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The University of Southern Mississippi

The Practice, Regulation, and Political Context of Midwifery in Mississippi:
Attitudes of Healthcare Professionals

by

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A Thesis

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The University of Southern Mississippi
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ABSTRACT

The current state-by-state system of midwifery regulation—or lack thereof—has made the issue a subject of debate amongst policy-makers, community-members, and healthcare providers as a whole. In Mississippi, the practice of midwifery is, at present, legal but unregulated, meaning there is no protocol for licensure, certification, or registration. In 2011, a bill that sought to require all non-nurse midwives in the state to become Certified Professional Midwives through the North American Registry of Midwives or a successor organization was proposed. Though the legislation passed the House of Representatives, it was never signed into law. This bill, along with past and current analogues of it, has led many to take sides as supporters or non-supporters of midwifery as well as supporters or non-supporters of varying degrees of regulation. As such, this project seeks specifically to examine healthcare professionals’¹ opinions regarding midwifery by analyzing data collected through both questionnaires and semi-structured interviews. Emergent themes this paper explores include: a general lack of familiarity and understanding regarding the practice of midwifery, the many facets of fear associated with pregnancy and childbirth, culture-specific influences on maternity care, and ideal regulations that could potentially pave the way for varying degrees of collaboration.

¹ Herein, the term “Healthcare professionals” refers to Doctors of Medicine, Doctors of Osteopathic Medicine, Nurse Practitioners, and nurses informed about and/or associated with labor and delivery.

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CHAPTER I: INTRODUCTION

The re-emergence of midwifery in recent years has brought long-standing rivalry, miscommunication, and distrust between physicians and midwives back to the surface. Traditionally, the physician model of care defines pregnancy and childbirth as potentially pathological and thus focuses relatively more on the medical aspects of birth. The midwifery model defines pregnancy and childbirth as natural processes and is characterized by continual care and minimal intervention. As such, much of the tension between the two is rooted in both the inherent divergence in the models as well as the historical and ever-evolving social and political contexts surrounding maternity care and its providers. This, considered amid the milieu of ever-current issues including the politics of healthcare reform in the United States and the employment of the midwifery model at relatively higher rates in a number of other countries, many of which would argue in favor of the efficacy of the approach, substantiates midwifery as a subject of popular research (CIA 2012).

Many researchers have explored the effectiveness of both the midwifery and medical models of care, often with inconclusive and/or conflicting results (Durand 1992; Wax et al. 2010). Others have analyzed the midwife-doctor-patient dynamic in varying degrees, usually in relation to a particular country or region of interest (Fisher, Hauck, and Fenwick 2006). However, since regulations pertaining to midwifery vary greatly from state-to-state, little research has been done relative to specific populations' attitudes towards midwifery regulation with respect to their particular region. What's more, there is a significant lack of research aimed specifically at analyzing healthcare professionals

views on such topics, as is the purpose of this study. Therefore, the specific research question this thesis addresses is: “What attitudes and beliefs do healthcare professionals hold regarding the regulation of midwifery in Mississippi?”

This paper first examines the history of childbirth in America as it has shaped the current status of midwives and maternity care as a whole. Understanding this historical context allows for analysis of both the midwifery and medical models of care as well as the many care providers that have stemmed from them over the years. Inter- and intra-vocational conflicts are then explored within the context of historical, societal, and cultural influences. These contexts are then used to develop the political circumstance concerning the regulation of midwifery in America and, more specifically, Mississippi.

By considering the status of midwives in other countries relative to those in the United States as well as the variance amongst states, there is an evident need to further explore midwifery as it relates to particular regions and informed persons’ views of the practice within said regions. This is approached herein by both surveying and conducting semi-structured interviews with healthcare professionals currently practicing in the South Mississippi area. Analyses of such data reveal healthcare professionals’ generally lack a solid understanding of midwifery relative to their training and education as well as their practice. Additionally, national and regional cultural themes further describe divergences in midwifery on a country-to-country and state-to-state level. These factors, coupled with healthcare professionals’ cautious approach to childbirth due to the inherent danger of potential complications ultimately bring about views of superiority of the medical model over the midwifery model, subjugating the latter to a secondary role in maternity care.

CHAPTER II: LITERATURE REVIEW

This chapter aims to both explicate the current status of midwives in Mississippi and provide a context through which to interpret healthcare professionals' attitudes and beliefs towards midwifery. It first explores the history of childbirth and expounds upon individual divergences of maternity care providers over time. Using this backdrop, literature regarding the current array of maternity care providers and relationships amongst them is presented. Finally, the intricacy of a political viewpoint affected by all of these factors is explored and, accordingly, related to inconsistencies in midwifery regulation and perspectives, thus justifying the research question this thesis aims to define.

