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The Midwife Vrs the Vroedvrouw-The Troubled History of Midwifery In The United States As Compared to the Stability of Midwifery In The Netherlands.

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The struggle for midwifery has been a long and arduous journey in the United States. Even today it is only legally recognized in sixteen states. This is a major contrast between the midwives in the Netherlands who have had complete autonomy over normal births since early in the 19th century.

The history of midwifery in these two separate countries is of great interest to me. I gave birth to a baby in Amsterdam and am about to give birth to one here in the United States.

In this paper I will trace the history of midwifery in both the USA and Holland and compare their different practices and philosophies. I will use myself as a case study in Holland and my sister as a case study in the state of Maine.

Midwifery arrived in the American colonies along with the Pilgrims. These were European women who undoubtedly practiced in Europe and brought their skills with them to the New World. It was beneath the dignity of male physicians to act as obstetricians, at this time, so women had a virtual monopoly over the practice. The doctors were few so midwives delivered almost all of the babies. They were not considered to be medical practitioners though some geographic areas did require licensing. Their role expectations were limited to simple delivery and if the birth was atypical the midwives were blamed for the complications (Radosh, 1986).

Midwives were well respected and considered prominent members of the community. They singularly provided an essential service available from no other source (Edwards & Waldorf, 1984). They had strong relationships with their patients and frequently participated in baptisms or burial of infants. Women with gynecological problems would consult a midwife instead of a doctor. They testified in court cases involving bastardy, verified birth dates, and examined female prisoners who had pleaded pregnancy to escape punishment (Radosh, 1986; p. 129).

New York City issued an ordinance that required the licensing of midwives in 1716. The state of Virginia also required licensing. Doctors were scarce and social traditions required the midwife's attendance at birth. The practice of midwifery thus flourished before the American Revolution (Radosh, 1986).

Major changes took place in 1730 with the introduction of male-midwifery. It had begun to emerge in England with the introduction of the Chamberlen forceps and was now developing in the colonies. The first American man-midwife began his practice in 1745. In 1762 a midwifery school opened in Philadelphia for instruction for men and women by Dr. William Shippen. Shippen assumed that with proper instruction midwives could take care of many cases while emergencies would be referred to qualified physicians. Three years later, in 1765, the first medical school began taking students, also in Philadelphia. Since women were barred from medical schools (either by the admissions requirements or by pressure from other students) and since it was claimed by the schools that only doctors could make childbirth safe, these

physicians gradually began to replace the midwives. By the 1780's the more affluent segments of the population had noticeably shifted away from the midwives toward the doctors (Radosh, 1986).

Childbirth increasingly became managed by physicians. Birthing became less of a communal experience and more of a private event confined to the immediate family. Prior to the opening of the first medical school the men and women served as general practitioners. No formal education was required and there was little regulation by the colonial government. Due to the opening of medical schools the practice of women was limited to midwifery which continued to receive less support as medical men became more educated and physicians became more available (Radosh, 1986).

Between 1780 and 1810 most states adopted licensing procedures for physicians and some states set up state appointed boards or started state medical societies. 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" (Radosh, 1986; p. 130).Male physicians who originally only assisted with difficult births gradually began to take over normal births. Male-midwives had developed and experimented with a variety of instruments before the introduction of the Chamberlen forceps. The expectant woman was thus promised less pain and quicker deliveries by physicians (Radosh, 1986).

Midwives didn't interfere with the normal birth process. They waited for nature to take its course. They caught the child, tied the umbilical cord and delivered the afterbirth. The patient was fortified with liquor when deemed necessary. She usually didn't lie in bed to deliver but squatted on a midwives stool, knelt on a pallet, sat on another's lap or stood supported by two friends (Radosh, 1986).

When physicians began to deliver babies the woman no longer squatted but rather took to the bed where she could be well covered and thus relieve some of her uneasiness caused by her fear of a man and a loss of her modesty. Unfortunately, since she was

lying in bed, she was unable to use the force of gravity to help with the delivery and instead had to push uphill (Radosh, 1986).

The most serious problem associated with the increased use of doctors over midwives was an increase in maternal and infant deaths. Physicians were more likely than midwives to use instruments in delivery and prior to the need of antiseptic precautions (circa 1860) interference by physicians with instruments was extremely hazardous and frequently led to the death of the mother from puerperal fever (blood poisoning) (Radosh, 1986; p.131).

