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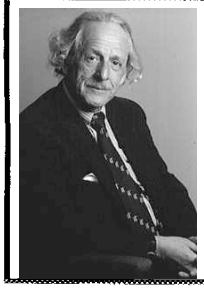

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Midwifery: Alternative Care for Pregnancy and Childbirth

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Midwifery represents an alternative to the medical practice of obstetrics for the management of normal pregnancy and childbirth, emphasizing family involvement and the avoidance of unnecessary medical intervention. Proponents argue that it treats these processes as natural, rather than pathological. The status of midwives varies significantly from one nation to another and even within the US.

Abby Able, who is pregnant, decides to have her baby at home. She receives prenatal care from a certified nurse-midwife, (CNM), and after months of preparation and planning, she delivers a healthy baby at home. A physician calls this an example of maternal trauma and child abuse. Bonnie Baker, also pregnant, does as many women do and visits her obstetrician/gynecologist. She and the physician also plan and prepare, but Bonnie's baby is delivered in a hospital. Bonnie later complains about the cold, sterile environment of the hospital, of being treated by strangers, of having no friends or family present at the birth, and of being treated like someone with a chronic disease.

These two cases are hypothetical. They reflect the attitudes described by Rose Weitz and Deborah A. Sullivan, Department of Sociology, Arizona State University, Tempe, in a discussion of the politics of childbirth.[1] They focus attention on midwifery—a field of health care that is often both controversial and misunderstood.

The word "midwife" comes from the Middle English words *mid*, meaning "with," and *wif*, meaning "woman," and it denotes a person who assists women in childbirth. As we shall see, the scope of a midwife's work has come to include much more than simple assistance in deliveries. Indeed, the profession of midwifery has grown. Midwives are caring for women in hospital-based maternity programs and in alternative settings such as freestanding birthing centers, and they are providing a wide range of services, including family planning and well-woman gynecology. This essay will attempt to define midwifery, find out what makes it unique, look at some of the problems, and characterize the literature and status of relevant research.

Lay Midwife and Nurse-Midwife

There are actually two basic types of midwife. The first of these is the lay midwife, a figure known throughout recorded history. This individual has no formal professional education but rather has learned her skills by word of mouth and practical experience. (I use the pronoun *her* since, although there are and have been male midwives, most members of the profession are women.) A subset of the lay midwives, the certified midwives, have received certification from a state authority.

The second type of midwife is the CNM. This individual is a registered nurse with additional professional training in midwifery. Consequently, a nurse-midwife has several years of basic nursing education, as well as a year or more of formal training in a midwifery course. The course may be either a master's degree program or a certificate program. The latter type of program is open to

nurses who hold associate or bachelor's degrees, as well as those with master's degrees or doctorates. In the US nurse-midwives who have received approval from a professional board are designated CNMs.

According to Misako Kojima, professor of medical-surgical nursing, St. Luke's College of Nursing, Tokyo, Japan, the typical educational program there includes classes in maternal and child health, midwifery (delivery practices), management and supervision of midwifery, community health management, and family sociology.[2] In spite of their extensive formal education, nurse-midwives are often confused with lay midwives.

What do midwives do? The American College of Nurse-Midwives (ACNM), Washington, DC, the professional organization for CNMs, defines midwifery practice in the US as "the independent management or care of essentially normal newborns and women, antepartally, intrapartally, postpartally, and/or gynecologically, occurring within a health care system which provides for medical consultation, collaborative management, or referral."[3] (The root word "-partal" comes from the Latin *partus*, meaning "parturition," or "childbirth.")