The Evolution of Childbirth Practices and Perspectives in America

Neither the phenomenon of childbirth nor women's relationship to it has remained static throughout history. Rather, it has evolved in a manner often reflecting the political, social, and cultural contexts of the time. In Colonial America, early settlers continued the European tradition of utilizing female birth attendants (Rooks 1997). Since few colonists were of the elite, university-educated class, these so-called 'midwives' were often the sole source of healthcare available to women (Rooks 1997). The expertise of these early midwives varied with the diversity of the population. Since Britain was one of the last European countries to develop midwifery training standards and regulations, many of the first 'Mayflower' midwives were not formally trained, but rather acquired their knowledge and skills via observation and informal apprenticeships associated with

familial lineage (Rooks 1997). Midwives that later came to America as immigrants were sometimes well-trained as a reflection of the advancement of midwifery education in Europe, but their preparation was often deeply rooted in folklore (Rooks 1997). Western Africa childbirth traditions, superstitions, and practices also made their way to America with the first slaves (Rooks 1997).

For the first couple hundred years of Colonial America, this diverse group of midwives attended the majority of births, passing their knowledge down through generations (Rooks 1997). Few cities licensed midwives and those that did relied on religious, mostly Puritan-based principles as guidelines (Wertz and Wertz 1977). For example, in some colonies, midwives were required to obtain civil licenses that “prohibited [them] from coercing fees, giving abortifacients, practicing magic, or concealing information about birth events or parentages from civil or religious authorities” (Wertz and Wertz 1977:7). Midwives were often called upon to testify in court cases pertaining to bastardy and thus they were afforded a certain degree of authority as “servants of the moral and civil order of the state” (Wertz and Wertz 1977:8). As a result, American midwifery grew into its own rite as it was adapted to a novel culture. (Rooks 1997)

This puritanical form of midwifery regulation forbade many midwives from calling upon the traditional powers they believed in. Since what we might regard as “magic” functioned, at that time, as a form of comfort, this was potentially detrimental to midwives’ competence (Wertz and Wertz 1977). In fear of punishment, many were lessened to an inferior role in which the only comfort they could offer was to call on God (Wertz and Wertz 1977). Unfavorable outcomes came to be seen as a form of pious

punishment and birth itself was a test of faith by God (Rooks 1997). Women believed that “if you suffer, it is not because you are cursed of God, but because you violate his laws,” meaning that their childbirth experiences, good or bad, were a reflection of their lifestyle and behavior (Wertz and Wertz 1977:115). As such, seventeenth century American women began to dread and fear childbirth (Wertz and Wertz 1977). Wertz and Wertz (1977), however, point out that this sentiment began to change at the onset of the eighteenth century, as analyses of women’s diaries from that time period evolve from expressing concerns about childbirth itself to those regarding more domestic topics. Perhaps this shift in perception is related to the concurrent rise of scientific understanding, as persons began to accept the laws of nature as potentially independent from what they came to view as a more benevolent God (Rooks 1997).

Under this philosophy, the birthing room scene began to gradually change from conventional midwives who were typically uneducated, illiterate women to formally educated men (Rooks 1997). Many colonial men went to England for medical training and brought back with them ideas of forceps, opium, and other theory-based methodologies (Rooks 1997). The doctors called their practices relative to birth “new midwifery” as it incorporated the medical aspects of their education into the traditional midwifery approach (Wertz and Wertz 1977). It should be noted, however, that these ‘doctors’ were likely either apprentice-trained or educated in relatively unstructured medical schools, as the phenomenon of medicine as the present-day profession did not come about until centuries later (Rooks 1997). Regardless, however, skewed perceptions of medically trained doctors deemed them better qualified than midwives, who most

people assumed had little to no training even though the majority were either grannied in or apprentice-trained (Rooks 1997).

