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Midwives in the United States: past and present

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Abstract. The main focus of the present paper is to place the current occupation of certified nurse-midwife (CNM) within the historical context of the decline of lay midwifery and the rise of the medical profession. The development and growth of nurse-midwifery is documented, as well as current problems facing the profession. The most salient contemporary issue is cancellation of malpractice insurance for 1400 CNMs in 1985. The consequences of this, and suggested policy changes, are explored.

Midwives in the U.S.: past and present

In colonial America the midwife's post was one of the most important in the community. Since it was beneath the dignity of male physicians to act as obstetricians, women had a virtual monopoly over the practice (Packard, 1963: 53). Our first midwives were European women who emigrated to the colonies. These women undoubtedly practiced in Europe and transported their skills to the New World (Thoms, 1961: 3). Yet, rigid role expectations for women of the period prevented extension of the practice of midwifery beyond simple deliveries, and if the birth was in any way atypical, midwives were blamed for the complications.

In spite of the danger of blame and punishment for difficulties, deaths, or birth defects which were encountered at the time of delivery, midwives did deliver the majority of babies born at this time. Midwives were rather well thought of and prominent members of the community. Thoms (1960: 10) reports how the Widow Bradley in 1655 was furnished with a house and lot rent-free in New Haven as long as she continued her services as a midwife. Other midwives received houses, money in the form of a yearly stipend, tobacco, or other gifts as support and in exchange for their services. In general, midwives were greatly respected and had strong relationships with their patients. They frequently participated in baptisms or the burial of infants, and women with gynecological problems would tell midwives things they would be reluctant to tell a doctor. In addition, midwives testified in court cases involving bastardy, verified birth dates, and examined female prisoners who had pleaded pregnancy to escape punishment (Scholter, 1977: 440).

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Some historians have called the years before 1750 the 'age of the midwife' (Wertz and Wertz, 1977: 6). Doctors were few and midwives delivered all of the babies. Although midwives were not considered to be medical practitioners, some geographic areas did require licensing. In 1716 New York City had an ordinance which required the licensing of midwives (Scholter, 1977: 428), and Virginia also required licensing. That doctors were scarce and that social tradition required the attendance of a midwife at birth assured that the practice of midwifery flourished before the American revolution. However, male-midwifery, which had begun to emerge in England with the introduction of the Chamberlen forceps (circa 1730), also developed in the colonies. The first American man-midwife is said to have commenced practice in 1745 (Corea, 1977: 222)[1]. And, in 1762 Dr. William Shippen, Jr., who had studied midwifery under the famous English man-midwife, Smellie, opened a midwifery school in Philadelphia for the instruction of both men and women. Shippen assumed that with proper instruction, midwives could take care of many cases while emergencies would be referred to qualified physicians (Shryock, 1960: 24).

Three years after the first midwifery school was opened, the first medical school began taking students (in 1765), also in Philadelphia (Thoms, 1960: 70). Since women were barred from the medical schools (either by the admission requirements or by pressure from other students) and since it was claimed by the schools that only doctors could make childbirth safe, physicians gradually began to replace the midwives. By the 1780s the shift away from midwives toward doctors among the more affluent segments of the population in the cities was noticeable (Corea, 1977: 223; Scholter, 1977: 427; Shryock, 1960: 24).

With the advent of men into midwifery, childbirth became less of a communal experience and more of a private event confined to the intimate family. And, it became increasingly regarded as a medical problem to be managed by physicians (Scholter, 1977: 426). Prior to the opening of the first medical schools, both men and women served as general practitioners. No formal education was required and there was little regulation by the colonial governments (Shryock, 1966: 6). With the opening of medical schools the practice of women was limited to midwifery, which received less support as medical men became more educated and physicians became more available.

Between 1780 and 1810, most states adopted licensing procedures for physicians and some states set up state-appointed boards or started state medical societies (Shryock, 1966: 11). Midwives were generally not licensed, although some states (such as Massachusetts and New York) required that midwives 'not act contrary to the accepted rules of their art' (Scholter, 1977: 429). As the occupation of physician received more popular support, the attendance of men upon maternity cases was still held to be 'most indelicate' (Shryock, 1936: 83),

even though more and more women called physicians rather than midwives to deliver their babies. Initially, the male physicians were called only to assist with difficulties, but gradually they began to take over normal birth, too.