Midwifery in the US

The US differs in certain ways from other countries in terms of the history and status of midwives, so we will begin here. Polly F. Radosh, Department of Sociology and Anthropology, Western Illinois University, Macomb, has written a concise account of midwifery in the US. She notes that the status of midwives has declined in the last 200 years. In colonial days their status was quite high, but during the nineteenth century, with the rise of obstetrics and gynecology as a physician specialty, it declined, and in the early twentieth century the medical community attempted to eliminate midwifery entirely, blaming it for much of the maternal and infant mortality rife at the time.[4]

Reinforced by the hostile attitude of the medical community, society at large increasingly rejected midwifery as unscientific and perhaps dangerous. Ironically, medicine was hardly offering women alternatives for safe childbirth for much of the period during which midwifery declined. For example, childbed fever, an often fatal infection frequently spread by physicians who went from the autopsy room to the delivery room without washing their hands, exacted a frightful toll even among well-to-do women. This occurred despite the fact that 50 years before, the Austrian obstetrician Ignaz Semmelweis had established the cause of the fever and suggested that aseptic conditions could prevent it.[5] The midwives, meanwhile, managed to achieve somewhat better clinical results, in many cases, than their medical rivals.[4]

The first professional or formal training program for nurse-midwives in the US was established in 1931 by the Maternity Center Association, New York, according to Helen Varney, chairperson, Maternal-Newborn Nursing/Nurse-Midwifery Program, Yale University School of Nursing, New Haven, Connecticut.[3] Subsequent growth has been gradual—about one new program every two years—and there have been some recent setbacks. According to Sandra Hvidsten, public relations specialist, ACNM, there are now 25 accredited training programs in the US.[6] Table 1 lists the institutions offering these programs.

During the late 1960s and the 1970s, public acceptance of nurse-midwives began to increase. Factors contributing to this acceptance included the consumer and feminist movements and a general desire of individuals to have more of a voice in decisions affecting their health care.

In more recent years dissatisfaction with the way conventional medicine has managed pregnancy and childbirth has contributed to the growth of midwifery. The New York County Medical Society examined this dissatisfaction in 1980. Its public relations committee, under Shepard G. Aronson, called a meeting with women's groups ranging from the League of Women Voters to the National Organization for Women to ask the question: "Is there an anti-doctor feeling among women today?" Meeting participants gave an emphatic "Yes!" as their answer.

Table 1: NURSE-MIDWIFERY PROGRAMS. Education programs accredited by the American College of Nurse-Midwives.

Certificate Programs

Baylor College of Medicine
Nurse-Midwifery Program
1801 Allen Parkway
Houston, TX 77019

Frontier School of Midwifery and Family Nursing
Frontier Nursing Service
Hyden, KY 41749

Midwifery Education Program
Education Program Associates
1 West Campbell Avenue
Campbell, CA 95008

State University of New York
Health Science Center at Brooklyn
Nurse-Midwifery Program
450 Clarkson Avenue, Box 93
Brooklyn, NY 11203

United States Air Force
Nurse-Midwifery Program
Malcolm Grow USAF Medical Center
Andrews Air Force Base, MD 20331

University of California, San Francisco
San Francisco General Hospital, Ward 6-D, Room 24
1001 Potrero Avenue
San Francisco, CA 94110

University of Medicine and Dentistry of New Jersey
School of Health Related Professions
Nurse-Midwifery Program
65 Bergen Street
Newark, NJ 07107-3006

University of Southern California
Nurse-Midwifery Program
Women's Hospital, Room 8K5
1240 North Mission Road
Los Angeles, CA 90033

Master's Programs

Case Western Reserve University
Frances Payne Bolton School of Nursing
2121 Abington Road
Cleveland, OH 44106

Columbia University
School of Nursing
Graduate Program in Maternity Nursing and Nurse-Midwifery
630 West 168th Street
New York, NY 10032

Emory University
Nell Hodgson Woodruff School of Nursing
Atlanta, GA 30322

Georgetown University
School of Nursing
Graduate Program in Nurse-Midwifery
3700 Reservoir Road, NW
Washington, DC 20007

Medical University of South Carolina
Nurse-Midwifery Program
College of Nursing
171 Ashley Avenue
Charleston, SC 29425

Oregon Health Sciences University
School of Nursing
Department of Family Nursing
Nurse-Midwifery Program
3181 SW Sam Jackson Park Road
Portland, OR 97201

University of California, San Diego
UCSF/UCSD Intercampus Graduate Studies
Family Nurse Practice, Nurse-Midwifery
La Jolla, CA 92093-0809

University of Colorado
Health Sciences Center, School of Nursing Graduate Program
Nurse-Midwifery Program
4200 East 9th Avenue, Box C 288
Denver, CO 80262