Through the remainder of the eighteenth and into the early nineteenth century, old and new midwifery philosophies coexisted under the promising visage that trained midwives were capable of attending normal deliveries whereas doctors were to be called to the more difficult ones (Wertz and Wertz 1977). As such, the British trained physician, Dr. William Shippen, Jr., offered the first formal midwifery instruction in the form of a course consisting of both first-hand experience and theory in 1762 (Rooks 1997; Leavitt 1986). However, given the status of lay midwives at the time as well as their inherent views of childbirth as both normal and within the female domain, few were able and/or willing to attend such courses (Wertz and Wertz 1977). Eventually, Shippen offered his instruction to only male students (Leavitt 1986). The circumstances of midwives and the newly found acceptance of science paved the way for the acceptance of doctors, particularly male doctors, in the birthing realm. The previously hopeful façade of coexistence never translated into practice and American midwifery became a competitive field charged by issues of both gender and eminence between the two, increasingly divergent models of care. In 1828, the term midwife, literally meaning “with woman” and historically defined as the care given to women during childbirth, independent of the specific type of caregiver, was officially differentiated next to the professional term obstetrics, meaning, “to stand before” (Rooks 1997:3).

The concept of professionalization within medicine and the desire for ‘new’ doctors to establish sustainable practices seemed to complement the specialty of obstetrics as women tended to use the same attendant for the sum of their births (Rooks

1997). Moreover, the continual advancement of science and the well-intended but often adverse desire to exploit it relative to birthing practices led many doctors to adopt less conservative methods (Wertz and Wertz 1977). This idea that a particular set of professional skills was needed to attend births inferred that a certain degree of expertise was necessary, a notion which dawning Victorian culture did not deem fitting for women (Wertz and Wertz 1977). Finally, the establishment of organizations like the American Medical Association and the American Association of Obstetricians and Gynecologists in the latter half of the nineteenth century as well as the state-level practice laws encouraged by them presented a socially and professionally organized front for medicine not reciprocated in midwifery (Rooks 1997). It did not take long for the idea to take root that medically trained physicians were superior to female midwives, apprentice-trained American physicians, and the like. Beginning with the urban, upper-class families, the perception of birth as a medical event best overseen by physicians trained in formal medical schools perpetuated throughout America (Rooks 1997). By the end of the nineteenth century, four medical schools, albeit lacking modern standards and protocol, had been established in the United States (Rooks 1997). A few midwifery schools were also opened, but they were often sub-par instructionally and/or financially (i.e. in terms of funding) (Rooks 1997). Additionally, some midwifery schools' close ties to the medical community led to their demise as it became clear that two divergent models of maternity care had emerged (Rooks 1997).

By 1900, doctors were attending approximately half of all births in the United States, particularly to middle and upper class families; midwives were sought by those who could not afford and/or access physician services—still, less than 5% of women

gave birth in hospitals (Wertz and Wertz 1977). However, a steep rise in both of these factions was seen throughout the 20th century. The Flexner Report, published in 1910, molded the practice of medicine into a professional model and, with this, present-day medical specialties advanced (Rooks 1997). By the 1960s, over 95% of births took place in hospitals with physicians (Rooks 1997). As medicine excelled, the practice, respectability, and training of midwives declined. Though the context presented herein certainly attributed to this, it was not the result of a plot by the medical community or men, for that matter. New medical doctors not only believed in the efficacy of their approach, but as a whole they were also eager to establish their professional role in society.

Current Approaches to Childbirth: The Midwifery Model and the Medical Model

It was not until the 1960s and 1970s that trends surrounding childbirth began to emerge in a new light. President John F. Kennedy challenged the nation to take on a sense of societal responsibility and, amid this philosophy, the civil rights movement, the feminist movement, the anti-war movement, the consumer movement, and the women's health movement, amongst others, symbolized the vast potential for reform. Healthcare became a critical topic on the government's agenda and, birthed from the Social Security Act, Medicare and Medicaid were born. Additionally, more and more young people, particularly women, were attending college. In due course, health services came to be viewed as a right rather than a privilege. With this ideal, people became actively involved in their own healthcare decisions, as evidenced by the legal debates of informed consent, the right to refuse care, and the still ongoing deliberation relative to health insurance.

This social context applied to women's resolve to acknowledge and take control of their healthcare needs perpetuated the re-emergence of midwifery in opposition to the aggressive, authoritative, interventionist style of the medical community's approach to childbirth. (Rooks 1997)

The re-emergence of midwifery brought about several forms of care providers. Nurse-midwifery had risen from the early twentieth century idea of professionalization within the field (Rooks 1997). Its existence during the rise of hospitals in the latter nineteenth and through the twentieth century as well as its inherent association with organized healthcare put nurse-midwives in a peculiar position during the 1960s and 1970s. The movement that re-vitalized the practice of midwifery was rooted in women's desire to totally free their birthing experiences from the influence of modern medicine (Rooks 1997). Some of these women were part of the counterculture movements of the time, others belonged to religious groups that, for one reason or another, discouraged hospital births, and still others were traditional members of the community who believed in the advantages of non-interventionist methods (Rooks 1997). The criteria laid out by these women led to not only a reform of birth within hospitals but also a demand for home-births, which was rarely met by physicians and nurse-midwives and more likely to be met by self-taught women (Davis-Floyd and Johnson 2006). As a result, new forms of lay midwifery were fashioned (Davis-Floyd and Johnson 2006).