In 1847, Sir James Simpson of Edinburgh, Scotland began to use chloroform as an aid to women in childbirth. This became a popular choice for pregnant women wishing to alleviate pain (Radosh, 1986).

The women suffered greatly in labor at this time, perhaps due to weariness of constant child birthing and general poor health exacerbated by tightly laced corsets, thus popularity of drugs grew rapidly. This access to drugs and instruments gave much advantage to doctors over midwives though this medical handling of childbirth remained crude. The brand of medicine practiced then before the scientific studies of the late 19th century were of the sort usually called heroic often employing violent means to cure diseases: terrible purges, scalding baths, emetics and bleeding. A laboring woman might have leeches applied to her perineum, or her veins might be opened to ease her pains, allowing her to bleed until she fainted, which served, after a fashion, to blot out the pain. Infusions of alcohol or vinegar might be forced into the uterus in an attempt to halt postnatal bleeding (Edwards & Waldorf, 1984; p.150).

In the 1880-1890 there was a great wave of European immigrants to the United States bringing old-world midwives with them. In NYC two out of five births in 1900 were attended by midwives. Middle and upper middle class women depended greatly on doctors. Midwives were only employed by poor working class women (Edwards and Waldorf, 1984).

The doctors, feeling threatened by the popularity of midwives, organized themselves to insure their survival. The American Medical

Association (AMA) was founded primarily to increase economic benefits to its members. It worked to reestablish licensing laws designed to secure their exclusive rights to the practice of medicine. Membership in the AMA became vital to a career and members were strongly urged to run for office (state or local) in order to influence legislation (Edwards & Waldorf, 1984).The AMA had a major influence on decreasing the desirability of midwives and led the way in its downfall.

At the turn of the 20th Century progressivism was creeping into the social and economic ways of American life. It stood for liberal social reform, although it actually hid subtle capitalist monopolization of business interests, racism and conservative social mores. 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 (Radosh, 1986; p.132). It was hoped that dreaded diseases such as tuberculosis would be controlled and that with a national effort to control social conditions, many public health problems would be eradicated (Radosh, 1986).

The midwife, who was symbolic of the dirty indigents who needed to be 'upgraded, was targeted to be eliminated in the medical reform movement (Radosh, 1986; p.137).

According to the prevailing group of the medical profession midwives could not be regulated or educated to provide the same care as physicians. Regulations would also cause competition with the physicians. A double standard of medical care would arise that would encourage class differences since the poor would be treated by the inferior midwives while the wealthy would be able to afford physicians, who offered superior care. The problem of the poor not being able to pay the higher physician fees if midwifery became illegal was dismissed as irrelevant since it was assumed that charity cases would be treated in teaching hospitals (Radosh, 1986).

The economic success of the medical establishment was dependent upon the role of protector and preserver of American health. The services of midwives, who represented unnecessary

competitive interference with the professional goals of the improved medical profession, were targeted for elimination (Radosh, 1986).

Medical practice in the United States at the turn of the century was very poor. Physicians were badly trained and unorganized. The standards of medical practice were so variant that attempts at licensure and state regulation could not identify clear qualifying standards. Physicians were as inept and as poorly trained as the midwives they sought to replace (Radosh, 1986). Obstetricians were so often inadequately trained that if poor women continued to seek midwives, student doctors would have no one on whom to practice (Edwards & Waldorf, 1984).

The midwife, who in some cases was completely uneducated, had at least equal success rates and sometimes superior success rates compared to physicians. Yet to solidify the emerging professional standards most physicians favored the abolition of midwifery. 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 (Radosh, 1986).

The debate over midwifery raged during the first two decades of the 20th Century. Those opposed to regulation, education and licensure of midwives were against improving qualifications of midwives. Their opinions were widely published in the popular and professional writings of the period. Proponents emphasized the superior care that midwives gave in many cases and stressed the potential for lower mortality levels from improved regulation The leaders of the anti-midwife coalition were for the most part well educated prominent obstetricians (members of the AMA no doubt). Much was written about the dangers of childbirth in the hands of midwives while the safety of obstetricians was repeatedly emphasized. The message they made was clear; hospitals were modern and scientific while midwives were old-fashioned and dangerous (Radosh, 1986).