Given the moral taboo of men in attendance at childbirth at this time in history, as well as the strong emphasis on female modesty which was typical of the Victorian and pre-Victorian periods, the general acceptance of men as obstetrical attendants is a bit surprising. However, men-midwives were able and willing to perform many services which female midwives were not likely to undertake. Men-midwives developed and experimented with a variety of instruments both before and after the invention of the Chamberlen forceps. Thus, the mother was promised less pain and quicker deliveries by physicians (Scully, 1980: 27).

Midwives virtually never interfered with the normal birth process. They managed deliveries by patiently waiting for nature to do the work. They caught the child, tied the umbilical cord, and delivered the afterbirth. Under the direction of the midwife, the woman was frequently fortified with liquor and she usually did not lie in bed to be delivered. Most women squatted on a midwife's stool, knelt on a pallet, sat on another woman's lap, or stood supported by two friends (Scholter, 1977: 430).

When male physicians began to deliver babies, women began to take to the bed to labor and deliver, rather than squatting. Presumably, a woman in bed could be well covered and this would relieve some of the uneasiness caused by fear of men and a loss of modesty. The doctor worked blindly under the blankets and the light in the room was dimmed (Scholter, 1977: 440). The problem with this was that, because she was lying on her back to deliver, the woman was unable to use the force of gravity to help with the delivery; instead she was pushing 'up hill' (Haire, 1973: 182). This prolonged labor[2].

The most serious problem associated with the increased use of physicians over midwives was an increase in mortality, both maternal and infant (Shryock, 1960: 15). Physicians were more likely than midwives to employ instruments in delivery, and prior to the discovery of the need for antiseptic precautions (circa 1860), interference by physicians with instruments was extremely hazardous and very frequently led to the death of the mother from puerperal fever (blood poisoning).

In 1591 a midwife, Agnes Simpson, was burned at the stake for having attempted to relieve birth pangs with opium or laudanum (Rich, 1976: 128). Yet, as physicians took control of both normal and abnormal childbirth, interference with the birth process became more commonplace. In 1847 Sir James Simpson of Edinburgh, Scotland, discovered that uterine contractions would continue even if the woman was anesthetized. He began to use chloroform as an aid to women in childbirth (McCleary, 1935: 130).

Some physicians opposed the use of ether or chloroform because they

believed that it spread puerperal fever. Actually, increased puerperal infection was probably caused by the fact that physicians were able to experiment with more procedures while the woman was anesthetized (Wertz and Wertz, 1977: 117). Puerperal fever was probably the greatest maternity problem of the nineteenth century, and it became more perplexing and predominant as midwives were employed less frequently. As early as 1773 Dr. Charles White of Manchester, England, argued that unclean linens and stuffy, dirty hospital wards could be causing the disease, and he dramatically reduced maternal mortality in Manchester Hospital by initiating sanitary procedures (Wertz and Wertz, 1977: 120). Physicians in the United States were not readily convinced that puerperal fever was a disease which could be spread by contagion, and they were reluctant to change their treatment techniques on the basis of the 'theory' of contagion. It was not until the late nineteenth century that American physicians began to take precautions against the spread of the infection from one patient to another.

In spite of the dangers of death from puerperal infection, the use of midwives declined steadily. Many women who could have employed midwives sought out physicians, and the midwives, who were generally illiterate and unorganized, did not offer resistance to the takeover of their profession by male physicians. The skills of midwives were downgraded by physicians, who claimed to have more knowledge and better treatment strategies than the midwives. With no organization and no legitimate mechanism for complaint, the midwives were easily swept out of the way. Women in rural areas and immigrant women, however, still clung to midwives so that by 1910 fifty percent of all births were still attended by midwives (Kobrin, 1966: 350).