University of Florida
College of Nursing
J. Hillis Miller Health Center, Box J-197
Gainesville, FL 32610

University of Illinois, Chicago
Health Sciences Center, College of Nursing
Department of Maternal-Child Nursing
Nurse-Midwifery Program
Chicago, IL 60680

University of Kentucky
College of Nursing
760 Rose Street
Lexington, KY 40536-0232

University of Miami
School of Nursing
1540 Corniche Avenue
Coral Gables, FL 33124

University of Minnesota
School of Nursing, 6-101 Unit F
308 Harvard Street
Minneapolis, MN 55455

University of Pennsylvania
School of Nursing
Nursing Education Building/S2
Philadelphia, PA 19104-6096

University of Utah
College of Nursing
Graduate Program in Nurse-Midwifery
25 South Medical Drive
Salt Lake City, UT 84112

Yale University
School of Nursing
Maternal-Newborn Nursing/Nurse-Midwifery Program
855 Howard Avenue, Box 9740
New Haven, CT 06510-0740

Doctoral Program

Rush University
College of Nursing
1653 West Congress Parkway
Chicago, IL 60612

Among the reasons cited were the failure of physicians to explain medical matters sufficiently to their female patients, a lack of understanding of women's attitudes and problems, and a lack of sensitivity towards patients.[7] This sort of feeling has led to an increasing demand for alternative birth centers (ABCs) and special hospital units designed around a program including nurse-midwives. Significantly, Aronson notes that many physicians agreed with the criticisms voiced at the New York meeting.[8]

Many of the issues leading to the dissatisfaction with the medical community's handling of pregnancy and childbirth have been examined in depth by Diana Korte and Roberta Scaer, La Leche League, in their book *A Good Birth, a Safe Birth*. This book was written as a guide for prospective mothers to provide information to enable them to make informed choices in planning for pregnancy and delivery.[9]

Midwifery Practice

The philosophy of health care provided by nurse-midwives differs substantially from that of the more conventional medical community. The differences can be found by reading basic texts such as those by Varney,[3] already mentioned, and by Constance J. Adams, professor and chairperson, Department of Obstetric and Gynecological Nursing, Rush University College of Nursing, Chicago, Illinois.[10]

According to proponents of midwifery, a major difference between midwifery and medicine is that medicine has traditionally treated pregnancy and birth as an illness, requiring medical intervention. Midwifery, on the other hand, considers childbirth a natural process that in most cases affects healthy, normal people. Consequently, it usually requires minimal intervention. In short, the exceptional cases should not be regarded as the norm. In the US midwives have been handling routine gynecological checkups for an increasing number of women.

Midwives, whether they practice in hospitals, birth centers, or elsewhere, are trained to emphasize family involvement. This means, among other things, that the mother-to-be is encouraged to have relatives and close friends of her choosing present during labor and delivery. This contrasts with what some view as impersonal standard hospital practices in which the mother may be left alone at times and is treated by strangers. (We should note that hospital practices have changed significantly in many locations in response to these criticisms.)

An important component of the family-centered birth is the choice of location. Midwives often favor the homelike atmosphere of special birth centers and even, in some cases, support a woman's decision to give birth at home. It should be stressed, however, that nurse-midwives are taught to refer women with special problems or complications to appropriate medical specialists.[11,12] Further, the ACNM requires that its members have written protocols describing how they handle complications and referrals.

My own experiences may reflect the change in American practices. In 1947 my first child was born at Stanford University Hospital, California. I was not permitted to be present during the delivery. However, when my youngest child was delivered by Dr. Mark B. Landon at Children's Hospital in Philadelphia, I was present during the entire process. I might add that in both cases the need for medical intervention was essentially unpredictable.

Midwifery also stresses careful consideration of aspects of treatment that proponents say have been too often ignored by physicians. Teresa Marchese, Georgetown University School of Nursing, Washington, DC, and colleagues point out these areas. They basically focus on midwifery's avoidance of unnecessary intervention and include the choice of the position the mother assumes during labor, less frequent use of fetal monitoring, minimal use of analgesics and anesthetics, and the use of perineal massage to stretch the perineum rather than episiotomy (an incision designed to prevent damage to the perineum). All of these subjects have been debated in the literature without clear resolution.[13] However, for patients who are

at risk or at high risk, the nurse-midwife is trained to comanage the patient with the physician. She can, for example, apply fetal monitoring devices, interpret the tracing, and perform and suture an episiotomy.