Proponents of midwives tried to counter their arguments by stating that midwives had success rates at least equal to those of physicians and in many cases lost fewer patients and had lower rates of injury and blindness than the physicians. At worst the midwife equaled the care given by the physician and

at best she offered superior care. Yet midwifery quickly became a vestige of the past or a practice associated only with the Southern poor. Modern American women employed obstetricians, not midwives (Radosh, 1986).

In the next decades the word midwife was hardly ever used without the prefix 'ignorant' and 'dirty' and racial ethnic slurs were hurled at them. Since many were immigrants they were not 'real' Americans and certainly not appropriate members of the health profession (Edwards & Waldorf, 1984; p.153)

Obstetricians that promoted hospitalization and the elimination of midwifery promoted the view that pregnancy is fraught with danger and that a normal delivery is a rare occurrence. Women rapidly yielded control over the birth process and left their homes, that were now labeled as harbors of germs and disease, for the hospital. Ironically the excessive use of forceps and operative procedures plus the presence of infectious diseases in the hospitals made giving birth there very dangerous to both mother and child (Evenson, 1983).

Midwives deliveries dropped from 50% of all births in 1900 to 12% in 1936 and 80% of these took place in the South. Maternal mortality rates did not plummet during this time as expected by those who had so readily blamed midwives. In 1930 a survey was taken of all NYC maternal deaths and the results found that 60% of the deaths of mothers were preventable, and the majority of these, 61.1%, had been caused by physician error (Edwards & Waldorf, 1984).

In spite of attempts to license and regulate midwives in several areas the profession continued to decline during the 1920's. By 1930 most midwifery practices had been replaced by physicians using hospitals to deliver babies. Midwives were still used in very isolated or very poor areas, but the American norm of physician attended hospital births had been firmly established by 1930 (Radosh, 1986; p.136).

With the near depletion of midwifery in 1930 one area made a concentrated effort to initiate a midwifery program. In Heyden, KY, Mary Breckenridge started the Frontier Nursing Service (FNS) in 1925. She, along with several British trained

nurse-midwives, began a midwifery service in which they traveled to homes of laboring women on horseback. Practitioners in this program were not only midwives but they were also trained and certified public health nurses. Thus a new concept of maternity care was established, combining the ancient art of midwifery with the modern scientific training provided for nurses (Radosh, 1986; p.137).

The occupation of nurse-midwifery grew out of Breckenridge's efforts to provide trained practitioners to assist laboring women in Kentucky. The new nurse-midwives practiced only at the FNS in KY until 1931 when the Maternity Center Association established the first school of nurse-midwifery in NYC. Other Nurse-Midwifery Schools established themselves in the 1940's, Tuskegee Institute in Alabama and the Catholic Maternity Institute in New Mexico. Programs were initiated in the 1950's at Columbia University, John Hopkins University and Yale University but the occupation of nurse-midwife in the USA did not take on professional importance until 1955 when the American College of Nurse-Midwives (ACNM) was established. University affiliated training programs became more common so that by 1970 there were 26 such training programs in the United States. Beginning about 1970, increases in public demand for the services offered by certified nurse- midwives (CNMs), together with the forecast of insufficient obstetricians to meet demands, spurred general increase in the acceptance of CNMs as legitimate practitioners who could oversee normal maternity care and deliveries (Radosh, 1986; p.137).

In 1971 the American Nurses Association 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. Thus CNMs were professionally recognized as legitimate maternity practitioners and accepted into modern obstetrical practices. As of 1985 there were about 2800 CNMs practicing in the United States (Radosh, 1986; p. 137).

CNMs provide a variety of services depending upon state law and medical regulation policies. Several states allow CNMs to deliver babies in hospitals, where they practice with

obstetricians (OBs). Other states allow them to practice independently in birthing centers or clinics. Some states allow CNMs to deliver babies in their client's homes, while other states require hospital supervision for the delivery but don't require that the CNM be responsible to a specific OB. Third-party reimbursement for CNM services is usually available. Sixteen states mandate private insurance reimbursement for the services of CNMs although voluntary reimbursement has been common in most states for some time (Radosh, 1986).