Midwives and the professionalization of medicine

At the turn of the twentieth century the medical marketplace in the United States was open to the forces of progressivism which had already begun to creep into other facets of American social and economic life. Progressivism stood for liberal social reform, although it actually hid subtle capitalist monopolization of business interests, racism, and conservative social mores (Kolko, 1963: 2). The mood of the country was reflected in a push for reform, decreased immigration, and corporate expansion. Medical reform, in keeping with these goals, was aimed at cleaning up society by obliterating the problems of the poor through hygiene training and public health programs (Kosmak, 1934: 292; Kolko, 1963). With advances in medical technology that had occurred, there was hope that dreaded diseases such as tuberculosis would be controlled and that, with a national effort to improve social conditions, many public health problems would be eradicated.

The midwife, who was symbolic of the dirty indigents who needed to be upgraded, was targeted to be eliminated in the medical reform movement. According to prevailing sentiment in the medical profession, she could not be regulated because regulations caused competition with physicians and reinforced a dual standard for care (Huntington, 1912: 87). Presumably, midwives could not be regulated or educated to provide the same care that physicians provided, and therefore legitimation of the profession would prolong a double standard of medical care (Huntington, 1913: 419; Moran, 1915: 126). If a double standard of care were allowed to persist, it would encourage class differences, since the poor would be treated by the inferior midwives while the wealthy would be able to employ physicians, who offered superior care (Huntington, 1912: 87; Ziegler, 1913: 33).

The fact that midwives had slightly better rates of success in treatment than physicians was glossed over to emphasize that midwives actually usurped training material from student doctors (see Ziegler, 1912; Huntington, 1913). How the poor were expected to pay the higher fees charged by physicians if midwifery were made illegal was dismissed as irrelevant since it was assumed that charity cases would be treated in teaching hospitals (Ziegler 1913: 33–34).

The economic success of the growing medical establishment was dependent upon a normative acceptance of their role as protector and preserver of American health. Thus, the services of midwives, who represented 'unnecessary' competitive interference with the professional goals of the improved medical profession, were targeted for elimination. American women had to be convinced that physicians could do the job better than midwives, in spite of evidence to the contrary:

> It will not get us anywhere to say that midwives do just as good work as the average doctor, which may be true. It should not be a question of the lesser of two evils. Neither is fit. We want something better, we want well trained doctors to attend women in confinement (Ziegler, 1922: 412).

Medical practice in the United States at the turn of the twentieth century was very poor. Not only were physicians badly trained and unorganized, but the standards of medical practice were so variant that attempts at licensure and state regulation could not identify clear qualifying standards. Physicians, prior to the reorganization of the American Medical Association (AMA) (circa 1910), were as inept and poorly trained as the midwives they sought to supplant (Ziegler, 1913: 33–34; Flexner, 1910; Brown, 1979).

While the physician had a poor record of treatment of obstetric patients, the midwife, who was in many cases completely uneducated, had at least equal success rates and in many places superior success rates compared to physicians. Yet, to solidify the emerging professional standards set by the AMA,

most physicians favored the abolition of midwifery (Brown, 1979: 147; Wertz and Wertz, 1977). This would serve the dual purpose of eliminating competition and tightening professional standards by removing the choice of which practitioner to call at the time of delivery.

Obstetrician versus midwife

During the first couple of decades of the twentieth century the debate over what should be done about midwifery raged in full force. Those opposed to regulation, education, and licensure were vehemently against improving the qualifications of midwives. Their position was widely published in the popular and professional writings of the period[3]. Proponents, on the other hand, tended to point out the inconsistencies in the opposing position, to emphasize the superior care that midwives gave in many cases, and to stress the potential for lowered mortality levels from improved regulation (Baker, 1912: 257; Levy, 1918: 43–44).

The leaders of the anti-midwife coalition – who were, for the most part, well educated, prominent obstetricians – tended to develop their arguments around emotional or patriotic themes. For example, such rhetoric as 'making the world safe for democracy' (Newman, 1919: 465), or 'a baby saved is a citizen gained' (Larson, 1919: 335), were typical tools of propaganda used to entice the American public into accepting the 'safety' afforded by the use of obstetricians instead of midwives. Much was written about the dangers of childbirth in the hands of midwives, while the safety of obstetricians was repeatedly emphasized. Even the popular press reinforced the claims of the obstetricians. *McClure's Magazine,* a popular women's publication, printed an article in 1915 by Anna S. Richardson, who was the Chairman of Hygiene of the Congress of Mothers and an organizer of the Better Babies Movement. In the article, Richardson emphasized the value of motherhood to the state and the importance of adequately trained obstetricians, and thus called for improved obstetrical education. Other publications, such as *Good Housekeeping* or the *Ladies Home Journal* (c.f. Dunbar, 1918 or Hutchinson, 1914), encouraged women to employ obstetricians and to have their babies in hospitals, while the old-world, backward character of midwifery was emphasized. The message was clear – hospitals were modern and scientific, while midwives were old-fashioned and dangerous.