Relations with the Medical Community

A significant problem for nurse-midwives is the establishment of good working relationships with the medical community. A nurse-midwife needs to be able to refer high-risk patients to an obstetrician/gynecologist. Physicians and midwives can and often do share mutual respect and cooperation. Many medical specialists, however, still oppose midwives. Barbara Katz Rothman, Department of Sociology, Baruch College, City University of New York, considers professional autonomy to be a major problem. Even when a referral relationship is established, the midwife loses autonomy by submitting to the professional control of the physician.[14]

Rothman questions whether midwifery can be considered a profession. A sociological definition of a professional occupation requires that the practitioner ultimately control his or her own work. This definition includes controlling professional standards as well as the body of knowledge used by the profession. In the case of midwives, these forms of control are largely in the hands of physicians.[14]

In addition to its struggle for professional autonomy, nurse-midwifery has also encountered resistance to its attempt to establish a separate identity from nursing and medicine. As Ruth Watson Lubic, general director, Maternity Center Association, reports, the controversy involves jurisdictional disagreements both among and within professions.[15] Currently, most states consider nurse-midwifery a subspecialty of nursing.

In spite of continuing problems, the differences between midwifery practice and hospital obstetrics and gynecology are not as great as they once were. In fact, many hospitals have established ABCs. C.T. Hardy, assistant clinic manager, Watson Clinic, Lakeland, Florida, and Lamar Ekbladh, Department of Obstetrics and Gynecology, North Carolina Memorial Hospital, Chapel Hill, describe such a center at the latter institution. The center provides a homelike setting for giving birth with minimal medical intervention. Interestingly, establishment of the center came in response to patient demands for alternatives to the usual hospital setting.[16]

Professional differences aside, midwives face certain problems faced by all disciplines in the health community. One such example is the AIDS epidemic. As Linda Baxter, associate editor, *Journal of Nurse-Midwifery*, points out, nurse-midwives, like a great many other health-care providers, have just begun to explore ways of dealing with this disease that is terrifying the public.[17] The recent annual meeting of the ACNM, in fact, had a working group considering the AIDS problem.

Midwifery and the Law

Nurse-midwives in the US face a patchwork quilt of regulations and licensing structures, since these are in the domain of state and local governments. Karen Mullinax, in collaboration with the Political and Economic Affairs Committee, ACNM, has published reports dealing with each of the separate jurisdictions. Her 1987 report points out great variations both in the nature of the regulatory authority and even in the definition of midwifery.[18,19]

Professional Liability Insurance Problems

Like physicians, nurse-midwives are currently having severe problems with liability insurance that are driving many out of their profession. The ACNM points out that fewer than 6 percent of all nurse-midwives have been sued since 1974, a low rate when compared to the 60 percent for obstetricians in the same period. According to Rosalind Kendellen, a New Jersey lawyer and mid-

wife, those midwives who have lost suits in the last decade have had average judgments of $70,000, much lower than those of obstetrician/gynecologists.[20] It is interesting to speculate whether the difference in the frequency and size of the awards is due to differing patient/professional relations or whether it is due to the greater potential payoff in suing doctors. In spite of this difference, insurers class midwives with the obstetricians and have been raising their rates accordingly. The economic pressures of the malpractice insurance crisis may eventually negate the fact that midwife-managed normal deliveries cost far less than physician-managed deliveries.[4] There are indications, however, that the situation is now improving somewhat.