The quality of care of CNMs is consistently high. They strive to offer safe and satisfying maternity care which centers on the family. They not only manage the labor and delivery of babies but also counsel women and help them develop plans for care that coincide with their specific needs. They not only assist with the physiological experience of birth but also concern themselves with the lives and needs of their clients (Radosh, 1986)

Although CNMs have been recognized as legitimate maternity practitioners by the AMA and ACOG a recent survey of CNMs in 45 states revealed that CNMs success is hindered by a lack of understanding by the public of what nurse-midwifery has to offer; too many physicians concerned about loss of income from CNM practitioners; A lack of acceptance by community M.D.'s of nurse-midwifery as a worthwhile profession; a lack of adequate access to practice settings; and a lack of strong commitment by involved physicians to the concept of nurse-midwifery. Certified nurse-midwives are viewed as competitive practitioners who weaken the current monopolistic control and dominance of the medical profession. An appropriate solution would be to increase the professional recognition of the occupation of nurse-midwife and concurrently to increase professional autonomy of CNMs (Radosh, 1986).

Recent recognition and acceptance of nurse-midwifery has been paralleled by efforts to entirely eliminate lay-midwifery (also referred to in this case as direct-entry midwifery). Sixteen states now either prohibit or no longer license the practice. Moreover, although the ACNM has taken no official position on lay-midwifery, many of

the states which have adopted licensing provisions for CNMs (circa 1967) have simultaneously repealed new licensing for lay-midwifes. While the provisions contain "granny" clauses, permitting previously licensed midwives to renew their licenses, no new license will be issued (Evenson, 1983; p.325).

A chart listing the individual states positions on midwifery is listed at the end of this paper.

Seventeen states and Washington D.C. expressly provide for licensing or registration of lay-midwives, the remaining 17 have no legislation which specifically permits or prohibits lay-midwifery. Midwives however do not practice freely in states of either category. In some states the regulations governing qualifications for licensing are so restrictive as to be prohibitive. In others, regulatory agencies have stopped issuing licenses despite a clear legislative mandate to do so. Even in states without express licensing provisions, the practice of midwifery without a license may be considered the illegal practice of medicine, subjecting the midwife to criminal prosecution (Evenson, 1983; p.325)

Several explanations are suggested for governmental efforts to restrict midwifery to a branch of nursing. Physicians and nurses are opposed to another competing health care provider, particularly one which could be independent. Another explanation is due to the medical establishment's condemnation of homebirth, which provides almost the entire clientele for lay-midwives. The most pervasive explanation for the professional opposition is that lay-midwives lack the necessary skills and training which nurse-midwives acquire in four years of nursing school plus graduate work in midwifery. Lay-midwives however, are not, and need not be, without training many undergo very rigorous programs which are far more demanding than those attended by CNMs (Evenson, 1983; p.326).

Institutions employing nurse-midwives also oppose lay-midwifery.Their reason is that they cannot tolerate more than one type of midwifery practice, licensed under varying standards, in their institutions. A more plausible reason to this active opposition is the economic competition from homebirths that the lay-midwifes might encourage (Evenson, 1983).

Lay-midwifery was practically ignored up to the 1960's where it was confined to remote rural areas. However in the 1960's the natural child- birth movement became popular and the number of physicians and midwives attending homebirths has grown. These women desiring homebirths are not only "counter-culture" types but are also many educated members of the middle class. Acceptance of homebirth by mainstream American families poses a significant economic threat to OBs and challenges their belief in the supremacy of the physician and of technology. Although some physicians do attend homebirths, medical society's attitudes and sanctions keep their numbers limited. Consequently it is the lay-midwife who is the most frequent attendant at homebirths. Obviously the one way to deter homebirth is to eliminate the attendant. Thus the medical profession has initiated and supported efforts to make lay-midwifery unlawful and to prosecute lay-midwives (Evenson, 1983, p.326).

Despite legal prohibitions and other efforts to discourage homebirths, lay-midwives continue to practice, grow in numbers and become more visible as providers of health care (Evenson, 1983).

Due to this increase in elective homebirth choice lay-midwives have not limited their practices to states which license them; they increasingly practice without licenses even in those states where it is deemed unlawful. Practicing without a license produces two serious problems for midwives: risk of prosecution and the inability at times to obtain medical backup for emergencies. Criminal prosecutions for midwives have taken the form of practice of medicine without a license and prosecution for murder. For the most part lay-midwives have been successful in defending criminal prosecution but have had no success in establishing an affirmative right to practice (Evenson, 1983).