Proponents of midwifery tried to counter the arguments and claims made by the anti-midwife faction, but their efforts were generally unsuccessful. The fact was that midwives had success rates at least equal to those of physicians, and in many places where even minimal standards for practice had been set, midwives lost fewer patients and had lower rates of injury and blindness than

physicians (see Levy, 1918). At worst, the midwife equalled the care given by the medical profession, and at best she offered superior care. Yet midwifery quickly became a vestige of the past or a practice associated with the southern poor. Modern American women employed obstetricians, not midwives.

Concurrently, births in hospitals increased, while births attended by midwives tended to decrease (Baker, 1925: 114–117). As Tables 1 and 2 indicate, by 1925 between 50 and 60 percent of births occurred in hospitals in many large cities, while the proportion of births attended by midwives was typically less than 30 percent in most states and less than 10 percent in many.

Many places, both in large urban centers and in isolated rural areas, attempted to use midwives to decrease infant and maternal mortality. As part of general public health reforms, there was supervision and education of midwives. As midwifery regulations increased, infant mortality decreased. For example, in New York City in 1914 the infant mortality rate was 94.6 per 1,000 live births, but by 1923, after several years of midwifery education and supervision, the rate had declined to 66.4 (Baker, 1925: 154). Newark, New Jersey, which had the highest infant mortality rate of any city in the country at the turn of the century, reduced the rate to the lowest in the country by World War I (Galishoff, 1975: 107). The decline was largely attributable to the initiation of strict supervision of midwives (Levy, 1918).

In spite of attempts to license and regulate midwives in several areas, the profession continued to decline throughout the 1920s. By 1930 most midwifery

Table 1. Proportion of births in hospitals in selected cities 1925

City	Percent hospital births
Minneapolis	62.1
St. Paul	60.4
Hartford	53.0
District of Columbia	52.9
Springfield, MA	50.1
Duluth	38.7
Cincinnati	36.7
Cambridge	36.3
Columbus, Ohio	33.6
Philadelphia	31.2
Newark	30.6
Trenton	20.1
New Orleans	19.0
Baltimore	18.7
Lowell	17.7
Fall River	16.1
New Bedford	8.2

Source: Baker, 1925: 114.

Table 2. Percent of births attended by midwives by states, 1925

State	Percent of midwife births
Louisiana	49.3
Florida	38.1
North Carolina	34.7
Virginia	33.3
Alabama	32.3
New Jersey	25.7
New York City	25.6
Maryland	22.3
Kentucky	18.0
Arkansas	16.6
Delaware	16.4
Connecticut	16.1
New York	16.1
Arizona	12.5
Tennessee	12.0
Wisconsin	9.7
Minnesota	9.5
California	8.0
Massachusetts	6.0
District of Columbia	4.4
Washington	3.9
Montana	3.4
South Dakota	2.7
Nebraska	2.1
Wyoming	1.4

Source: Baker, 1925: 117

practice in the United States had been replaced by physicians using hospitals to deliver babies (Wertz and Wertz, 1977: 133–134). The practice of calling midwives for rural women in very isolated or very poor areas was preserved, but the American norm of physician-attended hospital births had been firmly established by 1930 (Wertz and Wertz, 1977: 167).

The rise of nurse-midwives

As the demand for midwives in the United States declined in the 1920s and home deliveries were replaced by hospital births throughout most of the country by 1930, one area made a concerted effort to initiate a midwifery program. In Hyden, Kentucky, Mary Breckenridge started the Frontier Nursing Service in 1925 (Roush, 1979). She, along with several British trained nurse-midwives, began a midwifery service in which they traveled to the

homes of laboring women on horseback. Since most other midwifery practiced in the United States occurred in isolated rural areas among poor and generally untrained midwives, the efforts of Mary Breckenridge were unique. They were especially so because the practitioners in the program were not only midwives, but they were also trained and certified public health nurses. Thus, a new concept in maternity care was established, combining the ancient art of midwifery with the modern scientific training provided for nurses.