Midwifery in Europe

If midwives have had difficulty gaining acceptance in the US, this has not been so in other countries. In Europe, for example, midwives have long been part of the established health-care community. Luke I. Zander, physician, Lambeth Road Group Practice, London, UK, describes the midwife as the primary provider of care for most uncomplicated births and an important partner of the physician in some complicated births. One prominent model of care is that of the midwife, supported by a general practitioner, and is characterized by continuity of care and a low rate of medical intervention in the birth process. Home births, as in the US, are infrequent.[21] Landon, now at the Department of Obstetrics and Gynecology, Ohio State University, Columbus, notes that malpractice is hardly a problem in the UK.[22]

In the Federal Republic of Germany (FRG) there is a shortage of midwives (5,500 compared to 41,000 in the UK), according to Debra L. Luegenbiehl, writing as a doctoral candidate in nursing, Texas Woman's University, Denton. Most practice in hospitals and clinics, where they supervise 80 percent of all births. There is great mutual respect between physicians and midwives.[23]

Scandinavia and The Netherlands

Béatrice Blondel, Health and Medical Research National Institute (INSERM), Villejuif, France, and Detlev Pusch and Eberhard Schmidt, Pediatric Clinic, University of Düsseldorf, FRG, in a 1985 article, claim that, in Finland and Sweden, prenatal care takes place mainly in health centers and there midwives play a major role; they are responsible for approximately 10 of 13 or 14 visits planned. Indeed, in Sweden, Finland, and Norway, nearly 100 percent of normal pregnancies and deliveries are attended by midwives.[24]

The Netherlands departs somewhat from the European model. More than one-third of all mothers there give birth at home. Nevertheless, the perinatal mortality rate is one of the lowest among developed nations, lending some credence to arguments in favor of the safety of home births.[21]

China and Japan

Patricia Elder and Lily Hsia, State University of New York Downstate Medical Center, Brooklyn, toured the Shanghai First Maternal and Child Health Institute in the People's Republic of China in 1985. They found midwives active in all areas of the institute, where they were responsible for managing all normal prenatal care and all normal births. Chinese midwives differed from their US counterparts in resorting to episiotomy more frequently and in using acupuncture for pain relief.[25]

Midwifery in Japan has been heavily influenced by the US since World War II. Practice is governed by the Law Concerning Public Health Nurses, Midwives, and Nurses. In 1984 Kazuko Kodama, editor-in-chief, Japanese Nursing Association Publishing Company, reported that the number of Japanese midwives was about 27,400. Of these, 61 percent worked in hospitals and clinics and 36 percent worked in maternity homes, either as employees or as independent practitioners.[26] Kojima reports growth in the number of midwifery schools, from

Table 2: RISK IN PREGNANCY. Selected 1986 *SCI®/SSCI®* research fronts related to this topic. A=number of core papers. B=number of citing papers.

Number	Name	A	B
86-0040	Fetal effects of alcohol, ethanol, marijuana, and cocaine	33	250
86-0951	Maternal smoking during pregnancy and fetal growth	9	65
86-1407	Cefotetan and cefoxitin for prophylaxis in cesarean section	3	19
86-2523	Cesarean section anesthesia and cardiopulmonary resuscitation of pregnant women	3	20
86-3820	Imaging ultrasound used in fetal management and diagnosis of fetal defects	3	25
86-4290	External cephalic version of the breech presentation, preterm birth, low birth-weight infants, and neonatal mortality	19	115
86-5031	Prenatal care of adolescents and older women	3	17
86-5772	Pregnancy hypertension and early recognition of placental insufficiency	2	16
86-5861	Antibiotic prophylaxis in cesarean section	7	38
86-5896	Endometrial cultures performed at cesarean section and antibiotic prophylaxis	2	13
86-6140	Effects of drugs and environmental teratogens in pregnancy	5	52

59 in 1976 to 80 in 1986, with 1,995 students enrolled in 1986.[2]

The USSR

Women make up a substantial portion of the medical community in the USSR. According to Elizabeth Lee, a freelance journalist, however, the state of childbirth there is far from the ideal promoted by midwives in the US and other Western nations. Husbands are not allowed to be present at the births of their infants, and there are no visiting hours so they can visit their wives. As a rule, infants are separated from their mothers during the first 24 hours after birth. Of interest is the common use of electroanalgesia in place of drugs for pain relief.[27] V.I. Grischenko, Department of Obstetrics and Gynecology, Kharkov Medical Institute, USSR, notes that one role of the Soviet midwife is to visit the homes of expectant mothers who have missed scheduled prenatal appointments with their physicians.[28]