Even this threat of prosecution has not deterred the practice of lay- midwifery. It is practiced overtly and covertly in almost every state. One reason for this is that in many cases midwives have been successful in defeating charges. Mostly though they are committed to their profession and to a woman's right to deliver at home. The reality is that the focus of the lay-midwifery controversy is not adequacy over qualifications, but rather the debate over homebirth (Evenson, 1983).

Lack of medical backup for homebirths can create unnecessary risks and most of the unlicensed midwives expressed concern over this problem. In some cases physicians and hospitals are willing to provide such backup, in many they are not. Thus one of the problems of present medical attitudes and licensing laws is that it increases the risks to the women electing a homebirth (Evenson, 1983).

These barriers however have not stopped homebirth. The health care system should recognize qualified midwives and thus promote greater safety and support for homebirths, instead of trying to prevent it through punitive measures (Evenson, 1983).

My sister, Elaine Shank, delivered two babies (on separate occasions) at home, by lay-midwives, in Portland, Maine. I spoke with her and a friend, Krista Lair, a midwife's apprentice, about midwives and home births in Maine.

Midwifery is alegal in Maine. There is no legislation for/or against it.

Most of the midwives receive their training out of state. Elaine's midwife had studied midwifery in New Mexico where it is legal. After training all midwives serve as apprentices until they feel they are ready to deliver themselves. Most of them are certified by the Midwife's Alliance of North America (MANA). Many potential clients request that a midwife be certified to insure their validity.

Some midwives have backup physicians they can call in case of emergencies. Some clients have their own backup doctors they can call if need be. In my sister’s case, if there was an emergency, she would be brought to the hospital's emergency room and assisted by whatever doctor was on duty at the time. If the midwife was unable to deliver she would still advocate for the mother.

Elaine saw a flyer at the local health food store inviting people to a midwife conference. When she was three months pregnant she paid her first visit to the midwife practice. She received personal comprehensive, prenatal care and returned monthly until her ninth month when her visits increased to once a week. She called her midwives when she was in labor and they came right away. The midwives always travel in pairs and insist that one other adult besides the mother is present, so that in

case of an emergency the mother can be carried out. The midwives brought various supplies with them: a doptone, pitocin, oxygen, a fetal scope and homeopathic remedies. They also insisted that Elaine had emergency supplies also available in case something went wrong and they didn't get there on time. They coached Elaine through her labor, caught her baby, delivered the placenta, and had her husband cut the umbilical cord. They then left her, her baby and her husband alone for a half hour. They returned 30 minutes later and checked Elaine and her new infant. They also checked the placenta and told Elaine to keep it for a month in case there were any complications they'd be able to refer to it. They returned the next day and examined Elaine and her new infant and made an appointment with Elaine to see a pediatrician within a week. The whole birthing process was a natural, unencumbered, personal experience for the whole family.

In the Netherlands, during the Middle Ages, the midwife was an instrument of the church. Her main role was baptism and to save the soul of newborn infants. During the Dutch Republic (1579-1795) there was a major separation between church and state. The state was now concerned with only earthly duties while the church concerned itself with the care of the soul. All legislation and jurisdiction became the direct concern of the state, although they were actually delegated to local authorities with the regulation of medicine a municipal responsibility. Various towns appointed physicians whose duty it was to control medical practice including midwifery.Midwives tasks were now medical and hygienic they were no longer responsible to priests but to the doctors appointed by the town council. The town councils laid down fees for midwives to be paid per delivery (Abraham- Van der Mark 1993).

In 1668, Amsterdam made the midwives examination compulsory. The criteria for recruitment was no longer piety but citizenship, marital status (married or widowed), a good reputation, knowledge of writing, plus practical experiences in attending deliveries (Marland, 1993).

In the 18th Century, obstetrics was no longer the exclusive domain of women, since men began to assist delivering babies. The

master of obstetrics or man-midwife was introduced into the Netherlands. These man-midwives had more qualifications than women and were authorized to use instruments (such as various hooks and screws and early predecessors of the forceps), and could ask for higher fees. He usually performed the more complicated deliveries and also gave instruction to the midwife. Midwives were not permitted to use instruments so it appears that they specialized in manual techniques (Abraham-Van der Mark, 1993/Marland 1993).

