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Organized Labor: The Past, Present, and Future of Nurse-Midwifery in America

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ORGANIZED LABOR

The Past, Present and Future of Nurse-Midwifery in America

A Thesis
Presented to
The Faculty of the Department of American Studies
The College of William and Mary in Virginia

In Partial Fulfillment
of the Requirements for the Degree of
Master of Arts

by

Amy Procter Matthews

1990
APPROVAL SHEET

This thesis is submitted in partial fulfillment of
the requirements for the degree of

Master of Arts

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To Buster
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ABSTRACT

The purpose of this thesis is to determine the future of the profession of certified nurse-midwifery in America and the steps nurse-midwives should take to secure their place in this nation's health care system. The paper focuses on the medical model of childbirth and on how that model, along with the natural childbirth movement, has shaped the growth and development of nurse-midwifery in this country.

The historical analysis for this study was based on the examination of journal articles from the early twentieth century, letters, popular magazines, and secondary sources written specifically about midwifery. Analysis of the current status of midwifery and information for the recommendations given was derived from current health care literature, interviews, popular magazines, newspaper articles and personal experience as a health care administrator.

Examination of the history and current trends in American childbirth practices indicate that the use of certified nurse-midwives as educators and birth attendants is increasing, and that nurse-midwives offer a safe and cost-effective alternative to the medical model of labor and delivery. Nurse-midwives can also be instrumental in combatting infant mortality through their provision of comprehensive prenatal care to underserved women. There are certain steps, however, that nurse-midwives must take in order to strengthen and expand their place in American culture. Those steps are to:

1- Develop a market for services.
2- Increase that market by enlisting the support of the medical community.
3- Use that support to incorporate nurse-midwifery into the nation's health care policy.
4- Take advantage of current industrial trends to create a stable professional niche.
5- Ensure the future supply of nurse-midwives by taking an aggressive stance in combatting the nursing shortage.

Nurse-midwives can and should be a part of the solutions to the complex problems of access to care, infant mortality, maternal health, and the availability of choice for women in terms of birthing methods. These recommendations, if followed, should enable certified nurse-midwifery to do just that.
ORGANIZED LABOR

The Past, Present and Future of Nurse-Midwifery in America
INTRODUCTION

Childbirth in modern America has been, until quite recently, a very female act controlled almost exclusively by men. Although midwives played the central role in the birthing process through the mid-eighteenth century, childbirth since that time has been primarily a male, and medical, event; and in the process the American woman has been forced, either by finance or fashion, to follow what has generally been someone else's idea of the best method for giving birth. It is only in the last twenty years that American women have really begun to have a say in how, where, and with whom they wish to labor and deliver, and the battle is by no means over. Many American women do not realize that they have choices in the type of prenatal care they receive or the method by which they will give birth. The medical model of childbirth, which views pregnancy as a pathological state from which one must be safely delivered, is firmly imbedded in our culture, and that model is strengthened as men and women look to physicians, hospitals and technology for promises of a perfect baby. Women are willing to have their emotional and sometimes physical needs overlooked
during pregnancy and delivery if such action will guarantee the desired result of a healthy infant. They are not aware that all this highly technical, and very costly, activity is only necessary for a small percentage of the population. Nor are these women aware that there are indeed alternative birthing options, and that it is in fact possible and quite safe to deliver a baby without all the anesthesia and medical apparatus.

While some women may be using too much technology, others are denied access to the health care system by myriad roadblocks such as poverty, lack of education, or distance to a facility or practitioner. The American health care system is one of the most technologically advanced in the world, yet the United States currently ranks 22nd among industrialized nations in its infant mortality rate, a statistic that has worsened since its ranking of 15th in 1968 and 19th in 1987. While other countries are improving their birth statistics, the U.S. is experiencing a decline.¹ One reason for this statistic is a lack of prenatal care, especially among pregnant teenagers and those who fall below the poverty line. Physicians are concentrating their practices in affluent suburbs, and rural and inner-city areas are increasingly underserved. Hospitals that have

traditionally served indigent populations are being forced to curtail services as Medicaid payments continue to decrease despite spiraling costs. Interest groups on all fronts, from women's rights advocates to the medical establishment, are calling for commitment on the part of the nation's leaders to help rebuild a maternity system that "is fundamentally flawed, fragmented and overly complex." There is a critical need for a comprehensive, cost-effective method of maternity care which takes the wants and needs of the other into consideration. The field of nurse-midwifery offers such a method.

The common perception of the traditional midwife is that of a woman who attends an expectant mother, usually at home, during labor and delivery. Modern American midwifery, however, goes far beyond the birthing process. Today's certified nurse-midwives provide prenatal, postnatal and gynecological care, often in rural or other medically underserved areas. Certified nurse-midwives are registered nurses with at least one year of nursing experience who then receive advanced training in normal obstetrics and childbirth. The number of nurse-midwives has increased more than ten-fold in the last two decades, with much of that growth in the last five years. There are approximately 4,000 certified nurse-midwives (CNMs) in the U.S. today.

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Certified nurse-midwives practice in all 50 states in a variety of health care settings including hospitals, clinics, alternative birthing centers, and health maintenance organizations (HMOs). Some are in private practice while others are part of physician groups. The majority practice in hospitals, while others provide care in the traditionally underserved populations in rural areas and the inner-city.³ Certified nurse-midwives have brought back the midwife traditions of full attention, support and service to women before, during, and after delivery. Many women feel that the CNM "thinks of all the little things the doctors don't have time to talk about."⁴

This careful attention and understanding are in sharp contrast to the medical model of childbirth, and as women have become disillusioned with traditional hospital delivery, the demand for nurse-midwifery service has increased.⁵ Midwives are a part of the solution to this nation's astounding infant mortality rate, as well as a means by which skyrocketing healthcare costs can be reduced. Certified nurse-midwives are also an answer to women's desire


for a healthcare practitioner who understands and has time to attend to their emotional and physical needs during pregnancy and childbirth.

Despite such attributes, the role of the nurse-midwife in our society has yet to be well-defined or accepted. Midwifery in America has long been a topic of vigorous debate. From her near-extinction in the late nineteenth century to her modern-day existence, the midwife has been embroiled in an ongoing struggle for survival, acceptance, and autonomy. This thesis will examine the emergence of the nurse-midwife in American society and explore her role in the solution to the problems facing childbearing women and their families in today's climate of high technology and high cost. The thesis will relate the growth and development of the nurse-midwife to the medical model of childbirth that exists in our country and make specific recommendations for her future survival.

In order to understand those recommendations more fully, it is important to know some of the history surrounding childbirth and midwifery in this country. American birthing methods developed from a combination of social, cultural and medical forces characteristic of our culture, reflecting a uniquely American fascination for invention and daring. Unfortunately, that fascination resulted in an almost blind faith in science, technology, and the medicalized methods of childbirth that are widely accepted today. The first section
of this paper will summarize the social and medical history that helped create our current methods of childbirth and the modern-day nurse-midwife. The second section will examine the growth of the profession of certified nurse-midwifery and the dilemma in which CNMs find themselves as they struggle for autonomy. The final section will identify the steps that must be taken by nurse-midwives, legislators, the medical community, businesses, and the public if nurse-midwives, and our maternal health care system, are to meet the future needs of this nation.
CHAPTER I
"A WOMAN CONFINED"

Development of the American Medical Model of Childbirth

The medical model of childbirth in America has its roots in the eighteenth century. Until then, midwives played the central role in the birth process, starting with the delivery of three babies on the Mayflower. There were few rules and regulations governing midwives in colonial America, the craft of midwifery was held in high esteem, and any woman who had borne children and had assisted with births could practice the art of midwifery.6

The lying-in chamber was a woman's place. The laboring woman was surrounded by female family members and friends who supported her in delivery and stayed to help during the period of confinement following birth. Modesty and morality kept men far from the scene. Midwives allowed nature to take its course. They did not use the forceps that had become

popular with the barber-surgeons in Europe, nor did they take "heroic" measures such as bloodletting or purging. 7

In the mid 1700s, the work of William Smellie, a British physician, did much to open the world of obstetrics to men. Smellie popularized the use of forceps in the birthing process in addition to teaching midwifery to more than 900 students. By the latter part of the eighteenth century, the concept of male-midwifery was accepted by the English upper classes, and the increased popularity soon made an impact on American birthing practices. 8 Women were thought to be incapable of mastering the new obstetric techniques, and the status of traditional midwives declined.

The development of formal medical education in America during the third quarter of the eighteenth century provided male midwives with a decided advantage over their female counterparts. Women were excluded from the four American medical schools and were thus prevented from learning the new obstetric techniques and practices that would have made them better practitioners. Lacking advanced training, midwives were relegated to normal births and as the number of trained obstetricians increased, more and more women wanted physicians for their normal deliveries as well. 9 As the use of physicians for childbirth increased, the practice of

7Ibid., 5.
8Ibid., 8.
9Ibid., 12.
midwifery floundered. American midwives lacked the social networks and support systems of their European counterparts, and this isolation led to the retirement of many midwives, giving strength to the growing ranks of obstetric "specialists."  

Not all women were pleased with the new interventionist techniques of the medical world. The development of the popular health movement during the 1830s and 1840s gave a breath of life to midwifery and to natural childbirth as the working class expressed dissatisfaction with the fatal cures of "regular doctors." Women's rights advocates allied with lay practitioners in opposition to the established medical views, and some doctors were challenged by the movement.  