The occupation of nurse-midwife grew out of Breckenridge's efforts to provide trained practitioners to assist laboring women in Kentucky. As the Frontier Nursing Service continued in Kentucky, the traditional untrained midwives (lay midwives) who were still practicing in some areas were increasingly replaced by hospital deliveries. The new nurse-midwives practiced only in the Frontier Nursing Service in Kentucky until 1931 when the Maternity Center Association established the first school of nurse-midwifery in New York City (Roush, 1979). Other nurse-midwifery schools were established in the 1940s at Tuskegee Institute in Alabama and at Catholic Maternity Institute in New Mexico. Programs were initiated in the 1950s at Columbia University, Johns Hopkins University, and Yale University (Lubic, 1975), but the occupation of nurse-midwife in the United States did not take on professional importance until 1955 when the American College of Nurse-Midwives (ACNM) was created. With the establishment of ACNM, university affiliated training programs became more common so that by 1970 there were 26 such training programs in the United States (Lubic, 1975). Beginning about 1970, increases in public demand for the services offered by certified nurse-midwives (CNMs), together with forecasts of an insufficient supply of obstetricians to meet demands, spurred a general increase in the acceptance of CNMs as legitimate practitioners who could oversee normal maternity care and deliveries.

In 1971 the American Nurses Association of the American College of Obstetricians and Gynecologists, the ACNM, and the American College of Obstetricians and Gynecologists (ACOG) collaborated on a joint statement approving the management of normal labor and delivery by CNMs under supervision of a qualified obstetrician. This statement was tantamount to professional recognition of CNMs as legitimate maternity practitioners and thus fostered their acceptance into modern obstetrical practices. Currently there are about 2,800 CNMs practicing in the United States (McCarthy, 1985).

Throughout the 1970s and into the 1980s, CNMs became an increasingly important force in contemporary maternity care. General consensus about the quality of care offered by CNMs is that the care equals or surpasses services offered by obstetricians. Several studies have indicated a drop in neonatal mortality and prematurity when CNMs replace obstetrician-centered care (see Levy et al., 1971; Lubic, 1975; Rothman, 1982; Arms, 1975). The fact that

CNMs treat only normal cases may partially explain their high rates of successful treatment, but the commitment of CNMs to their patients is reminiscent of historical lay midwives who devoted full attention, support, and service to women before, during, and after delivery. This extra care and concern as well as an overarching commitment to family-centered treatment may also affect success rates. The soothing, caring attention CNMs give their patients causes the women they serve to hold them in high esteem and accounts for the demand for their services (McCarthy, 1985).

Certified nurse-midwives provide a variety of services, depending upon state law and medical regulation policies. Several states allow the delivery of babies by CNMs only in hospitals, where they practice with an obstetrician. Other states permit CNMs to operate birthing centers or clinics where they independently practice. Some states allow CNMs to deliver babies in the homes of their clients, while other states require hospital supervision for the delivery but may not require that the CNM be responsible to a specific obstetrician[4]. Third-party reimbursement for CNM services is generally available. Sixteen states[5] mandate private insurance reimbursement for the services of CNMs, although voluntary reimbursement has been common in most states for some time (Krause, 1985: 136).

Regardless of the variety of services provided by CNMs, the quality of care offered by them is consistently high. They strive to offer safe and satisfying maternity care which centers upon the family and upholds the right to consumer self-determination within the boundaries of safe care (Forman and Cooper, 1976). They assume responsibility for the management of labor and delivery of babies, but they also counsel women and help them to develop plans for care that interrelate with their other needs. CNMs concern themselves with the lives and needs of their clients, not just the physiological experience of birth. This creates a very close and satisfying relationship between the client and the CNM.