The American College of Nurse-Midwives (ACNM), founded in 1955, established accreditation protocol by 1965 and a national certification for nurse-midwifery program by 1970. Nevertheless, the concurrent rise in lay midwives challenged the dominance and legitimacy of the organization within the midwifery realm.

Despite ACNM's 1980 endorsement of nurse-midwifery in all settings, its stance against the accommodation of lay midwives led to the development of the Midwives Alliance of North America (MANA) in 1982. Discussions of legitimatizing all midwives without the stringency presented by the ACNM and the associated issue of professionalization eventually led MANA members to adopt the term 'direct-entry' in lieu of 'lay' midwives and, in 1994, establish its daughter organization, the North American Registry of Midwives (NARM). NARM established the Certified Professional Midwife (CPM) credential, a competency based certification program entailing an examination and national registration for those who pass it. In keeping with the goal of MANA to respect the diverse practices of midwifery, this process honors multiple routes of entry, including apprenticeship, self-study, private midwifery schools, college- and university- based midwifery programs and nurse-midwifery.

Despite the intrinsic differences between nurse- and direct-entry midwifery, both associate themselves with the practice of midwifery and the "midwives model of care" (discussed below). As such, many members of the ACNM sought to distinguish their practice from the medical community and its related regulations (i.e. in terms of practice, perspective, and legality) (Davis-Floyd and Johnson 2006). In 1994, the Certified Midwife (CM) credential, a form of accreditation for direct-entry midwives, was established (Davis-Floyd and Johnson 2006). In contrast to CPM certification requirements, the American College of Nurse Midwives Certification Council (ACC) honors only DOA-accredited college- and university-based midwifery programs as an avenue to CM accreditation, which also entails the same examination administered to prospective CNMs (Davis-Floyd and Johnson 2006). It is estimated that there are

approximately 6,000 CNMs, 50 CMs, 2,000 CPMs, and around 1,500 midwives who are neither state-licensed nor nationally-certified currently practicing in the United States (Davis-Floyd and Johnson 2006). (See Appendix A for a full summary of the types of midwives.)

Not surprisingly, these variations in how a “midwife” is defined have led to multiple levels of division, both inter- and intra-organizational, within the midwifery community, particularly on ideas of home versus hospital births, competency, and politics. In “Fear of Difference,” Kirkham (2009) expresses concern that midwives “are becoming more fearful and less tolerant of differences amongst [themselves].” She cites America’s medicalized society and the related hierarchical distribution of knowledge and social authority as a source of fear, as persons are afraid of “not following expert advice” (Kirkham 2009:7). A direct result of this is, according to Kirkham (2009), micro-management of midwifery practices. Since any less than desirable outcome a midwife has reflects poorly not only on the individual’s practice but also on the profession as a whole, governing bodies attempt to “manage events more closely [and] create more rules as to how things should be managed” (Kirkham 2009:7). Consequently, “the opportunities to get things wrong proliferate” leaving midwives “increasingly fearful of doing the wrong thing” (Kirkham 2009:7). Furthermore, since midwives largely share a reputation, there is often tension amongst midwives who either “take it upon themselves to harass those who do not fit in” or attempt to “induce conformity” (Kirkham 2009:8).

Despite the many dissimilarities discussed thus far, the core of the midwifery approach to childbirth is relatively homogeneous. On their website, the Midwives Alliance of North America (2012) defines “The Midwives Model of Care” as “based on

the fact that pregnancy and birth are normal life events.” The website (Midwives Alliance of North America 2012) then lists four bullet points further defining this model:

1. Monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle
2. Providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support
3. Minimizing technological interventions and;
4. Identifying and referring women who require obstetrical attention

Davis-Floyd (2003:155) refers to this approach as the “wholistic model” of birth, which she contrasts to the “technocratic model,” associated with the medical approach. The technocratic model is characterized by a more objective stance as inherent in its relation to medicine, science, technology, and the interrelations thereof (Rothman 1982).