In 1848, however, the American Medical Association, having established itself as the nation's official medical organization, gave "regular doctors" a secure base from which to practice and prosper. Man and machine were in control. Naturalism was once again the deviant and backward way of doing things, intervention the norm. Birth was becoming an increasingly private affair, one that was attended by a physician armed with the latest in technology.  

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10 Ibid., 18.  
11 Ibid.  
12 Ibid., 19.  
13 Catherine M. Scholten, "On the Importance of the Obstetrick Art: Changing Customs of Childbirth in America, 1760-1825," in Women and Health in America: Historical
A variety of medical discoveries during the 1800s served to widen the gap between trained physicians and midwives. The introduction of anesthesia in the late 1840s significantly altered the birth process. Queen Victoria's use of what she termed "that blessed chloroform" for her delivery in 1853 was noted around the world, and women seeking relief from birth pain began to demand its use. The development of germ theory and discovery of the contagious state of puerperal (childbed) fever in the 1840s revolutionized the process of childbirth. Independent discoveries by Oliver Wendell Holmes and Ignaz Semmelweis revealed that physicians were carrying germs on their hands as they moved from one patient to another. Although their theory was initially dismissed by the medical profession, their findings eventually led to the use of antiseptic and aseptic techniques for Caesarian sections and other obstetric and gynecologic procedures, while new instruments enabled the physician to listen to the fetal heartbeat, dilate the cervix


14Romalis, 19.

15Litoff, 14.

and induce labor contractions. Dr. J. Marion Sims, the "father of modern gynecology," designed the curved vaginal speculum, and in 1855 established the Women's Hospital of New York City, the first hospital in the United States devoted entirely to the care of women and children. Midwives were not invited to study these developments, and by the late 1800s, most manuals for mothers and pregnant women were written with the assumption that women would hire a physician to deliver her baby.19

Childbirth had evolved from a natural process to a pathological one, and in 1888, the American Association of Obstetrics and Gynecology declared obstetrics "a complicated specialty which only the physician was capable of pursuing."20 Midwives were no longer equipped to handle the job they had performed for centuries, and their continued role was seriously in question. During the early twentieth century, obstetrics was considered the least appreciated branch of medicine. Critics of midwifery believed that there was a correlation between the number of midwives and the low status of obstetricians. While British physicians were organizing training programs and regulatory systems for their midwives, American doctors viewed the elimination of the

17Romalis, 19.
18Litoff, 18.
19Ibid., 14.
20Ibid., 21.
midwife as essential to the advancement of their specialty.21 What was viewed by the British as a help was seen by Americans as an adversarial force.

In 1898, Dr. H.J. Garrigues, a New York City obstetrician, published an article stating that midwives were "inveterate quacks, who are consulted in regard to almost anything. They never acknowledge their ignorance, and are always willing to give some advice."22 Dr. Garrigues urged the United States to "form a vanguard in a war of extermination against the pre-antiseptic days, midwives, and schools of midwifery."23 Hospitals, according to the doctors, were no longer dangerous places. Trained, skilled physicians practiced there, and the hospital would provide a haven from the germs and disease of the outside world. Although immigrants, adhering to European tradition, continued to be attended by midwives, most urban middle class American women at the turn of the century viewed midwifery as something poorly suited to the "progressive" American situation. Increasing numbers of women were inviting doctors to attend their labors, and a growing number


23Ibid.
of the well-to-do were choosing the hospital as a place to give birth under the watchful eye of their private physician. 24

Midwives found themselves competing with physicians for patients, and without the support of an association to represent their professional and legislative interests, they were powerless. 25 At the same time, nursing was rising as an acceptable profession and legitimate outlet for women, and many women who might have chosen midwifery as a career enrolled in nursing programs instead. Those who did choose midwifery found that they were denied access to middle class women and were relegated to the poor and to those who lived in areas where admission to a hospital was not feasible.

The midwife was not the only one losing ground, for as the use of obstetrical tools and anesthesia moved childbirth to the hospital, women lost even more control over their own labor. The fear of pain, debilitation and death was very real for parturient women up to the twentieth century. High maternal and infant mortality rates and widely-held perceptions of childbirth as a possibly fatal procedure contributed to women's willingness to make the move to the

24Litoff, 28.

These worries help explain why women relinquished the close-knit relationship of mother, friend, and midwife and allowed the obstetrician to take control. They left their friends and families behind during hospital deliveries in hope of a healthier outcome.

In 1900, less than five percent of American women delivered in hospitals; by 1920 more than half of the births in large cities such as Spokane, San Francisco, Washington, D.C., Hartford, and Minneapolis took place in hospitals. Hospital deliveries in Cleveland, for example, increased steadily from one quarter of all deliveries in 1920 to three quarters a decade later.27 By 1939, half of all American women and three quarters of all urban women were delivering in hospitals. Rural women followed suit as increased use of the automobile enabled them to travel considerable distances to medical facilities, making a hospital birth a possibility even after labor had begun.28

The urban poor sought out hospital care for different reasons; since many midwives had either retired or been prohibited from practice, there were no attendants for home delivery. Further, the "Americanization" of second


27Ibid., 133.

28Ibid.
generation immigrants was such that they no longer had the social networks to support home birth, and they too went to the hospital for delivery.29

In a 1920 article written for the *American Journal of Obstetrics and Gynecology*, Chicago physician Dr. Joseph B. DeLee outlined the procedure for a routine hospital birth designed to spare both mother and child. The procedure required sedating the woman through labor, administering ether for the delivery and removal of the baby with forceps, and performance of an episiotomy, after which drugs would be administered to expel the placenta and prevent postpartum hemorrhage.30 Dr. DeLee portrayed the birth process as a dangerous journey, stating that in a normal birth the infant risked brain damage when its head was crushed against the pelvic floor "as if being slammed in a door," likening the force of the infant against the perineum to that of a woman "falling on a pitchfork."31 He thus argued that labor was a pathological process, one that must be carefully controlled by the physician. Dr. DeLee's procedures represented the

29Ibid., 159.
30Rothman, 58.
best intentions of obstetrics, and by the 1930s, were standard in many hospitals.  

Dr. DeLee's rationale seemed sound. Women were experiencing perineal tears, and episiotomies avoided that problem; yet as with puerperal fever, doctors were slow to question whether they might be creating some of the problems. Women in the hospital delivered flat on their backs with their legs strapped into stirrups, the classic lithotomy position. While convenient for the doctor, this position placed great strain on the perineum, making tears more likely; it also made labor more difficult by forcing the woman to fight gravity as she pushed the baby up and out of the birth canal. As one South American physician put it, "Except for being hanged by the feet . . . the supine position is the worst conceivable position for labor and delivery."  

As late as 1973, doctors were still looking for scientific proof that Dr. DeLee's hypothesis about protecting the child's head via episiotomy and forceps was true.  

One medical intervention often required the use of another. Anesthesia slowed labor, oxytocin started it up again; the lithotomy position combined with the force of

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34Wertz, 1977, 143.
induced contractions would necessitate an episiotomy, which in turn would require more anesthesia, and so on. Thus while better procedures and techniques might have made the hospital a safer place to give birth than in the past, the routinization of interventions may well have negated any progress that had been made.35 Doctors continued to view birth as an abnormal, pathological process requiring routine medical assistance in order to avoid disaster.

This is not to say that women did not request such medical treatment. As early as 1918 many American women were eager to let someone else do the worrying; "I have placed myself in the hands of a specialist in obstetrics," wrote Lella Secor in a letter to her mother. "I have nothing to worry about. I have every confidence in him and it is a great relief."36 Although professional medical care was desirable, cost was a considerable factor for women giving birth in the 1920s and 1930s. There were few prepaid health plans that covered maternity care, and couples shopped carefully for the best buy.37 A letter to Ladies Home Journal in 1923 stated:

Our first baby cost: for layette - with strictest economy - $25; ten days in a maternity hospital, $35; dressings and laundry at hospital, $5; doctor's charge, $25; anaesthetic, $5; total, $95. I nursed my baby, took entire care of her, and did all my own

35Ibid.


housework. . . We now have $46 in the bank to meet expenses for the new baby. . . Let the doctors make a more nominal charge, and let the magazines and newspapers quit scaring people into thinking that medical and nursing attention are necessary for weeks afterward. 38

Despite these concerns for cost, the popular journals of the time such as Harper's, Atlantic, and Ladies Home Journal embraced the medical model of childbirth, publishing countless articles on the steps that should be taken to get "the best" in maternity care. 39 A 1939 Atlantic article instructed women that childbirth was a surgical procedure, one that could be performed only under the most sterile conditions, and women believed it.

In certain parts of the country, however, hospital delivery was not possible, and it was in those underserved regions that midwifery survived. In 1925, Mary Breckinridge, a graduate nurse and native of Kentucky founded the Frontier Nursing Service. Breckinridge and several British nurse-midwives formed a traveling midwifery program, riding on horseback to care for laboring women in the isolated Kentucky mountains. Breckinridge and her fellow midwives were unique in that they were not only trained midwives, but certified

38 Ibid., 158.
39 Ibid.
public health nurses as well, and they were able to provide a broad spectrum of care to their patients.40

For most middle class Americans of the 1930s and 40s, however, hospital delivery by a physician was seen as the only way to give birth. A popular column in *Ladies Home Journal* during the post World War II "baby-boom" years was "Tell-Me-Doctor," in which Dr. Henry B. Stafford discussed a medical issue with an anonymous female patient. Dr. Stafford instructed readers to obey the hospital staff, for they were professionals who certainly knew more than the reader about how to give birth.41 When asked by his invisible patient whether or not the doctor would be with her throughout the labor, "Tell-Me-Doctor" replied:

> It won't help much to have him sit by the bedside and hold your hand. . . . it is far better that he come in with a fresh point of view at the time when he is needed.42

"Tell-Me-Doctor" informed readers that family members would only be "well-intentioned but uninformed advisors" and should thus stay at home until the patient, after being strapped to the delivery table and anesthetized, was safely

91 Radosh, 137.


and scientifically delivered of her infant. Such faith on the part of both patients and the American public played a major part in elevating the medical profession to a high status in American society. Not all women, however, were completely happy with the medical model.