Midwives were regulated by the laws of 1818 and 1865 which reiterated the prohibition of the use of instruments by women. It also stated that women could only attend deliveries that were the work of nature and which could be executed by hand. Only setting enemas and the use of the catheter were permitted to the midwife (Abraham-Van der Mark, 1993).

In the 19th C. Dutch midwifery and obstetrics incorporated a number of features that set them apart from other European countries and the USA. These were an early introduction to legislation control and licensing for both male and female OB practitioners, the institutionalization of midwife training and the very low incidence of hospital births (Abraham-Van der Mark,1993).

In the law of 1865 the midwife was declared indispensable. Legal regulation came early and without much commotion. After 1865, midwives came increasingly under the control and authority of male medical authority. Faced with increasing competition with doctors, midwives lacked the assertiveness and organization to defend their professional interests. These women came mostly from the lower middle class. Though some middle and upper-middle class women entered nursing they did not become midwives. They considered it an occupation of the lower classes. Nursing and midwifery developed separately and remain distinct up to the present (Abraham-Van der Mark,1993).

Midwives lives were not easy, they worked long hours for meager salariesand were held in low regard. Yet they maintained a high level of autonomy and the establishment of Midwife College ensured good training. In the 19th century the midwives' position was consolidated, firmly anchored within the Dutch

system of obstetric care (Abraham-Van der Mark,1993 p. 146.

Alarmed with the steady increase in home deliveries managed by general practitioners (with higher costs), legislation was drafted in 1925 to protect midwives against the competition of doctors. The Secretary of Health emphasized that the argument in favor of the midwives monopoly was not based on cost, but rather the higher quality of obstetric care they provide. He stated that they were better trained in obstetrics than general practitioners and that they had the right professional attitude of being patient. In 1941, during the German occupation of the Netherlands, the Ziekenfondsen (the Dutch National Health Insurance System that covers 65% of the population) was established. The board of this institution decided (in 1941) to give midwives a monopoly over normal obstetrics, without the use of instruments. This marked an important advance in the midwives' position. The monopoly implies that in normal home deliveries the insurance pays for the services of a midwife, which includes all prenatal and postnatal care. Hospitalization is only covered where there is some evidence or suspicion of a problem. Women who have private insurance are free to choose between delivery at home or in a hospital, and between the services of a midwife or a general practitioner. Since the early 1980's however, Ziekenfondsen reimburses women who prefer the short stay hospital delivery to home birth, thus giving them greater freedom of choice (Abraham-Van der Mark, 1993 p.147).

Before 1987 the midwife had to consult with an OB about whether or not a pregnant woman was low or high risk. The low risk woman can give birth at home while the high risk woman is referred to a fully equipped OB department. Since 1987 the midwife is now able to define what is normal and abnormal and she is the one who makes the final decision (Benoit,1992/ Abraham-Van der Mark '93)

The midwife's education is aimed at enabling her to function autonomously. The criteria for recruitment and curriculum for midwives, have repeatedly been made more rigorous. There are three colleges for midwives, in Amsterdam, Rotterdam and Heerlen. It is difficult to be admitted to any of them. Of the annual 1,000 applicants only 75 new students are admitted. They must have at

least five years of secondary education with A grades in chemistry and biology. They are also screened for personal characteristics through interviews. About 80% of all students obtain the license and take the Hippocratic Oath, which leads to independent practice. Men were only admitted to midwife colleges in the 1970's and by 1991 there were 36 men enrolled compared to 1115 women (Abraham-Van der Mark, 1993 p.150).

The training course lasts 3 or 4 years with theoretical and practical work combined each year. Theory includes chemistry, anatomy, human physiology, obstetrics, pediatrics, gynecology, family planning, psychology and sociology. Each school is allied to a large OB/GYN unit that specializes in low- and high-risk pregnancies and deliveries. Students receive practical training in these units, as well as with midwives who have a private practice.They are required to perform 40 supervised deliveries before they can takethe licensing examination (Abraham-Van der Mark, 1993 p. 150).

Midwife schools from the beginning have had male OBs for directors. This changed in the 1970's when a woman OB was appointed as director. When she retired in 1991, she was replaced by a midwife, and it was decided that this position would now only be available to midwives. This control over training is yet another advance in the midwives' professionalization (Abraham-Van der Mark, 1993).

