of the board authorized by the board to do so may administer the oath;

(6) The board shall not be bound by rules of judicial procedure or by the laws of evidence in the conduct of its proceedings, but the findings of fact and conclusions of law shall be based upon legal evidence which will sustain its orders and in compliance with chapter 25 of Title 3 and this chapter and the board's rules;

(7) The person complained against is entitled to appear personally and to be represented by counsel, to cross-examine witnesses appearing in support of the complaint, and to produce evidence and witnesses in defense;

(8) A record of all complaints and charges presented and heard under this section and the disposition of those charges shall become a part of the permanent public record of the proceedings of the board.

(c) Appeals.

(1) Any person or institution aggrieved by any action of the board under this section or section 1581 of this title may appeal by one of the following procedures: to the appeals panel as provided in chapter 25 of Title 3; or to the superior court for the county where such person resides or if such person is a nonresident, such appeal may be to the Washington county superior court.

(2) The questions raised by such appeal shall be thereupon heard de novo, and the parties shall have the right to demand a trial by jury.

(d) There shall be no liability on the part of, and no cause of action for damages shall arise against, any member of the board for any act or proceeding undertaken or performed within the scope of the functions of the board, if such member acts without malice, has made a reasonable effort to obtain the facts of the matter as to which he or she acts, and acts in reasonable belief that the action taken by him or her is warranted by the facts known to him or her after such reasonable effort to obtain facts.

§ 1583. EXCEPTIONS

This chapter does not prohibit:

(1) The furnishing of nursing assistance in an emergency;

(2) The practice of nursing which is incidental to their program of study by persons enrolled in nursing education programs approved by the board, or graduates of approved nursing education programs pending the results of the first licensing examination scheduled by the board following graduation. Graduates shall so practice under supervision of a professional nurse and shall have an application for registration and licensure by examination on file;

(3) The practice of any nurse who is employed by the United States government or any bureau, division or agency thereof, while in the discharge of her or his official duties;

(4) The practice of nursing by a nurse currently licensed in another state or United States territory for a period of sixty days pending licensure in Vermont, if the nurse upon employment, has furnished the employer satisfactory evidence of current licensure and evidence of having submitted proper application and fees to the board for registration and a license by endorsement before beginning employment;

(5) The practice of nursing in this state by any currently licensed nurse whose engagement was made outside of this state but required the nurse to accompany and care for the patient while in Vermont. This exception shall not exceed six months;

(6) The normal work and duties of medical secretaries, laboratory technicians and x-ray technicians, physicians' assistants and dental assistants in the employ of the doctor or dentist and while they are actually under the direct control of the physician or dentist;

(7) The care of the sick by domestic help of any type, whether employed regularly or because of illness, provided such person is employed primarily in a domestic capacity;

(8) The work and duties of attendants in the Vermont state hospital at Waterbury and Brandon training school at Brandon.

§ 1585. VIOLATIONS OF CHAPTER; PENALTIES

(a) It shall be a violation of this chapter for any person, including any corporation, association or individual, to:

(1) Sell or fraudulently obtain or furnish any nursing degree, diploma, certificate of registration, license, or any other related document or record, or to aid or abet therein;

(2) Practice nursing under cover of any degree, diploma, registration, license, or related document or record illegally or fraudulently obtained or signed or issued unlawfully or under fraudulent representation;

(3) Practice nursing unless duly registered and currently licensed to do so under the provisions of this chapter;

(4) Use in connection with a name any designation tending to imply that a person is a registered professional or practical nurse when not registered under this chapter;

(5) Practice nursing during the time a license issued under this chapter is suspended or revoked;

(6) Conduct a nursing education program preparing individuals for entry into the practice of professional or practical nursing unless the program has been approved by the board;

(7) Employ unlicensed persons to practice as professional nurses or as practical nurses;

(8) Otherwise violate this chapter.

(b) Violations of this chapter shall be punishable by a fine of not more than $1,000.00 or imprisonment for not more than six months, or both.

(c) Violations of this chapter shall be prosecuted by the attorney general or the state's attorney of the county in which the violation occurred. In ad-

dition, the attorney general, or a state's attorney may seek an injunction in any court of competent jurisdiction to enjoin any person who is not currently licensed from practicing as a professional or practical nurse.

Sec. 2. REPEAL

Chapter 27 of Title 26, V.S.A. is repealed.

Sec. 3. 26 V.S.A. § 3102(b)(4)(D) is amended to read:

(D) Chapter 28 of Title 26, V.S.A. on nursing;

Sec. 4. EFFECTIVE DATE; TRANSITORY PROVISIONS

This act shall take effect July 1, 1980. The Vermont state board of nursing established by Sec. 1 of this act is intended to be a continuation of and successor to the state board of nursing repealed by Sec. 2 of this act. All members of the board shall continue in office until replaced under the terms of this act. All funds appropriated to the state board of nursing shall be transferred to the Vermont state board of nursing established by this act. All records, documents and personnel of the state board of nursing shall be transferred to the Vermont state board of nursing established by this act. All rules promulgated by the state board of nursing shall remain in full force and effect until amended or terminated under this act.