As the medicalization of childbirth progressed, women discovered that instead of being comforted by the efficiency of the hospital, they were alone among strangers. The laboring woman felt as though she was on an assembly line and learned, perhaps too late, that by moving to the physician's realm she had given him the reins. Twilight sleep, a procedure developed in Germany at the turn of the century and used in this country during the 1920s-50s, is an example of the double-edged sword that women faced when they went to the hospital for delivery. The procedure combined the use of morphine for pain in labor and scopalmine, a supposed amnesiac, for delivery. Twilight sleep was a first sign of women's attempt to regain control over their labor and delivery. Yet in demanding and obtaining the pain free labor provided by twilight sleep, women also gave themselves up completely to the medical realm; for the use of the powerful drugs required careful monitoring, especially as

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43 Edwards, 30.

women tended to thrash about and were in danger of throwing themselves out of bed. Women were confined to canvas cribs for their own safety and had to be watched as closely as the newborns which they were about to deliver.

Despite these physical restraints, women felt "delivered from bondage" even though, due to the drugged state of both mother and infant, they might not be introduced to each other for days.45 Yet some women began to wonder whether such total anesthesia was indeed the only way to deliver, and whether such total submission to the physician, and to hospital procedure, was really necessary. Medicine had made labor and delivery safer, and thus less fearsome, and having a child began, for some, to look more like a natural process than a painful and destructive one. Women began to admit that "going down into blackness, coming up to only know that something big and dreadful is happening" might not be the only way to give birth.46

Dr. Grantly Dick-Read, a British physician, had a great impact on American mothers-to-be with the 1944 publication of his book Childbirth Without Fear. Read argued that women's pain during labor and delivery stemmed from fear and tension. He wrote that if a woman's fear could be removed by preparation for birth as a natural event, she would relax

45Rothman, 60.
46Wertz, 1977, 180.
and thus not suffer. 47 The Lamaze method of childbirth, developed during the 1950s by Paris physicians Ferdinand Lamaze and Pierre Vellay, also used relaxation techniques along with a shallow breathing pattern that became an integral part of the "Lamaze Method" of childbirth. 48

Using breathing and relaxation techniques and little or no anesthesia, a woman regained control of birth. This reclamation of control in childbirth became popular among educated, middle-class women. Some physicians, such as anesthesiologist Virginia Apgar, did agree that less anesthesia was indeed safer, and that childbirth education could work for the doctor's convenience as well as the patient's. 49

Unfortunately, the Read and Lamaze methods were not readily adaptable to the American way of birth. Read developed his method in the British system, one that was very different from the American medical model of the 1940s. British women were routinely attended by midwives and had their support and encouragement during labor, as well as the benefit of thorough prenatal care and education. American women, on the other hand, were often left to labor alone,

47 Ibid.
49 Virginia Apgar pioneered research in the effects of anesthesia on newborns, and developed the Apgar Test which is given to neonates at one minute and five minutes after birth as a measure of reflexes and cognition.
vulnerable to fear and anxiety. The Lamaze clinic in Paris had an informal atmosphere. A woman labored and delivered in one room, where her husband or partner and a "monitrice" (a trained birth attendant) coached and supported her. American hospitals, on the other hand, moved the laboring woman from one location to another as she progressed, and although some facilities allowed husbands to accompany their partners, they were looked upon as more of a controlling force, someone to keep the woman quiet, rather than as part of the obstetric team.50

The Americanized Lamaze method left the doctor in charge. The manual for A Practical Training Course for the Psychoprophylactic Method of Childbirth, written in 1961 by Elisabeth Bing and Marjorie Karmel, explicitly stated that "In all cases the woman should be encouraged to respect her own doctor's word as final . . . he is responsible for her physical well-being and that of her baby. She is responsible for controlling herself and her behavior."51 Moreover, the physician was allowed to judge the extent of a woman's pain. "If your doctor himself suggests medication," advised the authors of the manual, "you should accept it willingly--even if you don't feel the need for it--as he undoubtedly has very

good reasons for his decision.\textsuperscript{52}

Thus while American physicians and hospitals did make adjustments for "prepared" childbirth, it can hardly be said that the movement shook the foundations of the medical establishment, and Lamaze instructors told their students to expect the standard medical routine.\textsuperscript{53} In the late 1950s, however, increasing numbers of women rebelled against that standard routine and the way they were treated by both physicians and staff during their hospital stays.

In May 1958, an anonymous maternity nurse wrote to that American institution, \textit{Ladies Home Journal}, urging that something be done about the "cruelty on maternity wards." The publication of her letter was a first for the \textit{Journal}, which up to that time had stood by the Tell-Me-Doctor tradition of printing that doctor knew best. The \textit{Journal} received hundreds of letters in response to the nurse's letter reporting countless instances of "dehumanization" and "unconcern for mother and baby."\textsuperscript{54} Women from all classes and in all situations found that hospital births could be inhumane. One woman wrote:

\begin{quote}
I was left alone all night in a labor room. I felt exactly like a trapped animal. . . . Never have I needed someone, anyone as desperately as I did that night.
\end{quote}

and another:

\begin{quote}
\hspace{1cm}
\end{quote}

\textsuperscript{52}Bing, 33, in Rothman, \textit{Childbirth}, 170.

\textsuperscript{53}Rothman, 91.

\textsuperscript{54}Wertz, 1977, 170.
I was strapped to the delivery table on Saturday morning and lay there until I delivered on Sunday afternoon. When I slipped a hand from the strap to wipe my face I was severely reprimanded by the nurse.55

Women reportedly had episiotomies sewn up without anesthesia, were left alone for sixteen hours of labor or were literally battered by nursing staff.56 Nearly half the letters charged that they were prevented from giving birth until the doctor arrived.

I was strapped on the delivery table. My doctor had not arrived and the nurses held my legs together. I was helpless and at their mercy. They held my baby back until the doctor came into the room. She was born while he was washing his hands.57

Women went for hours after delivery without seeing their babies, and many women left the hospital feeling that they did not really know or feel attached to the infant which they were taking home. Nurses whom Journal editors consulted did not deny that the patients' allegations could be true.58

The publication of "Cruelty" and of the ensuing response was an important step for Ladies Home Journal. The magazine represented traditional American values, and the fact that the editors viewed these women's letters as important

55Ibid., 171.
56Ibid., 172.
58Edwards, 55.
illustrates the changes that were taking place as American women entered the 1960s. Although the article did not have a direct impact on hospital practices, it did give women an outlet, enabling them to see that they were not alone in their dissatisfaction with the hospital experience. The article brought to light a topic which, until that time, had been shrouded in medical secrecy, and allowed women at least to question the necessity of all the policy and procedures involved in a modern delivery.

Thirteen years later, another publication, one much less traditional, addressed the same issue. *Our Bodies, Ourselves*, published by the Boston Women's Health Book Collective, covered health issues ranging from body image to birth control. The purpose of the book was to make health information readily available to women and to help them take charge of their own health care. 59 *Our Bodies, Ourselves* gave clinical descriptions of pregnancy and childbirth not previously available to the lay reader. The authors let readers know exactly what they should expect from their bodies, and from the health care professionals who would be taking care of them. That first issue of *Our Bodies, Ourselves* was a landmark in that it not only informed women that they could control their pregnancy and other aspects of their health care, but gave them the step-by-step

instructions on how to do so. The book was also intended to help women "fight, whenever possible, for improvements and changes" in the existing medical system.\textsuperscript{60}

In 1984, \textit{The New Our Bodies, Ourselves} was published, this time with a greatly expanded section on midwifery and natural childbirth. The authors of the new edition were proponents of natural, yet safe childbirth and were much more vocal in encouraging readers to obtain their prenatal care outside the traditional medical realm. They believed that eighty-five to ninety percent of births were "normal" and could be attended by a midwife with little or no intervention. The authors stressed the fact that one of the most important elements of childbirth was "confidence in our ability to give birth well."\textsuperscript{61} The book suggested that medical back-up should be available, but more important was "a skilled, wise, practitioner whom we trust and like, a place of birth which feels comfortable and safe, and continuity of care throughout the childbearing year."\textsuperscript{62}

In that single sentence, the authors identified many of the failures of the medical model of childbirth. Women did not like their doctors, or even know them, especially if they were clinic patients, and the hospital setting was anything

\textsuperscript{60} Boston Women's Health Book Collective. \textit{The New Our Bodies, Ourselves}. (Boston: Simon and Schuster, 1975), xiii.