In spite of the high demand for the services of CNMs and the outstanding success of their practices, the profession is currently in danger of becoming a casuality of the rising costs of health care. The problem of obtaining and keeping malpractice insurance is beginning to drive CNMs from their occupation. The major insurer of CNMs – Mutual Fire, Marine, and Inland Insurance Co. – recently terminated all of its malpractice policies, including those which covered 1400 CNMs throughout the United States (McCarthy, 1985)[6]. McCarthy (1985) describes the case of one CNM who had been in practice for 10 years, who had delivered over 600 babies, and who had never been sued. In 1981 her malpractice insurance was $125; in 1983 it was increased to $250; in 1985 it went up to $800, but was canceled in mid-year. Moreover, she had been in practice with four other CNMs who had together delivered 2,500 babies without a single malpractice suit. Nationally, CNMs have been the objects of

very few malpractice suits, with only six percent having been sued since 1974. By comparison, 60 percent of obstetricians have been sued for malpractice at least once (McCarthy, 1985).

The ACNM has pursued several solutions to the problem of malpractice insurance cancellation, such as unsuccessful solicitation of new carriers and the possibility of self-insurance (Yates, 1985). Self-insurance offers the most viable hope, but it also faces many obstacles. Any insurance option must provide $1–3 million coverage, since most CNMs need such limits to maintain hospital privileges. This means that CNMs will face malpractice insurance premiums of from $3000–$5000 annually (Yates, 1985). Reinsurance (an insurance for insurance companies which absorbs the risk of payments for catastrophic claims) is a major obstacle toward self-insurance, and the ACNM is hoping that the federal government might provide at least temporary reinsurance (Yates, 1985). The most important obstacle to self-insurance is the fact that under the insurance laws of virtually all of the states a new insurance company (such as ACNM self-insurance) could not write insurance unless it became licensed in each state, which is a very costly and time-consuming process (Yates and Prah, 1986). At this writing, federal legislation has been introduced (H.R. 4301 and S. 2129) which would override the various federal and state insurance laws to permit the formation of group-owned insurance companies. If this legislation is passed, it will greatly enhance the probability that CNMs will be able to insure themselves through the ACNM.

One of the conceptual problems in the malpractice insurance cancellation drama has been the tendency for insurance carriers to combine CNMs with obstetricians. In spite of the fact that CNMs provide low cost and low risk health care, malpractice insurance has represented them as compatriots of obstetricians who represent great malpractice risk.

Physicians, generally, pay high malpractice insurance premiums, with an average payment of 8 percent of their pre-tax income ($8,400/year) already assigned for malpractice insurance, and many are facing rate hikes of from 29 to 65 percent (Curtin, 1985: 7). Because of these very high malpractice insurance costs, many obstetricians are beginning to refuse to deliver babies. The California Medical Association reports that about 25 percent of the obstetricians it polled no longer deliver babies, while another 46 percent were reducing their high-risk case load (Curtin, 1985: 7). If physicians are reducing the number of deliveries and CNMs cannot get malpractice insurance, Americans are faced with a dilemma. The obvious solution seems to be that CNMs should have malpractice insurance to match the risk factor in their practices, rather than being classified with medical practitioners who practice as obstetricians.

Research and policy recommendations

Midwifery as an occupational specialty in the United States has had a very tumultuous history, which has culminated in professional recognition only within the last few decades. The history of midwifery has been well documented by medical historians (c.f. Packard, 1963; Shryock, 1936, 1960, 1966; Thoms, 1960, 1961) and more recently by critical feminist theorists (c.f. Arms, 1975; Corea, 1977; Rothman, 1982; Scully, 1980), but systematic, national, empirical research about midwifery is badly needed.

All of the research to surface to date has indicated a strong relationship between quality maternity care and midwifery, as well as statistically significant declines in neonatal mortality when nurse-midwifery programs are initiated (c.f. Levy et al., 1971; Rothman, 1982; CNM Fact Sheet, 1985). What is needed, however, are systematic comparisons of midwifery-based care with obstetrician-based care to determine qualitative differences in treatment strategies. Several researchers have pointed out the disease-orientation of obstetrics compared to the CNM emphasis on the normal course of pregnancy and birth as the most important points of departure in philosophical differences between obstetricians and CNMs (Rothman, 1982; CNM Fact Sheet, 1985; Arms, 1975). Empirical research addressing the treatment implications derived from philosophical orientations would, perhaps, enlighten and expand our understanding of qualitative differences in treatment strategies. For example, does the crisis intervention training of obstetricians pre-dispose obstetricians to more heroic intervention in even normal childbirth, where the ancient 'art of waiting' characteristic of historical midwifery and contemporary CNMs poses less risk to parturient women? Rothman (1982: 130–181) and others (c.f., Wertz and Wertz, 1977; Arms, 1975) have discussed these issues as if they are causally related to declines in problematic childbirth when CNMs are employed, but empirical evidence of this link has not been forthcoming.