The midwives training course is totally separate from nursing. The two occupations evolved separately, and there is an essential difference in orientation and outlook. The nurse is devoted to the care of the sick, injured, and dying while the midwife assumes the care of the normal healthy woman and her infant (Abraham-Van der Mark, 1993).

Midwives attended 45% of all deliveries in 1991. They are required to give prenatal care, care during the labor and delivery, and post-natal care independent of other health care professionals. Only in the case of complications is the woman or baby referred to an OB or pediatrician. Midwives attend births independently at home or in hospitals. Those working in private practice come to the hospital to attend clients during

labor and delivery. 15% of all midwives are hospital employed (A'ham-Vd.Mark,1993).

The midwives task is directed towards the prevention of unnecessary medical intervention and when possible the prevention of pathology. Midwives are expected to function as psychological and social counselors for their clients, and must be reluctant to intervene in the birth process. They boost the self-confidence of the mother and try to create a tranquil atmosphere. They believe that it is essential for a laboring woman to feel that she is in control in order to give birth effectively and without fear. They assume this will prevent a considerable amount of pathology (Abraham-Van der Mark '93).

This method used by Dutch midwives is known as the physiological approach, and is based on the principle that in human beings, pregnancy and birth are essentially normal physiological processes that generally require only good prenatal care and counseling. Continuity of care is considered essential: ideally the woman sees the same midwife during her entire pregnancy, labor, delivery and lying in period. Though now there is an increasing number of group practices where several midwives work together and take turns seeing their various clients (Abraham-Van der Mark, 1993).

In 1990 71% of all midwives were in independent practice (15% were employed in hospitals). Of this 71%, 37% had a solo practice, though others worked as partners or in group practices. The group practices are increasing the fastest. The midwife must be available at any hour, day or night, through a physicians or messaging service. In a group practice they require 24 hour availability and readiness can be divided among the group (Abraham-Van der Mark, 1 9 93).

Although there is an increase in the professionalism of midwives, their use of technology has remained extremely limited. For prenatal care their technology includes a monoauricular stethoscope for listening to fetal heart sounds, a doptone, a sphygmometer, stethoscope, blood taking equipment, strips for testing urine, and a scale. The kit that a midwife

takes with her to a woman in labor consists of 2 kochers (for cutting the umbilical cord), needles and suturing equipment in case an episiotomy is needed, resuscitation equipment and oxygen, sterile gloves and a scale to weigh the baby, a few medicines, and a birthing stool. The mother is given a list of articles that she must have ready for the birth. These are simple, cheap objects that can serve various purposes and are available to everyone (Abraham-Van der Mark, 1993).

There is an ongoing controversy about whether or not to use ultrasound, some midwives use it, others do not.

I went through a midwife practice in Amsterdam in 1990 when I was pregnant. The office was at the top of a set of very steep stairs. The waiting room was very cozy with a comfy couch, lots of plants, a basket full of children's toys, and loads of books and magazines. The midwives' office was the same homey atmosphere. A single narrow bed stood behind a screen for examination, next to it was a device to listen to the baby's heartbeat.

There were three midwives in the group practice I chose. I saw a different one each time. They were all very friendly and helpful and full of good advice. I saw them once a month. I remember one of the first questions they asked me was whether I wanted to deliver at home or in the hospital (I had private insurance. Being American I chose the hospital.)

When I was 36 1/2 pregnant my water broke, at 1:00 A.M. I called my midwife and she came over immediately. Though she was unable to deliver my baby since I was under the 37 wk. "normal" birth regulation she still accompanied me to the hospital and came to check on me when I returned home. I was in the hospital for about 30 hours. I sat on the end of my bed in a birthing room and a woman doctor caught my baby. My husband was my coach. There were absolutely no drugs offered to me. My brand new infant was placed on my belly immediately after delivery, my husband, later, cut the umbilical cord. We walked home with our baby the next morning. My midwife came to examine my son and I the next morning and for the next 8 days a kraamzorg (room help, literally) came every day to briefly examine the baby and I, answer any questions we had, and help with whatever was needed. The whole experience, besides the

pain of labor, was a very comforting, natural life giving experience.

I have found that the major difference between childbirth in the United States as opposed to the Netherlands is the basic philosophies they maintain. In Holland childbirth is considered a natural process and treated as such. In the USA it is considered a medical procedure (in most cases).