\textsuperscript{61} Ibid.
\textsuperscript{62} Ibid., 327.
but comfortable. Hospitals reduced labor and birth to a clinical, debilitating event. The authors stated that a woman entered the hospital as a healthy, energized individual, but that the institution isolated her and made her dependent and anonymous. Intravenous lines and monitors immobilized her and slowed labor, and continuity of care was nonexistent.63

The New Our Bodies, Ourselves stripped away the mystery that surrounded pregnancy and childbirth and gave women the facts about the delivery process. The book, unlike the manuals of Dick-Read or Lamaze, told women to take charge of the childbearing experience as fully as possible. In her introduction to the section on childbearing, The New Our Bodies, Ourselves contributor Jane Pincus asserted that the medical system "ignores or suppresses the sexual and spiritual dimensions of childbearing." Moreover, the system looks askance at women and practitioners who choose to create alternatives such as out-of-hospital birth centers and informed home births, despite clear evidence that many alternative practices can be as good or better, and safer, than conventional obstetric practices.64

The New Our Bodies, Ourselves was the first widely read publication to promote modern-day "natural childbirth." It encouraged women to rely on themselves and each other for

63Ibid., 364.
64Ibid., 328.
support, education, and guidance. It was not a "method" or scheme or quick fix, nor did it promise a pain-free birth. What it did was compile information and reference sources about the choices women had, and it did so at a time when many women did not realize that they had any choice at all.

The authors of *The New Our Bodies, Ourselves* also understood the limiting factors that many women faced in making birth decisions. They knew that cost as well as geographical factors were important in the type of birth a woman chose. For example, home birth or an alternative birthing center might not have been an option in parts of the country where physicians refused back-up assistance. They also knew that women often had little control over the environment, but they did encourage women to explore the possibilities, check out the options. They urged women to ask questions and most important, to communicate openly with their health care practitioner about how they want the pregnancy handled.65

*The New Our Bodies, Ourselves*, while acknowledging the necessity of a skilled physician in an emergency, encouraged home birth and birth in freestanding birth centers. "Midwives," the authors state, "have cared for childbearing women for centuries, and when midwives are free to practice as they want, they offer us continuous care during pregnancy,

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65Ibid., 334.
labor and birth, and after the baby is born." The authors brought midwifery back into the realm of modern day health care, at least in print. Midwives were described as respecting the birth process and trusting nature. The midwife was patient, and she was an expert in normal birth. She could recognize complications, knowing which required a doctor's care and which she could handle herself. Midwives were said to be supportive and understanding; they were the antithesis of the medical model, and for many women who had experienced traditional hospital birth, they were a Godsend.

For me, Janet, my nurse-midwife, meant the support I'd hoped for, I felt such confidence after Jackie was born, I felt only Janet understood what I'd been through and what I was going through.67

Both the Journal letter of 1958 and Our Bodies, Ourselves were, in their own way, agents for change. This is significant for it is rare to see two such disparate publications come together on an issue. Although published at different times and by different camps, both pieces gave women the opportunity to see that their voice mattered and that they were not alone. Women were regaining the female ties that had been lost with the medicalization of birth, and they were being allowed to see that they could have a say in the birthing process and in their own health care.

The Boston Collective was not the sole organizing force of

66Ibid., 337.
67Ibid., 336.
the natural childbirth movement. In the mid 1970s, in Summertown, Tennessee, on a religious commune called The Farm, a group of midwives was having tremendous success with unmedicated home birth. The Farm midwives, chronicled by Ina May Gaskin in *Spiritual Midwifery*, began as part of a group of 300 "settlers" traveling in a caravan. There were seven midwives and one physician on the Farm at the time of *Spiritual Midwifery*, and from the start, they "set out to learn everything we could about the care and delivery of babies and mothers and to equip ourselves to provide a high standard of maternal and infant care." 68 Where *Our Bodies, Ourselves* gave printed instructions, the Farm midwives were putting those words into action.

For the most part, the Farm midwives relied on the basics of good nutrition, prenatal care, education, and open communication between the parents and the midwife. The "Amazing Birth Tales" recounted in Gaskin's work are evidence of the careful preparation that went into the natural births on the Farm. The women knew what to expect, and they were confident in their ability to give birth and comfortable with their surroundings. Relaxation and learning to "ride with the rushes," Gaskin's word for contraction, were key elements in the pregnant woman's preparations. For 1000 babies delivered between 1970 and 1979, the midwives delivered 930

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at home with only fifteen Caesarean sections, three forceps deliveries, and seven inductions of labor. There were three perinatal deaths and seven stillbirths. More than half of the mothers had no tear and no episiotomy, and of the 264 perineal tears, 166 were minor. All but ten mothers breastfed their babies, and only a fraction required any type of anesthesia. More than three quarters of the babies had perfect Apgar scores (measures of the newborn's health and alertness) of 10 after five minutes. National statistics for the same time period for hospital births included a 97% episiotomy rate and a perinatal mortality rate of between 21.7 and 36.3 per 1000. Birth was a spiritual event for the Farm families, and although their approach may have been too countercultural for mainstream America, it is important to note how successful the midwives were.

The Farm was not the only place where midwife-attended home births were taking place. In 1971, in Northern California, a group of lay-midwives, many of whom fell into the profession by accident, had been deemed a public menace by the local medical society. Though not licensed in California, the midwives, led by Raven Lang, banded together and taught women how to provide their own prenatal care and created the Santa Cruz Birth Center. The midwives had tremendous success, but the publicity of their excellent

69 Ibid., 474-475.
70 Ibid., 475.
statistics led to their undoing. Between 1974 and 1982 the midwives found themselves charged by authorities with everything from practicing medicine without a license to murder, and despite the fact that they were eventually exonerated, the negative publicity had its effect. Many of the midwives retired, while others continued to attend home births quietly, ever fearful that they might have to bring a woman with complications to a hospital where physicians and staff might treat her poorly or even refuse care because the woman had chosen to deliver at home.\textsuperscript{71}

Statistical studies of home birth in the U.S. showed similar results to those on the Farm, with lower infant mortality rates, higher Apgar scores, and lower rates of intervention.\textsuperscript{72} Dr. Lewis Mehl, who performed several studies on home birth success rates, also pointed out that the home delivery kit of a physician or nurse-midwife would contain many of the instruments found in the hospital, including forceps, emergency drugs, suture supplies and oxytocin. Lay midwives could arrange to have the expectant mother fill prescriptions for emergency drugs and have them

\textsuperscript{71}Margot Edward and Mary Waldorf, \textit{Reclaiming Birth} 146-147.

on hand for the delivery.\textsuperscript{73} The drawbacks in the home birth studies were that the sample sizes, even when they numbered in the hundreds, were very small when compared to that of the entire childbearing population. The home birth movement also faced formidable opposition by the American medical establishment, including the American College of Nurse-Midwives, who viewed the movement—especially that involving lay-midwives—as a danger to the progress they had made in terms of being accepted by the medical profession. More important, however, was the fact that America in 1976 was not The Farm, and, despite impressive statistics, the idea of home birth was too "countercultural" for most American women. The move towards more midwife deliveries was a crucial one, but as feminist author Adrienne Rich states:

> There is much to question in the idealized photographs of young and lively pregnant women, naked or in flowered dresses, in rural communities, romanticized as hippie earth mothers. The conditions affecting the majority of mothers, poverty, malnutrition, inadequate prenatal care—are ignored in these accounts.\textsuperscript{74}

Today, the home birth question is also an economic one. With a decreasing birth rate, obstetricians and hospital administrators are consolidating deliveries to regional hospitals and closing maternity units in smaller local


\textsuperscript{74}Adrienne Rich, "The Theft of Childbirth," in \textit{Seizing Our Bodies} 152.
facilities. These local hospitals are the ones that might provide the five to ten minute access to emergency care that is desirable for home deliveries.

Women are having only one or two children, and they want the very best in care. For many, that means traveling to the regional medical center for labor and delivery.\textsuperscript{75} It can also mean suing the physician if the baby is not perfectly healthy, thus prompting many physicians to limit their practices to hospitals that have the latest neonatal technology. This combination of legal, social, economic, and practical issues has prevented home birth from entering the American mainstream, but this does not change the fact that many women still want to have as natural a birth as possible. They want the best of both worlds—a safe, yet natural birth. What these women want has led to the rise of modern day nurse-midwifery in America.

\textsuperscript{75}Wertz, 1977, 241.
CHAPTER II
"WIDE NEIGHBORHOODS"

The Development of Nurse-Midwifery in the United States

In the midst of the early twentieth-century midwife debate, while the medical model was making its way to the forefront, a few physicians and public health advocates began to endorse the idea of a trained and regulated nurse-midwife. She would be trained in both nursing and obstetrics, posing a possible solution to "the midwife problem."

Dr. Frederick J. Taussig, a St. Louis physician, introduced the term nurse-midwife in 1914 in a paper presented to the second annual meeting of the National Organization for Public Health Nursing. He suggested that the solution to the midwife problem lay in the training of graduate nurses who would specialize in midwifery.

During the 1920s and 1930s, two organizations, the Maternity Center Association of New York City and the Frontier Nursing Service in Kentucky, laid the foundations for nurse-midwifery education in the United States.

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76Litoff, 142.

States; and although the number of women trained during the 1930s was small, it has been growing ever since, providing a typically American compromise between lay midwifery and the technologically complex medical model of childbirth.

The first nurse-midwives in the U.S. were those who worked with Mary Breckinridge as part of the Frontier Nursing Service. Breckinridge believed that if a successful nurse-midwifery program could be established in the poverty-stricken Kentucky mountains, a similar program could work anywhere in the United States. The first school of nurse-midwifery was opened at the New York Maternity Center Association in 1931, and in Kentucky the Frontier School of Midwifery and Family Nursing followed eight years later. Forty-one nurse-midwifery programs were established between 1931 and 1977, and of those, twenty-five are in operation today offering either certificate, master's or doctorate degrees in nurse-midwifery. Columbia University, Yale University, the University of Utah, the State University of New York and the Frontier School currently operate five of the larger nurse-midwifery programs.