Nurse-midwives, as a group, are more troubled by their image and misperceptions about their capabilities than by any insecurities connected with their collective ability to provide quality maternity care, however. A recent survey of nurse-midwives in 45 states (*Quickening,* 1985: 3) reported that the factors which most hinder the success of nurse-midwifery are:

- a lack of understanding in the public sector of what nurse-midwifery has to offer;
- too many physicians concerned about loss of income from CNM practitioners;
- lack of acceptance by community M.D.s of nurse-midwifery as a worthwhile profession;
- lack of adequate access to practice settings;

- lack of strong commitment by involved physicians to the concept of nurse-midwifery.

While other factors which hinder the success of CNMs were listed in the report, the thematic problems remain the same. Nurse-midwifery practice is hindered or threatened by factors which are external to individual CNMs and which greatly reflect a lack of commitment on the part of the medical profession to encourage or assist the enhancement of nurse-midwifery practice. The issue of professional dominance which has characterized the struggle for monopolistic control of medical knowledge by physicians for most of this century is renewed once again. Certified nurse-midwives who represent subordinate medical practitioners are viewed as competitive practitioners who weaken the current monopolistic control and dominance of the medical profession (cf. Friedson, 1985).

Since CNM practice has been strongly associated with reduced risk to parturient women and ultimately to reduced malpractice liability, it seems a cooperative relationship between existing obstetrical practice and nurse-midwifery would be in the best interests of all concerned. The role relationship between obstetricians and CNMs should be further entwined to provide a mutually beneficial service to pregnant and parturient women.

While the ACNM has undertaken many attempts to increase acceptance of CNMs by the public and the medical profession (c.f. *Quickening,* 1985), the acknowledgement of the professional competence of CNMs has been slow and cautious. Renewed efforts to foster cooperative interaction between CNMs and obstetricians would more likely yield stronger support from the rank-and-file of the medical profession if it were initiated by the AMA or the ACOG. Also, public acceptance of CNMs would be better facilitated after wider endorsement by the medical profession.

Conclusion

The ancient practice of midwifery was exclusively the domain of women until men became interested in it approximately 250 years ago. As modern medicine, which was almost exclusively male dominated, became more advanced and exhibited more precision and efficiency in its application, the practice of midwifery gradually yielded to medicine. American midwifery practice was effectively usurped by the expanding medical profession in the first two decades of the twentieth century. Except for very isolated cases, the traditional midwife ceased practice in the United States prior to World War II.

Currently the only alternatives available to women seeking maternity care in the United States are traditional obstetrics or the services of CNMs.

Malpractice insurance costs have severely threatened both groups, but the CNMs have been especially hard hit by high costs and termination of their policies by insurance carriers. The CNMs, who do not have a salaried Washington lobby and whose individual salaries average less than 20 percent of the average salaries of obstetricians (McCarthy, 1985), are no match for the insurance industry or for the medical establishment, which has offered only tacit support for their predicament.

At the turn of the twentieth century the unorganized, fragmented midwives offered no collective resistance to the takeover of their profession by male physicians. The sex roles of the period relegated women to non-professional spheres by definition so that support for regulation or legitimation of midwifery came only from those who endorsed the health care potentialities offered by midwives. The fact that the profession was female-dominated, and thus low status, assured that usual professional concerns for economic, social, or political viability were not salient for the women who practiced midwifery. Midwives were women and thus occupied a dispensible occupation. The rhetoric of the period repeatedly emphasizes this fact: 'The midwife is incapable of preventing problems of pregnancy, this takes a trained man' (Huntington, 1913: 419). Male obstetricians were not concerned with the displaced midwives because the latter were women who occupied what they believed to be inferior social and occupational positions. Without organized efforts to resist the takeover, midwives were easily swept aside in the push for medical professionalization.