Approved: May 6, 1980

Appendix F

H.302

Introduced by Mr. Chaloux of St. Johnsbury

Referred to Committee on

Subject: Professions and occupations; midwifery; licensing

Sponsor's statement of purpose: It is the purpose of this bill to license the practice of midwifery, establish standards for admission to practice, and establish procedures for regulation and discipline of the practice

Own Vote			Legislative Vote						
Yes	No		Date	Senate	House	Yes	No	Date	Comments
		1st Reading							
		Committee Report							
		2nd Reading							
		3rd Reading							
		Amended—Calendar							
		Amended—Journal							
		" "							
		Committed							
		Recommitted							
		Ordered to Lie							
		Called up							
		Passed							
		Messaged							
		Com. of Conference							
		Withdrawn							
		Signed by Governor							

AN ACT TO ADD 26 V.S.A. CHAPTER 24 RELATING TO REGULATION OF THE PRACTICE OF MIDWIFERY

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. 26 V.S.A. Chapter 24 is added to read:

CHAPTER 24. MIDWIFERY

§ 1425. DEFINITIONS

As used in this chapter, unless a different meaning clearly appears from the context, the following words shall mean:

(1) "Board", the state board of midwifery established under section 1426 of this title.

(2) "Midwifery", the practice of attending a woman in childbirth for compensation, or advertising as such, but nothing in this chapter shall be construed to prohibit gratuitous service in the case of emergency, nor the service of any legally qualified physician or surgeon of this state.

§ 1426. BOARD OF MIDWIFERY

(a) There is hereby established a state board of midwifery composed of five members including:

(1) a nurse-midwife certified by the American College of Nurse-Midwives;

(2) a midwife not certified by the American College of Nurse-Midwives;

(3) a pediatrician licensed to practice in the state;

(4) an obstetrician licensed to practice in the state;

(5) a member of the public having no financial connection to the midwifery or medical professions.

(b) Members of the board shall be appointed by the governor for five-year terms, except that of the initial appointments one shall

serve for one year, one for two years, one for three years, one for four years and one for five years. For official duties, members shall receive per diem compensation in the amount of $30.00 and reimbursement for actual and necessary expenses.

§ 1427. LICENSES REQUIRED

A person may not practice midwifery or hold himself or herself out to the public as a midwife in a manner that is intended to indicate or calculated to induce members of the public into believing that he or she is a qualified midwife without first being licensed under this chapter.

§ 1428. QUALIFICATIONS FOR LICENSE

A person may be licensed as a midwife if he or she:

(1) is at least 18 years of age;

(2) is a resident of the state;

(3) has satisfactorily passed an examination administered by the board under section 1429 of this title, or has been certified by the American College of Nurse-Midwives.

§ 1429. EXAMINATION

(a) The board shall examine all applicants for a license to practice midwifery in the following subjects:

(1) Anatomy and physiology of the pelvis, female generative organs, menstruation and pregnancy;

(2) Fetal development;

(3) Maternal-fetal nutrition;

(4) Diagnosis and management of pregnancy, fetal presentation and position;

(5) Mechanism and supervision of normal labor and birth, including early detection of abnormalities requiring physician assistance, and post-partum;

(6) Injuries to genital organs following labor, including repairs of first and second degree tears of perineum, performance of small episiotomies;

(7) Knowledge of changing familial relationships during child bearing years;

(8) Hygiene of mother and infant in birth environment;

(9) Anatomy and physiology of lactation;

(10) Resuscitation of newborn, detection of other abnormalities such as malformations, asphyxia, jaundice and failure to thrive;

(11) Development and care of normal newborn;

(12) Causes, effects and treatment of opthalmia neonatorium;

(13) Knowledge of the physiology of pain and the various methods of childbirth preparation;

(14) Knowledge of current modes of management of complications, including medications and methods of analgesia, anesthetics, and surgery.

(15) Counselling for family planning.

(b) The examination shall be sufficient to test the scientific and practical ability of candidates to practice midwifery, and the board

may require examination on other subjects relating to midwifery from time to time.

§ 1430. FEES

(a) The board shall charge the following fees:

(1) application for license	$10.00
(2) examination fee	$15.00
(3) license and license renewal	$20.00

(b) The fees so collected shall be paid into the general fund of the state.

§ 1431. LICENSES, RENEWAL

(a) Licenses shall be renewed every two years upon payment of the required fee.

(b) On or before April 15 in each appropriate year the secretary of the board shall forward to the holder a form or application for renewal thereof. Upon the receipt of the completed form and the renewal fee on or before June 15, the secretary shall issue a new license for the year beginning July 1. Any application for renewal of a license which has expired shall in addition require the payment of a renewal fee, or in such cases as the board may by rule prescribe, by a new application fee.

§ 1432. REFUSAL, REVOCATION OR SUSPENSION OF LICENSES; HEARING

The board may refuse to grant, or may revoke or suspend, a license for any of the following reasons: the conviction of a crime involving moral turpitude; application for examination under fraudulent representation; neglect or refusal to make proper returns to a health

officer or health department of births, or a puerperal, contagious or infectious disease, within the legal limit of time; failure to secure the attendance of a reputable physician in case of miscarriage, hemorrhage, abnormal presentation or position, retained placenta, convulsions, prolapse of the cord, fever during parturient state, inflammation or discharge from the eyes of the newborn infant, or whenever any abnormal or unhealthy symptoms appear either in the mother or infant during labor or the puerperium. Before any license shall be revoked or suspended, the accused shall be furnished with a copy of the complaint and given a hearing before the board, in person or by attorney, and any midwife refused admittance to the examination, or whose license has been revoked or suspended, who attempts or continues the practice of midwifery, shall be subject to the penalties hereinafter prescribed.

§ 1433. PENALTIES

Any person practicing midwifery in this state in violation of the provisions of this chapter shall be liable to a fine of not more than $500.00 or imprisonment for not more than six months or both.

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