The American College of Nurse-Midwives (ACNM), established

78Ibid., 124.


in 1955, gave professional status to the "new" nurse-midwife. The ACNM functions primarily as an advocacy organization, representing the interests and concerns of nurse-midwives before Congress, to other health organizations and to the American public. The ACNM is also responsible for evaluating the education programs in nurse-midwifery across the nation.81

The role of the nurse-midwife, as with other forms of midwifery, has been and continues to be a topic of discussion. Between 1930 and 1970, nurse-midwives worked extensively with the rural and urban poor, providing maternal and infant care to those who could not obtain access to the American hospital system. By the late 1960s, however, the nurse-midwife was discovered by more affluent consumers, enabling the CNM to broaden her sphere of activity.82 At the 1968 conference on the status of the midwife in the United States, Dr. Allan Barnes stated that:

she will function in a medical center, where adequate physician consultation is available and where she will be a member of the team concentrating on total maternity care . . . she will most certainly not go into private practice by herself, nor will she move towards a return to domiciliary care."83

81 Ibid.
In 1971, the Nurse's Association of the American College of Obstetricians and Gynecologists (NAACOG), the ACNM and the American College of Gynecologists (ACOG) approved a joint statement stating that CNMs could manage normal labor and delivery under the supervision of a qualified obstetrician. This statement gave CNMs professional recognition as legitimate maternity practitioners, something that midwives had not enjoyed in over a century.

One area in which CNMs have been able to respond to client demand for a more natural, family-centered birth experience has been through the development of alternative birthing centers (ABCs) and freestanding birth centers. The first contemporary birthing room in the U.S. was opened at Manchester Memorial Hospital in Connecticut in 1964, but the rise in ABCs has been most noticeable in the past five years. Today, hospitals from Washington, D.C. to Washington state have family-centered birthing as the rule, rather than the exception.\(^8^4\) The ABC is located within the hospital, but the parturient labors and delivers in a "birthing room" which is usually decorated to be as homey and unhospital-like as possible. The ABC can be staffed by physicians, CNMs, and

\(^8^4\)New London Hospital, a 37-bed facility in New London, New Hampshire, is in the process of concerting its five bed delivery suite to a four room birthing center where patients will labor, deliver and recover in one place. The George Washington University Medical Center has converted all seven of its labor rooms to birthing suites, and the delivery room is used only for surgical cases.
labor and delivery nurses. Medical intervention is kept to a minimum, and, as with home delivery, careful screening is used so that only low-risk cases are admitted. Fathers and in some cases entire families are encouraged to attend the birth, and the newborn is left with his parents instead of being taken to the nursery. Early discharge, sometimes within six to twenty-four hours of delivery is often possible. Results in birthing centers have been overwhelmingly positive. The authors of a recent study of over 11,814 births in 84 free-standing births centers concluded that "birth centers offer a safe and acceptable alternative to hospital confinement for selected pregnant women, and that such care leads to relatively few cesarean sections." 86

Freestanding birth centers such as the Childbearing Center run by the Maternity Center Association in New York, are out-of-hospital centers that attempt to reach "a population which


rejects and distrusts hospitals. The number of freestanding birth centers grew from three in 1975 to 103 less than a decade later. With the exception of surgical facilities, freestanding birth centers generally offer the same amenities as an ABC with the additional service of follow-up care at home by either a nurse-midwife or visiting nurse.

At the midwife-run Birth Center of Delaware, four-fifths of the women who come in the door are able to give birth naturally, without medical intervention. The Center has a 3.7% Caesarian section rate, compared with a national average of 25%, and an 11% episiotomy rate, compared to 63% nationally. Only two of the 1000 women who have delivered there have requested pain relief medication. There have been no maternal or infant deaths. Studies at other birth centers have revealed similar statistics. Although there may be some self-selection by low-risk women to choose the Center, the fact remains that the chances of intervention for those same women are less at a birthing center than in the traditional hospital setting. Families are welcome at the


88Committee on Assessing Alternative Birth Settings, 3.

89Armstrong, 75.

90A.B. Bennetts, "Out of Hospital Childbearing Centers in the United States: A Descriptive Study of the demographic and medical-obstetric characteristics of women beginning labor
Center, and women can move about, eat, sleep, relax, and labor in any position that is comfortable. The midwife follows her, knowing that there is no one way to experience labor and that the key is to relax and let the parturient's body work.

The Pennsylvania Hospital in Philadelphia offers the best of both worlds for women who want a natural delivery with technology close at hand. Its midwife-run birthing suite, opened in 1987, is located across the street from the hospital and is connected by an underground tunnel. The suite has its own nursing staff and uses as few interventions as possible, but both mothers and midwives are more secure knowing that physician back-up is only minutes away.91

Ironically, a faction of the very movement that helped bring modern midwifery to the forefront has become a negative force against the nurse-midwifery effort. Some proponents of lay midwifery and home birth contend that the CNM is too medical, too technological. Author Suzanne Arms states that the nurse-midwife is simply one of a whole list of deceptions in the process of hospital births and that the CNM is trained to have "a lusty respect for modern forms of interference . . . she looks and acts much like the physician authority whom

9 Armstrong, 80.
she is licensed to assist."92 Others argue that nurse-
midwifery places the emphasis on the nurse, to the exclusion
of the true midwife. "No matter how it is that a person
acquires midwifery techniques, there is an element to being
a midwife that cannot be taught. It is a gift."93
Proponents of lay midwifery assert that once a woman enters
the hospital, even with a midwife as an attendant, she has
given up control, even though she may be planning a natural
birth. Once in a medical setting, even an ABC, the woman
risks undergoing medical intervention ranging from fetal
monitoring to transfer to a traditional delivery room. A
1983 study showed that one quarter of women who initially
showed an interest in using the ABC were screened out before
entry, and that another quarter were transferred during
labor. Vague definitions of ABCs lure women into the
hospital, only to discover that the one birthing room is
occupied or that the ABC simply means being allowed to
deliver in bed.94 Other home birth advocates contend that
ABCs are really a ploy of the medical establishment to

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92Suzanne Arms, Immaculate Deception: A New Look at
Women and Childbirth in America, (Boston: Houghton Mifflin,
1997), 156.

93Thya Merz, "A Working Lay Midwife Home Birth Center,
Madison Wisconsin," in D. Stewart and L. Stewart, eds.,
Twenty-first Century Obstetrics Now!, (Marble Hill, MO:
NAPSAC, Inc. 1977), 548.

94Raymond DeVries, "Image and Reality: An Evaluation of
Hospital Alternative Birth Centers," Journal of Nurse
"coopt the resurgence of interest in midwifery by providing more home-like birth settings." They state that these reforms do not solve, and in fact cloud the basic issue of the women's health care movement—the medical professions's control over women.95

Despite the complaints of the lay midwives, the fact remains that the medical establishment continues to disapprove of home birth, and strict licensing laws in many states make the legal practice of lay midwifery next to impossible. Nor will lay midwives find an ally in the medical insurance lobby, for although home births might cost less than the traditional hospital delivery, conservative health insurers fear that infants born at home will have a higher rate of brain damage, and thus a higher rate of medical claims.96 Home birth is not the wave of the foreseeable future, "unless the legal and insurance issues are resolved—which seems improbable in the near future—the number of home births is unlikely to increase."97

Both ABCs and freestanding birth centers offer excellent opportunities for the CNM to assist women with their births. Through the required risk screening and thorough prenatal


96 Wertz, 1989, 296.

97 Ibid.
care, the CNM is able to know her client well. Certified nurse-midwives spend an average of thirty to sixty minutes on a prenatal visit, as opposed to the customary ten minutes spent with an obstetrician.\textsuperscript{98} The typical CNM welcomes questions and is interested in more than the woman's vital signs. This role of midwife as educator is especially important today because the hospital stays for childbirth are being limited to one or two days and the nurse-midwife may be the new mother's only source of childcare instruction.\textsuperscript{99} Another integral part of the midwife's role is to get to know the woman and her family so that she can provide the best possible support during the stress of labor.\textsuperscript{100} Perhaps the most important aspect of the CNM's care is that she encourages the women to take control of her pregnancy and delivery.

Certified nurse-midwives do more than just deliver babies. In addition to their prenatal and delivery services, the CNMs also provide general gynecological care and family planning counseling.\textsuperscript{101} Nurse-midwives give that same type of care in clinics and group practices throughout the nation. The fact that CNMs use less medication, fewer interventions, have a

\textsuperscript{98}\textit{Our Bodies, Ourselves}, 337.

\textsuperscript{99}\textit{Wertz}, 1989, 256.

\textsuperscript{100}\textit{Ibid}.

\textsuperscript{101}Jane Record and Harold Cohen, "Introduction of Midwifery in a Prepaid Group Practice," \textit{American Journal of Public Health} 62 (March 1972) 368.
record of healthy outcomes for both mother and infant, and have lower salaries than physicians makes them a logical choice for cost-effective maternity care. In its evaluation of CNMs for the Senate Committee on Appropriations, the Office of Technology Assessment writes, "Using CNMs rather than physicians to provide certain services would appear to be cost effective."

CNMs have become an important force in contemporary maternity care. Expert opinion regarding the quality of care provided by CNMs is that it "equals or surpasses services offered by obstetricians." Indeed, several studies conducted at alternative birthing centers or in freestanding birth centers indicate that neonatal mortality and prematurity rates are lower with CNM attended births than with traditional obstetrician attended deliveries. Recent studies by the Office of Technology Assessment and the Institute of Medicine state that a woman experiencing a


healthy pregnancy, labor and delivery is as safe as in the hands of a physician, and nurse-midwives would argue that she is even safer, as CNMs have also been credited with decreasing low birthweight rates and increasing the number of "kept" prenatal care appointments.\textsuperscript{105}

For the childbearing woman in 1990, the availability of the CNM in some ways makes childbirth that much more difficult, for now there are choices and decisions to make, and it is the mother who is ultimately responsible for those choices.