The Third World

Midwifery can be especially important in the Third World, where physicians and medical facilities are often spread very thin. H. Bella and G.J. Ebrahim, Tropical Child Health Unit, Institute of Child Health, London, conducted a study of midwife care in the Sudan. That nation has had formally trained village midwives (not nurse-midwives) since 1920, and there are now 6,000 in practice, with 18 schools training new ones. A survey found that the practicing midwives were well versed about when to refer pregnant women to a physician for special care, thus supporting the view that the midwives are providing safe care. Further, midwives are a preferred source of health care and information among village women and a potential resource for future efforts at measures such as immunization.[29]

Midwives have a major role to play in World Health Organization goals of achieving good health for all the world's people by the year 2000. According to James P. Smith, Fellow of the Royal College of Nursing, London, midwives can provide a valuable service in communities by helping to educate people in health matters and by mobilizing social support for institutional changes.[30]

Literature on Midwifery

Having defined midwifery and examined its history and professional status, let's examine its literature. In October 1984 we discussed the nursing literature and identified the journals and most-cited articles in this field.[31] Midwifery is a smaller field than nursing and, as we expected, a search of ISI®'s files indicated that there were no 1986 or 1987 research fronts dealing directly with the subject of midwives. There are, of

Table 3: MIDWIFERY JOURNALS. Selected list of journals that publish articles about midwifery.

Birth Gazette (1977)
I.N. Gaskin, ed.
Practicing Midwife Foundation
Summertown, TN

Jordemodern (1888)
A. Karlsson, ed.
Swedish Association of Midwives
Stockholm, Sweden

Josanpu Zasshi/Japanese Journal for the Midwife (1952)
Igaku-Shoin
Tokyo, Japan

Journal of Nurse-Midwifery (1955)
M.A. Shah, ed.
Elsevier Science Publishing
New York, NY

Katilolehti/Tidskrift foer Barnmorskor (1896)
M. Kennovaara, ed.
Federation of Finnish Midwives
Helsinki, Finland

Midwife, Health Visitor and Community Nurse (1965)
N. Morris, ed.
Newbourne Group
London, United Kingdom

Midwifery (1984)
A. Thomson, ed.
Churchill Livingston Medical Journals
Edinburgh, United Kingdom

Midwives Chronicle (1887)
A. Graveley, ed.
Nursing Notes
London, United Kingdom

course, many on medical issues related to childbirth and pregnancy. Table 2 lists several research fronts on aspects of risk in pregnancy. These include "Antibiotic prophylaxis in cesarean section" (#86-5861), "Fetal effects of alcohol, ethanol, marijuana, and cocaine" (#86-0040), and "Prenatal care of adolescents and older women" (#86-5031).

To determine the size of the literature on midwifery per se we used *Social SCISEARCH®*, the online version of the *Social Sciences Citation Index®* (*SSCI®*). From 1972 to the present, we found over 425 articles with midwifery in their titles.

Another source offering bibliographic information on midwifery, the *International Nursing Index* (*INI*), a quarterly publication produced by the American Journal of Nursing Company in cooperation with the National Library of Medicine, indexes more than 260 nursing journals. At least nine of these have titles indicating that they specialize in the fields of midwifery or childbirth. It also indexes articles from other allied health and biomedical journals. Included in the *INI* is the *Nursing Citation Index™* (*NCI™*), created by ISI. Similar in concept to the *Science Citation Index®* (*SCI®*), the *NCI* lists the articles cited by papers indexed in the *INI*. Thus, it offers a means of identifying related papers in various areas of nursing, such as midwifery. This source picks up more articles in this field than the *SCI* or *SSCI* does.

Table 3 lists some of the journals that currently focus on midwifery. The *Journal of Nurse-Midwifery* is the publication of the ACNM and is indexed in the *SSCI*. The other journals are listed in the *INI* and *NCI*. Journals such as *Jordemodern* and *Katilolehti/Tidskrift foer Barnmorskor* are examples of national midwifery association journals from Sweden and Finland, respectively. Two of the newest journals are *Birth Gazette* and *Midwifery*. Of course, articles on midwifery and related subjects appear in many journals in fields such as medicine, nursing, health-care administration, and sociology. Most of the nursing literature ISI covers is found in the *SSCI* rather than in the *SCI*.