Currently, the crisis in malpractice liability insurance has brought up this issue again. CNMs are in danger of losing the position of legitimate maternity practitioner which they have spent most of this century securing. Once again the occupation of CNM is female dominated, with lower status than the male dominated profession of obstetrics or the corporate structure of insurance. Once again, the female dominated profession is underrepresented in influential organized lobbying efforts. And, once again, the nurse-midwives, who offer exceptional service oriented toward holistic health with outstanding treatment records, are penalized for their success while obstetricians who have tended to be more oriented to disease and treatment, and who have many more malpractice complaints, continue to occupy higher, more influential social and professional statuses.

While the status differential created by sex-typed occupational stratification is much more subtle than it was 80 years ago, it has not disappeared. In the case at hand, the high status occupation of obstetrician is almost exclusively dominated by men who permit or encourage the lower status female-dominated occupation of midwife at their own discretion. The century-long struggle of midwifery and nurse-midwifery for occupational legitimacy has only recently culminated in professional recognition, but teeters on the brink of dissolution

if malpractice insurance coverage is not available. Support from the ACOG and the AMA for the continued use of CNMs or insistance from the ACOG that insurance carriers separate CNMs from obstetricians would significantly strengthen the bargaining power of CNMs. Yet neither the ACOG nor the AMA has taken a stand in support of the CNMs. The fact that the professional power distribution is stratified into traditionally 'male' or 'female' occupations replicates the earlier power struggle which resulted in the loss of traditional lay midwifery at the turn of the twentieth century. While many other issues undercut the current struggle in nurse-midwifery (such as rising medical costs and competition created by CNMs who offer reduced-cost services), the sex-based stratification differential mirrors occupational stratification of other occupations in the society, where men usually occupy the higher paid, more secure occupations while women occupy the lower paid, lower status, more tenuous occupations.

The overt competition between physicians and CNMs clusters around questions of professional competence and concerns on the part of physicians that CNMs will undercut the economic market demand for services (*Quickening*, 1985: 3). However, the more subtle sex-related conflicts endemic to occupational stratification complicate the picture further since the occupation of physician reflects the autonomy and hierarchical independence associated with male professions and the occupation of CNM embodies the female commitment to caring professions and social powerlessness (Rosenblum, 1986: 101). While it is not suggested here that sex-typing in occupations is necessarily the result of discrimination (cf. Kamalich and Polacheck, 1982), the power relationship associated with sexual stratification is well documented (cf. Wuthnow, 1986; Rothman, 1982: 64–71; Tavris and Wade, 1984: 258–262; Benokraitis and Feagin, 1986: 14–22). Current solutions to sex-typing of occupations usually suggest changes in socialization patterns which have channelled children into sex-typed life patterns and occupational choices (Tavris and Wade, 1984: 240–243). For the case at hand, the more appropriate solution would be to increase professional recognition of the occupation of nurse-midwife and concurrently to increase professional autonomy of CNMs.

Notes

1. Packard (1963: 53) says that John Dupuy, M.D., was probably the first man-midwife, or obstetrician in the colonies, but he sets the year of his death as 1745.
2. It is interesting that most American obstetrical practices still require the woman to lie flat on her back (lithotomy) position, even though this position is known to be the least advantageous delivery position, and is only used in the United States.
3. See for example: Ziegler, 1912, 1913; Huntington, 1913; Moran, 1915; Richardson, 1915.
4. See Forman and Cooper (1976) for further details on regulations by state and DeVries (1985) for a discussion of how regulations are applied in each state.

5. The jurisdictions which mandate private insurance reimbursement of nurse-midwifery services are: Alaska, Connecticut, Maryland, Minnesota, Mississippi, Montana, New Jersey, New Mexico, New York, Ohio, Oregon, Pennsylvania, South Dakota, Utah, Washington, West Virginia.
6. Certified Nurse Midwives are temporarily insured by the American Nurses' Association (ANA), which offers liability insurance for registered nurses who are members of their state nurses' association. This is somewhat problematic because those CNMs who are employers, who are in private practice, or who own their own business (such as a birth center) are not covered by this insurance (Prah and Gilbert, 1985).

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