Our mothers made the "right" choice for the times when they gave birth to us in hospitals. Today the "right" choice is far from obvious. What is safe? What is best? What if something goes wrong? These are questions that every mother wants answered. Beyond those, however, lie even deeper questions, about womanhood and mothering and our own abilities. Charlotte Houde, Director of the Midwifery Service at The Dartmouth-Hitchcock Medical Center, states:

Birth is as much about being human as it is a physiological process. It is about our childhoods, our marriages (or lack of them), our sexuality, our faith, about love and trust. Ultimately, it is about parenting--for which a woman might feel ill-prepared, inadequate or resentful.\textsuperscript{106}

For American women, these fundamental issues are further

\textsuperscript{105}American College of Nurse-Midwives, "Contributions of CNMs to Improved Health Outcome," Fact Sheet (Washington, D.C.: 1988).

\textsuperscript{106}Armstrong, 78.
complicated by the mixed history of childbirth in this country. There is no tradition, no familiarity with birth. For many it is a mysterious and frightening concept. Few non-medical personnel have witnessed a birth before they become pregnant, and the rapid pace of technology allows the medical model of birth to stay more than a few steps ahead of the layman, making a clear understanding of the birth process appear out of reach for many.

Midwives are teaching American women how to regain control of the birthing process. Certified nurse-midwives have the skill, knowledge, and most of all time that it takes to allow women to make fully informed choices. She can educate the uninformed, calm the fearful, and bring a personal touch to a medical specialty that appears to have lost that dimension. Unfortunately, it is not that simple, for just as the choices in childbirth are complex, so is the situation facing today's certified nurse-midwives.
CHAPTER III
FACING THE CHALLENGE, THE 1990s AND BEYOND

The Future of Nurse-Midwifery in America

The midwife, once the traditional birth attendant, is now an alternative to the physician, and thanks to the profession of nurse-midwifery, she is a viable one. For the first time, women have a choice in childbirth that does not compromise their safety, the safety of the baby, or their desire to witness birth as a natural and beautiful event. Midwives are delivering more babies now than they have for decades, and more and more American women are demanding alternative birth centers and birthing rooms.  

A recent report by the American Hospital Association revealed that the number of hospitals with birthing rooms increased by seventeen percent from 1984 to 1988, and 63.3% of U.S. hospitals are now equipped with the birthing room option.

Unfortunately, these strides will not be enough to secure the future of midwifery in America, for certified nurse-

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107 American College of Nurse Midwives, "Nurse-midwifery in the United States 1987,"

midwives face as many, if not more of, the complex economic, legal, and social constraints that face all health care professionals today. Competition, low reimbursement, uninsured clients, and difficulty in obtaining malpractice insurance are only a few of the roadblocks that could impede the CNM's path to success. These problems, however, are not insurmountable. Nurse-midwives can carve out and protect a professional niche by creating and sustaining a demand for their services and by gaining the acceptance of those in the medical realm, including health care policy makers and regulators. To accomplish this, however, they must prove that they have a place in the increasingly competitive and costly world of health care, and that they can serve the needs of those who use their services and of those who pay, be it the insurance company, the government, or the client herself.

Today's nurse-midwives are in a uniquely American predicament. They are faced with a complex situation with no clear-cut solution. There is no one Central Midwives Board, as in England, to tell them what to do. There is no one governmental agency that will promise support or even recognition. It is too late to build a history of support for midwifery, but it is not too late to plan for its future. The U.S. is not Britain, and it is unlikely that a truly national form of health service or insurance will be developed here, but a national health policy that includes
midwives in its master plan is not beyond our scope. The future of nurse-midwives in this country rests on their ability to see what is facing them and formulate a plan of action. A recommendation for such a plan involves five steps:

1- Ensure a demand for nurse-midwifery services at the community level through an aggressive informational campaign that will inform all classes of potential clients, from the educated woman seeking an alternative birth method to the urban poor who may have no other means of prenatal care.

2- Increase that demand by enlisting the support of the medical community, including health care administrators, by educating and informing them about the profession of midwifery and the benefits that it offers.

3- Use that support to lobby health care regulators and legislators so that certified nurse-midwives are incorporated in the nation's health care policies.

4- Take advantage of current industrial trends (such as the increase in number of HMOs) to create a stable and visible niche from which the profession can grow.

5- Ensure the future supply of certified-nurse midwives by taking an aggressive stance in combatting the nursing shortage.

The first step, that of continued demand for nurse-midwifery services, can be viewed on two fronts. One is demand by choice. These clients will be the same ones who are currently selecting nurse-midwifery care out of a desire to have a natural and non-interventionist birth. They will continue to seek an alternative method of childbirth. This demand can be expected to continue as long as the CNM is accessible and as long as she fulfills the woman's expectations. A midwife's practice will not expand,
however, unless her clients voice their preferences on a larger front. Clients and proponents of midwifery must speak out to women and their families and let them know that the midwife or midwife/physician team is an important option for women's health care. Methods for spreading the word about nurse-midwifery range from classified advertising to appearances at health fairs to presentations to civic groups. Midwives should take advantage of the current prenatal care media campaigns to highlight the fact that they can provide personal, comprehensive care at reasonable cost.

Community surveys indicate that it is the personal referral from a friend or physician that influences most people's choice in selection of a health care provider.109 Thus proponents of nurse-midwifery need to spread the word at the grass-roots level to increase public awareness of CNMs and their capabilities.110

Although word-of-mouth should be an important component of the midwifery campaign, history indicates that educated women are the trendsetters for health care consumption.111 Educated women in the nineteenth century chose doctors instead of midwives, and educated women of the twentieth century moved

109 Two community surveys conducted by New London Hospital, New London, NH, in April, 1989 and February, 1990 indicated that the recommendation of a friend or physician had the greatest influence on their choice of health care provider.


childbirth from the home to the hospital. In the last
decade educated women have led a dramatic revival in
breastfeeding, with the percentage of breastfed newborns
rising from 25% in 1973 to 54% in 1980. Thus midwives
should target that educated population when they embark on
their marketing campaign and hope that the positive
experiences of educated women will lead to an increase in the
use of nurse-midwives by all classes.

Hospitals, too, can market their midwifery services by
informing potential clients that they offer a full range of
women's health care, from the technically skilled
obstetrician-gynecologist to the competent and compassionate
nurse-midwife. Activity at the community level has brought
issues to the national forefront throughout American history,
from women's suffrage to abortion rights. Nurse-midwifery
must have that base of support if it is to gain the backing
of insurers, physicians, hospitals, and legislators which it
sorely needs.

The other form of demand for midwifery is need-based.
Nurse-midwives started out as providers of care for
underserved mothers and infants. That population's need for
comprehensive maternity care has, if anything, increased; for
while there is no agreement about the way to handle births so
as to produce the best babies, there is a basic agreement

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112Ibid.
113Ibid.
that sound maternal and child health depend on a healthy environment, including proper nutrition and prenatal care. What we must also agree on is that American society has been slow to place an equal value on all women's pregnancies and that basic preventive health care is not reaching all classes in our society. The recently released fourteenth annual report on the health status of the nation revealed that the health gains made by whites are not matched by blacks, and that blacks have an infant mortality rate of 17.9 per 1000 births, more than double the rate for whites. In 1985, one-fifth of white women and two-fifths of black women did not receive prenatal care in the first trimester, a statistic that has remained almost unchanged since 1975. Certified nurse-midwives can be effective in providing care to the underserved population, as was noted in a 1985 Institute of Medicine study.

Certified nurse-midwives . . . have been shown to be particularly effective in managing the care of pregnant women who are at high risk of low birthweight because of social and economic factors . . . the committee recommends that more reliance be placed on nurse-midwives to increase access to prenatal care for hard-to-reach groups . . . and state laws should be supportive of nurse-midwives and of nurse-midwifery practice.

114 Ibid., 297.
A plan for a new maternity care system was developed in 1988 by the Institute of Medicine's Committee to Study Outreach for Prenatal Care, and that system specifically calls for the use of CNMs because of their:

proven ability to work well with low-income, often high-risk client; the probability that the program costs will be less if physicians are not relied on exclusively; and the difficulty in some communities of finding physicians willing to work in public clinics or with low-income women.118

Perhaps as important as having a practitioner who will go to public clinics is the act of getting clinic patients to make and keep their prenatal appointments. Recent studies by the Office of Technology Assessment and the Institute of Medicine credit nurse-midwives with decreasing low birthweight rates and increasing the number of "kept" prenatal care appointments.119

While it is evident that there will continue to be a stable demand for nurse-midwives for some time to come, the ability of CNMs to address some of those demands is hampered by continued resistance on the part of the medical community to accept them as capable practitioners. Traditional medical training teaches physicians to view pregnancy as a "condition" that needs a "favorable outcome."120

118Ibid.


120Wertz, 1989, 133.
hospital is oriented towards specialties. The more technology one uses, the more specialized one becomes. Since obstetrics is a specialty, it should not be surprising that many obstetric residents have never seen an unmedicated delivery and that a "normal" or "natural" delivery routinely involves analgesics, anesthesia, fetal monitoring and episiotomy. Thus the principles and practices involved in midwifery may be questioned by many physicians, and it is not surprising that they are hesitant to view nurse-midwives on a professional level.