There are several authors prominent in the field of midwifery. Varney, mentioned previously, has written one of the basic texts on midwifery.[3] This work has been cited in about 25 mainly socially oriented papers. Varney has also published papers on aspects of clinical care and midwifery as a profession.

Adams, also mentioned earlier, is the editor of another major source book.[10] However, the use of these works in practice is hardly reflected in formal citation. Adams also publishes papers on subjects such as human fertility and midwifery education.

Rothman has written *In Labor: Women and Power in the Birthplace*, which discusses politics in maternity care, the status of

such care in the US, and the role of midwives. This book has been cited in about 25 papers identified in the *SSCI*.[32] Rothman has also published papers on matters such as interprofessional rivalry.

Raymond G. DeVries, Department of Sociology, Westmont College, Santa Barbara, California, is the author of *Regulating Birth: Midwives, Medicine, & the Law*, an important examination of legal issues.[33] This book, published in 1985, has been cited eight times in the *SSCI* in the last three years. Other publications by DeVries include papers on regulation of the health professions, evaluation of the success of ABCs, and other subjects.

A recent report—*Nurse-Midwifery in America*—edited by Judith P. Rooks, epidemiologist, Portland, Oregon, and J. Eugene Haas, consultant to the Carnegie Foundation, and published by the ACNM in 1986, gives an overview of the current status and problems of nurse-midwifery in the US.[34]

Organizations

Table 4 presents a selected list of organizations representing midwives here and abroad. The principal US organization is the ACNM, with 53 chapters and over 2,700 members. The ACNM is a professional organization responsible for maintaining standards of practice and for certifying nurse-midwives. It also provides for continuing education and for advocacy of the profession.

Another US group is the Nurses Association of the American College of Obstetricians and Gynecologists (NAACOG). This organization represents nurses involved in its title field. Not all members are midwives, but many nurse-midwives hold memberships in both the ACNM and the NAACOG, and the two groups cooperate in various programs.

The UK Central Council for Nursing, Midwifery and Health Visiting was established in 1979 to set and improve standards of training and professional conduct for nurses, midwives, and health visitors (visiting nurses) in Great Britain.

The International Confederation of Midwives is an umbrella organization representing national midwifery groups worldwide.

Table 4: MIDWIFERY ORGANIZATIONS. Selected list of organizations concerned with midwifery.

American College of Nurse-Midwives
1522 K Street, NW
Suite 1120
Washington, DC 20005

Association of Radical Midwives
8A The Drive, Wimbledon
London SW20 8TG
United Kingdom

Federation of Finnish Midwives
Dagmarinkatu 8 B
00100 Helsinki 10
Finland

International Confederation of Midwives
57 Lower Belgrave Street
London SW1W 0LR
United Kingdom

Nurses Association, American College of Obstetricians and Gynecologists
600 Maryland Avenue, SW
Suite 300
Washington, DC 20024

Royal College of Midwives
15 Mansfield Street
London W1M 0BE
United Kingdom

United Kingdom Central Council for Nursing, Midwifery and Health Visiting
London W1P 0HA
United Kingdom

Conclusion

Nurse-midwifery, as a distinct profession within the health-care field, is a well-established form of care in many countries and is gaining popularity in the US. The future of nurse-midwifery in the US will depend on how midwives address problems such as those of professional autonomy, regulation, and, especially, liability insurance. Considering the importance of midwifery in health-

care delivery, especially in the Third World, and the key role midwives can play in birth-control education and practice, there is surprisingly little research in either the social-sciences or medical literature on this topic. Perhaps we will see an increase as national governments realize that midwives can be trained to be one of the best sources of information on the AIDS epidemic.

* * * * *

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7. **Robertson N.** Women critique medical profession: the prognosis is grim. *Chicago Tribune* 19 October 1980. Sec. 12, p. 10.
8. **Aronson S G.** *Anti-physician beliefs among certain women's groups.* 1980. 5 p. (Unpublished report.)
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