In the Netherlands a normal birth consists of a midwife assisting with the birth in the home or hospital and letting nature take its course. There are no drugs and no operating room procedures.

A typical birth in the United States can be characterized as physician attended and professionally managed with an orientation towards medical technology and pharmaceutical methods of pain relief (Jordan, 1978 p.33).

In the US 95% of all babies are born in the hospital. In Holland one-third of the babies are born at home. Of these US hospital births a large percentage of the women receive drugs during labor. They can't cope with the pain because they know that they can have medication for it. In Holland the Dutch women learn how to deal with the pain (through breathing exercises) since they're not expecting any medication (Jordan, 1978).

Prenatal care in the US is seen as a doctor's event. A pregnant woman sees a doctor in the beginning of pregnancy and continues monthly visits until the ninth month and then at weekly intervals. These visits include checking weight, blood pressure, having blood and urine analyzed, the fetus' growth is assessed and problems are discussed (Jordan, 1978).

In Holland prenatal care is free, universal and comprehensive. Midwives first distinguish between normal and abnormal pregnancies and assign an appropriate environment to each. In the US no differentiation is made between the two -the OB caters to both normal and abnormal pregnancies). The midwives prenatal visits are conducted in an atmosphere much more relaxed, unhurried and supportive and personal than is usually the case in medical consultations (Jordan, 1978).

In the US 25% of pregnant women have no prenatal care at all. The absence of prenatal care is unheard of in Holland. The availability of abortion upon demand results in a low number of unwanted pregnancies. Women in Holland are highly motivated to play an active part in assuring the best possible preparation for birth (Jordan 1978).

In Holland, walking around during labor is encouraged. Women can choose to deliver on a birthing stool, in a squatting position, or however they feel is best. In the US the woman is often confined to a bed with her feet in stirrups, and a sterile barrier between her and her OB (Jordan '78).The mothers and therefore babies are often drugged at birth and separated immediately in the US. In the Netherlands the baby is placed immediately on the alert mother's stomach.

The midwives in the Netherlands have complete autonomy over childbirth whereas in the US it is still a renegade operation in about two-thirds of the states.

The movement back to midwifery in the United States would certainly help to end some of the medical intervention in childbirth. My sister's birthing experience with lay-midwives in the state of Maine was very similar to the midwives homebirth deliveries in Holland. If we could take some advice from the Dutch and provide appropriate training and licensure for all midwives in the United States and grant them autonomy over normal births the laboring woman would feel that she was in control and not just a participant in a medical procedure. This would lower risks for renegade homebirths and lessen the workload for OB physicians. Less space would be taken up in the hospital (which could therefore be used for people who are actually sick) and the expense to the expectant family would be drastically decreased.

The whole issue of midwives and home birth is similar to the campaign for the right to choose. Shouldn't we, the women have the right to decide where and with whom we want to have our baby??

INDIVIDUAL STATES' POSITIONS ON MIDWIFERY

The following states do not provide licensing for direct-entry midwives and have laws prohibiting the practice of midwifery. It is illegal to practice midwifery in these areas and the midwives who choose to practice do so at great personal risk.

Illinois	Kentucky	West Virginia
Iowa	Maryland	Pennsylvania
Kansas	New York	North Carolina

The following states make no determination concerning the practice of direct-entry midwifery. These areas are referred to as "alegal." Midwives who practice in these areas are subject to random selective prosecution for practicing medicine or midwifery without a license.

Alabama	Indiana	Nebraska	Tennessee
Connecticut	Maine	Nevada	Utah
Delaware	Massachusetts	North Dakota	Vermont
Georgia	Michigan	Ohio	Virginia
Hawaii Idaho	Minnesota	Oklahoma	Wisconsin
	Missouri	South Dakota	Wyoming

The following states have enacted legislation that regulates the practice of direct-entry midwifery. Each state has its own requirements for obtaining and maintaining a license to practice midwifery. It is up to the individual practitioner to decide whether or not to follow the state mandates in her home state to apply for licensing and to work within the guidelines of practice. Some midwives obtain licenses and others do not.

Alaska	Colorado	Montana	Oregon
Arizona	Florida	New Hampshire	Rhode Island
Arkansas	Louisiana	New Jersey	South Carolina
California	Mississippi	New Mexico	Texas

(Harper 1994, p. 123-124.

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