Therefore, the second step which CNMs must take is to focus the attention of physicians and administrators on the positive results, both clinical and fiscal, which CNMs have achieved in recent years. Statistical data from the birth center studies are readily available, and it is up to midwives and their clients to educate and inform doctors, administrators, and hospital trustees about the services and cost savings which CNMs can provide. Nurse-midwives can ease some tension among physicians by pointing out that the number of CNMs, while on the rise, is not astronomic. Nurse-midwives are delivering fewer than five percent of the babies born in the U.S.\textsuperscript{121} Certified nurse-midwives are hardly a threat to the financial well-being of our nation's obstetricians, and given the critical nursing shortage facing us today, it is unlikely that they will become one in

\textsuperscript{121}Committee on Assessing Alternative Birth Settings, 3.
the future. What CNMs can do, however, is help meet the demand for comprehensive prenatal and maternal health care in this country.

One problem midwives face in working within the current health care system is preparation. Certified nurse-midwives are trained to handle all aspects of a normal pregnancy and delivery, and many of the complications as well, and as long as they stay in a hospital and work under the guidance of a physician (often an obstetric resident), all is well. But CNMs feel they are capable of handling more than normal deliveries; and often resent having to work under the guidance of a physician who may have less experience. Today's nurse-midwife is struggling to be recognized as an independent practitioner, and this is where the trouble begins, for once she has declared independence, she becomes a threat to both the physician's practice and the hospital's need for that physician's "normal" cases, and the fees which these cases generate. If the CNM takes her patients to a birthing center, both physician and hospital will lose revenue.122

Certified nurse-midwives are caught in a peculiar paradox as they attempt to assert their independence. On the one hand, they are viewed by physicians as nurses, and all of the

traditional nurse/doctor and female/male role issues come into play, with the CNM being viewed as inferior. On the other hand, they are seen as competitors who will undermine the demand for the physician's services. Certified nurse-midwives must prove they can work with the physician, because the future of nurse-midwifery rests in great part with its continued acceptance within the medical realm.\textsuperscript{123}

Nurse-midwives should also market themselves as professionals who can increase a facility's client base. They should stress the fact that today's women are better informed than their counterparts of the 1960s and that it is not uncommon for a woman to "shop around" for her birth attendant and her birthing facility. She may want the companionship of a midwife with the security of a back-up physician, thus creating a need for a physician/midwife team. Physicians and CNMs can satisfy that need, as is evidenced by those who currently work together either in HMOs or in group practices. Nurse-midwives should point out that obstetric patients have the potential to bring the rest of their medical business, and that of their families, to the practice or facility. Physician/midwife teamwork is also ideal in rural communities which might not have the population to support two obstetricians. It is often difficult to find a solo practitioner who is willing or able to provide round-the-clock coverage, seven days a week to the childbearing

\textsuperscript{123}Radosh, 143.
members of a community; but an MD/CNM team or group is able to serve a greater number of people and give them choice in their method of childbirth. Nurse-midwives must not overlook the importance of this first educational step, because it is only with the support of the medical community that they will be able to move forward in the acceptance process.

Once nurse-midwives educate their peers, they must rally those forces to stand behind them as they approach the regulators and legislators who influence and control the laws governing midwives and the purse strings which make service to rural and inner-city clients possible. When taking this step, CNMs should marshal the financial data which illustrate how they can be an integral part of a cost-effective national health policy. They can use statistics from birthing centers, HMOs, managed-care plans, and government reports from groups such as the Committee on the Assessment of Birth Alternatives which will convince both insurers and law makers that CNMs are a sensible solution to one of the nation's most critical health problems, infant mortality.

America is entering the 1990s without an official national health care policy. There is no set of agreed-upon health care goals for the nation, no specific course or direction. The costs of health care are staggering. There are 30 million uninsured Americans and premiums for those who have health insurance continue to climb. Federal dollars for maternal health are often spent on temporary, experimental
programs that serve only selected populations. Hospitals are cutting back or closing services in order to save money, and obstetrics, which for many facilities is a "loss leader," is often one of the first to go. Fewer physicians are choosing obstetrics due to the high risks, and many of those already in the field are trying to limit or eliminate the obstetric side of their practices. Yet babies continue to be born, and for women in the inner cities or rural areas, even minimal prenatal or maternal care may be unavailable.

Midwives need to inform legislators that one logical step towards a solution to our nation's health care crisis is to include certified nurse-midwives in any maternal health policy. Midwives must emphasize that they are effective providers of maternal and infant care and that there is no reason why the nation should not use this valuable resource.

The General Accounting Office estimates Americans will spend over twelve percent of their gross national product on health care in 1990. Spending on healthcare services is expected to climb from $599 billion in 1989 to $661 billion in 1990. There is a need for more cost-effective methods of health service delivery. Most people would agree that it costs far less to provide prenatal care than it does to

124Wertz, 1989, 221.
125Langton-Stewart, 1.
maintain a premature infant in a neonatal intensive care unit. Most people would also agree with the adage about an ounce of prevention being worth a proverbial pound of cure. Unfortunately, most people also see a critically ill premature baby as news, while a report showing improved outcomes from prenatal care is simply dry reading. The cost savings which could be realized by the increased use of CNMs could make prenatal care more accessible to the underserved and perhaps move the U.S. out of 22nd place on the infant mortality list. Nurse-midwives, through the ACNM and with the backing of the AMA, must use their political power to lobby for such action, working for a common goal instead of for their own self-interest. Certified nurse-midwives can take this opportunity to integrate the childbirth reform movement with larger social issues such as health care as a right instead of a privilege or equal access to care. Through the Congress, they can work to ensure not only their own future, but the future health of this country's women and children.

Once CNMs have improved their professional and legal status, they will be ready for the fourth step in the process: securing a niche for their future growth and development. It is here that conflicts arise between the role the CNMs want to play and the one assigned them. The American Medical Association, one of the most powerful health care lobbying powers in the nation, has, from its inception,
taken a stand against lay midwives. The American College of Nurse-Midwifery has been wise to adopt the attitude that while they cannot beat the AMA, they might be able to join them by operating within their structure. By having CNMs work with the guidance of a physician in a medical setting, nurse-midwives have been able to make a place for themselves. Instead of butting heads with physicians, CNMs have kept a relatively low profile, accomplishing their goals without rocking the foundation of the medical establishment.

To some, this might appear as if the CNM has given in to the medical model. Yet in one sense her approach has meant survival. Only through cooperation have nurse-midwives have been able to come this far, thus they must take care in choosing their place in medical society. It is quite possible the managed-care industry will be the enterprise which will allow the profession of nurse-midwifery to flourish, for it is an industry which is increasing both in size and in its employment of certified nurse-midwives.

Federal funding cuts to the Medicare program have forced many hospitals and other health care providers to shift their costs to the commercial insurers. These insurers in turn pass those costs on to employers who are purchasing premiums for their workers. These increasing costs have prompted both employers and individuals to seek out managed-care providers such as health maintenance organizations which offer complete coverage with lower deductibles and co-payments. Until
recently, many Americans have been reluctant to enroll in managed-care plans. We are accustomed to choosing our own doctor and are not accustomed to waiting for care. Many people resist the team or group approach used in many managed-care plans, where a patient is first seen by a nurse-practitioner or physician's assistant (or nurse-midwife), and the physician is called in only when certain criteria are met. We are used to seeing the doctor and are often reluctant to accept the diagnosis or opinion of anyone else.

At the same time Americans are reluctant to bear the brunt of their health care costs. It is this squeeze on the pocket book that is making the idea of managed-care more palatable. Almost half of all Americans with health insurance are currently covered by prepaid managed-care health plans, which include health maintenance organizations, preferred provider organizations, and independent practice associations, and coverage is predicted to rise to over sixty percent during the 1990s. Although only ten percent of CNMs currently report being employed by a managed-care plan, an increase in enrollment is one key to their future. Since these insurance plans operate on a capitation payment system where the provider or organization is paid a set fee per enrollee instead of on a claims basis it is to the provider's advantage to give the most cost-effective care possible, and

the CNM is the perfect provider of that care.

Managed-care plans are generally marketed to the younger (and generally healthier) population, the same population which is in the prime of their childbearing years. Younger enrollees are attractive to the provider because they get sick less often. That same provider is in turn attractive to the younger population because it can offer total coverage, with low or no co-payments for even routine office visits. This type of coverage is very appealing to young families who do not want to be faced with a claim form every time their child needs a check-up. This logic is borne out by the Group Health Association of America's HMO industry profile, which indicates that women of childbearing age account for a disproportionate share of the established HMO membership.\textsuperscript{128} Certified nurse-midwives are proving to be effective providers of managed-care. Group Health Association of Washington, D.C., one of the oldest health maintenance organizations in the nation, recently increased its midwifery practice from four CNMs to twenty-four. These midwives currently have more referrals than they can handle.\textsuperscript{129} Physicians are also looking to managed-care plans as a means of employment. A 1989 survey of 300 medical residents revealed that thirty percent will choose an HMO as


\textsuperscript{129}Telephone interview with Brin Burke R.N, C.N.M., 10 July 1989.
their first choice in practice setting.\textsuperscript{130} Although managed-care may not be as lucrative for the physician as private practice, it offers the benefits of set hours, liability insurance, and a steady paycheck, none of which is guaranteed for a doctor who is trying to establish a practice. The fact that managed-care plans often pay their physicians a set salary benefits the nurse-midwife by enabling her to work with, instead of for the physician. Both doctor and midwife are employees of the plan, and instead of competing with each other, they are able to function as a team.

Another reason for nurse-midwives to choose a managed-care setting over independent practice is malpractice insurance coverage. The insurance carrier sees the independent midwife as a professional with liability exposure as great as a physician.\textsuperscript{131} In the hospital or HMO, the CNM can be covered as a nurse by a group malpractice policy.\textsuperscript{132} She is also much less likely to be sued as part of the hospital team because there is much more to be gained monetarily by using the deep pocket theory and suing the physician and the hospital than by suing a midwife who carries a much smaller

\textsuperscript{130}Mary T. Koska, "Medical Staff." \textit{Hospitals} (9 October 1989):56.


malpractice policy. On her own, the CNM is the sole target and must obtain her own coverage.\textsuperscript{133}

The managed-care setting has much to offer the CNM, and she in turn has much to offer it. Managed-care plans can provide a steady supply of clients and an equal, or at least stable footing with the physician, both of which are key components to her success. At the same time, executives in HMOs and other plans should be eager to use nurse-midwives as a method of providing quality care at a fraction of what it would cost to hire and insure an equal number of physicians. Certified nurse-midwives must seize this opportunity and make a concerted effort to secure their place in the managed-care structure.

Once CNMs have secured their place, they must ensure their own survival by taking the fifth step and recruiting nurses into the profession. The United States is in the midst of a national nursing shortage which is being caused by a combination of demographic changes and increased career options for women. There are fewer students moving through the educational system, and nursing and teaching are no longer the only choices women have as they select their major field of study. Nurse-midwifery requires more than R.N. credentials. Rigorous training and long hours require dedication and sacrifice of personal time. This is not to say that a career in nurse-midwifery is not rewarding. It

\textsuperscript{133}\textit{Ibid.}, p.20.
offers a unique focus on the healthy woman, something that is lacking in many nursing specialties. Nurse-midwifery also provides the opportunity for long-term relationships with patients through community practice, along with a diverse choice of work arrangements and career options in teaching, research, public health, public policy and administration.\(^{134}\) What is called for, however, is recruitment to encourage students to enter nursing.

In 1987, a panel was appointed by the Secretary of Health and Human Services to address the nursing shortage. In the Final Report of the Secretary's Commission on Nursing, the panel made sixteen recommendations in the areas of utilization of nursing resources, nurse compensation, health care financing, nurse decision making, and development and maintenance of nursing resources. (see the Appendix) The Commission outlined specific steps it viewed as critical if a shortage of crisis proportions is to be averted.\(^{135}\)

The shortage is not being taken lightly. The National Commission on Nursing Implementation Project recently announced plans to launch a two-year, multi-million dollar image campaign which will target teenagers and adults searching for a second career. The Commission wants to characterize nurses as people who are not only compassionate


but also knowledgeable professionals.\(^{136}\) The nursing shortage poses a serious threat to certified nurse-midwifery, for without the RN credential, one cannot obtain midwifery training. Proponents of nurse-midwifery will do well to take the recommendations of the Commission one step further and think of potential nurses as potential CNMs; a career in nursing might be much more attractive if the option of midwifery is known.

Recent statistics released by the American Association of Colleges of Nursing revealed that after five years of declining enrollment, the number of first-time students entering four-year nursing programs was up almost six percent in 1989.\(^{137}\) Nurse-midwives should target the student population now. Competition for health care workers will be fierce in the 1990s, and nurse-midwives will need to plan ahead if they want to attract high quality nurses to the specialty.

These five steps will expand the role of nurse-midwifery in American society and will enable nurse-midwives to improve the level of prenatal and maternal health care in this country. The steps will allow her to satisfy mothers and fathers through her provision of safe and satisfying care, payors through her cost effective manner of delivery of that care, malpractice carriers through her excellent results in


practice and her low rate of litigation, and the taxpaying public through her prevention of premature and low-birthweight babies who drain hospital and government resources. These steps will also allow the nurse-midwife to gain the autonomy for which she has longed. She will, by following the recommendations, enable herself to practice in a professional setting where she is accepted by her peers.

These steps may seem logical, and one might wonder why nurse-midwives have not taken such action before. Advocates of nurse-midwifery argue that the CNMs' hands have been tied by the complex system of licensure which varies from state to state, while physicians argue that CNMs are not doctors and that they must be prevented by strict legislation from practicing as such. One can speculate that there is more than humanitarianism at stake here and that there has been some self-interest on both sides, with the CNMs wanting their independence and the physicians wanting to eliminate any competition. But, as we have seen, the crux of the issue is not purely regulatory, nor is it purely demand, for the two are inextricably intertwined, and the failure of nurse-midwives to recognize or acknowledge this has placed their profession in a precarious position.

The demand for midwifery services is unimportant as long as political and professional obstacles are in the way. Similarly, total acceptance and professional recognition is useless without a demand for services. Until now,
physicians, legislators and nurse-midwives have chosen to focus on one issue or the other, never stopping to notice that the two are interdependent. The future of midwifery in this country is not so much a matter of one group trying either to maintain or establish its profession as it is a sorting out of those social, economic, and political issues which will allow each group to see there are benefits to all from a system which incorporates midwifery into the birth process. The five steps just described should accomplish that goal.

There is no guarantee that any of these steps will be easy or successful. Each requires communication and compromise, and although the nurse-midwife is familiar with both criteria, the same cannot always be said for physicians, legislators, or the general public. The certified nurse-midwife must realize, however, that her future depends on her ability to assess accurately the current situation. The economic and political climate will neither allow her to wait patiently for her day to come, nor will it allow her to bully her way to the top. She must make some difficult choices, but there is a future for the CNM in America; and if she follows the recommended path, she will certainly have a positive impact on American life. We can only hope she will take the necessary action and be allowed to flourish.
APPENDIX

The Secretary's Commission on Nursing presented their sixteen recommendations in six clusters addressing the following issues:\textsuperscript{138}

I Utilization of nursing resources
II Nurse compensation
III Health care financing
IV Nurse decision making
V Development of nursing resources
VI Maintenance of nursing resources

RECOMMENDATIONS
I Utilization of nursing resources

1. Health care delivery organizations should preserve the time of the nurse for the direct care of patients and families by providing adequate staffing levels for clinical and non-clinical support services.

\textsuperscript{138}The following list of recommendations was taken from the Final Report, Volume I, of the Secretary's Commission on Nursing, Washington, D.C., 1988, pp.17-50.
2. Health care delivery organizations should adopt innovative nurse staffing patterns that recognize and appropriately utilize the different levels of education, competence and experience among registered nurses, as well as between registered nurses and other nursing personnel responsible to registered nurses, such as licensed practical nurses and ancillary nursing personnel.

3. The Federal government should sponsor further research and encourage health care delivery organizations to develop and use automated information systems and other new labor-saving technologies as a means of better supporting nurses and other health professionals. Health care delivery organizations should work with researchers and manufacturers to ensure the applicability and cost-effectiveness of such information systems and technologies across all practice settings.

4. Health care delivery organizations, nursing associations, and government and private health insurers should collaborate to develop and implement methods for costing, budgeting, reporting and tracking nursing resource utilization, both to enhance the management of nursing services and to assess their economic contribution to their employing organization.
II NURSE COMPENSATION

5. Health care delivery organizations should increase their R.N. compensation and improve RN long-term career orientation by providing one-time adjustment to increase RN relative wages targeted to geographic, institutional and career differences. Additionally, they should pursue the development and implementation of innovative compensation options for nurses and expand pay range based on experience, performance, education and demonstrated leadership.

6. Government should reimburse at levels that are sufficient to allow efficiently-organized health care delivery organizations to recruit and retain the number and mix of nurses necessary to provide adequate patient care.

III NURSE DECISION MAKING

7. Policy-making, regulatory, and accreditation bodies that have an impact on health care at the national, state, and local levels should foster greater representation and active participation of the nursing profession in their decision making process.
8. Employers of nurses should ensure active nurse participation in the governance, administration, and management of their organizations.

9. Employers of nurses, as well as the medical profession, should recognize the appropriate clinical decision making authority of nurses in relationship to other health care professionals, foster communication and collaboration among the health care team, and ensure that the appropriate provider delivers the necessary care. Close cooperation and mutual respect between nursing and medicine is essential.

IV DEVELOPMENT OF NURSING RESOURCES

10. Financial assistance to undergraduate and graduate nursing students must be increased. The burden of providing this assistance should be equitably shared among the federal and state governments, employers of nurses, philanthropic and voluntary organizations. The preferred method of providing this support is the use of service-payback loans as well as scholarship funding for those in financial need.

11. State Governments, nursing organizations, schools of nursing and employers of nurses should work together to minimize non-financial barriers to nursing education for
individuals desiring to enter the profession as well as for nurses wishing to upgrade their education.

12. Schools of nursing, state boards of nursing, and employers of nurses should work together to ensure that the curricula are relevant to contemporary and future nursing practice, prepare nurses for employment in a variety of practice settings, and provide the foundation for continued professional development.

13. The nursing profession should take primary responsibility for providing immediate and sustained attention to the promotion of positive and accurate images of the profession and the work of nurses.

14. The Department of Health and Human Services should create a commission having a duration of at least five years that will monitor the implementation of the recommendations in this report as well as the development and maintenance of nursing resources. This commission should be constituted as an advisory body reporting directly to the secretary.

15. The Department of Health and Human Services, private foundations, and employers of nurses should support and carry out research and demonstrations on the effects of nurse compensation, staffing patterns, decision-making authority,
and career development on nurse supply and demand as well as health care cost and quality. Research should be sponsored on the relationship of health care financing and nursing practice.

16. The federal government should develop data sources needed to assess nursing resources as they relate to health planning and manpower.
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