Additionally, being that the term “technocracy” is rooted in ideas of both technology and hierarchy, Davis-Floyd (2003) infers the model is symbolic of both the medical approach and the societal context surrounding it. Reflecting this stance, the American Congress of Obstetricians and Gynecologists (2010) asserts the following:

While childbirth is a normal physiologic process that most women experience without problems, monitoring of both the woman and the fetus during labor and delivery in a hospital or accredited birthing center is essential because complications can arise with little or no warning even among women with low-risk pregnancies.

This statement reflects ACOG’s belief in the technocratic model of care as the medical approach to childbirth.

Glantz (2011) suggests that divisions not unlike those seen in the evolution of midwifery throughout history now riddle the specialty of obstetrics. In a commentary entitled “The Times, They Are a-Changin,” Glantz (2011) analyzes the idea that the re-emergence of midwifery concurrent with the natural childbirth movement of the late

twentieth century fostered a class of obstetricians who are less accepting of technology and stronger proponents of non-interventionist, vaginal deliveries than their younger counterparts. Glantz (2011:140) attributes this to the fact that “as one is trained, so one believes and practices, and in today’s teaching hospitals, rates of labor induction, intrapartum epidural anesthesia, and cesarean section are at record highs.” Evidencing these record highs, Menacker and Hamilton (2010) found that cesarean rates rose from 5.5% in 1970 to 32% in 2007. Ironically, Glantz’ argument deems older obstetricians the “progressives” (Glantz 2011:140). In the study on which Glantz’ proposal is based, “Attitudes of the New Generation of Canadian Obstetricians: How Do They Differ from Their Predecessors,” Klein et al. (2011), concludes that, in general, younger generations are more in favor of the interventionist-style methods of analgesia, equally or more concerned with the complications of vaginal deliveries than cesarean sections, more supportive of repeat sections, and less supportive of the woman’s right to choose as it relates to birthing plans and locations. Glantz (2011) relates this back to the recurring theme of societal context influencing birthing practices and perspectives, citing the current generation’s heavy and extensive reliance on technology in addition to the scheduling and productivity demands set forth by physicians and consumers alike. Additionally, he reasserts the equally persistent contention that such contexts, though exploited, are rooted in good will (Glantz 2011).

Social & Political Contexts of Midwifery & Medical Approaches to Childbirth

The effects of the current condition of childbirth practices in the United States in relation to the social and political contexts that surround them are extensive. Kirkham

(2001:123-124) holds that midwives “learn helplessness, dissociate from the women in [their] care, and ‘go with the flow’ of authoritative knowledge within the institution.” Such a milieu perpetuates what Kirkham (2009:124) refers to as a form of “bullying” amongst the field of maternity care providers. Fielder et al. (2004) propose that midwives’ desire to differentiate their wholistic approach to childbirth from that of the medical approach has created a dichotomous way of thinking that further divides maternity care and its providers. For example, the terminology used to compare practices alone is full of opposites; a few highlighted by Fielder et al. (2004:6) include “normality-abnormality, safe-unsafe, health-illness, safety-danger, midwifery model-medical model, and home-hospital.” Obviously, such comparisons infer a ‘good versus bad’ mindset that effectively demonizes one approach over another (Fielder et al. 2004). Addressing one ‘opposite,’ home versus hospital, Fielder et al. (2004) analyze the occurrence of a home birth transfer to a hospital due to potential complications and ask ‘why is the opposite not true if everything is going well?’ In this example, hospitals take the authoritative position yet the two are obviously not opposites as there are in fact instances in which they overlap. Fielder et al. (2004) believe that this system further fuels not only the division between midwifery and obstetrics, but also the intra-organizational issues of bullying proposed by Kirkham (2009), as it compels a stigma on transfer births as well as both the midwives and laboring women who ‘allow’ them.

In consideration of medicine’s generally authoritative position in these dichotomies, Glantz (2011:140-141) concludes the following:

Whether for reasons of faith in medicine, trust in technology, submission to a system they are unwilling to challenge, lack of faith in themselves, or fear of anything less than the perfect baby, the result has been women’s widespread

acceptance of increasing medicalization of pregnancy and concurrent evaporation of enthusiasm for natural childbirth, trends that obstetricians are only too willing to perpetuate.

The mere existence of such trends raises the question: how do these many discrepancies in the field of maternity care providers affect the patient population (i.e. expectant mothers and their babies)? Kirkham (2009) suggests that the system challenges the midwife's competency, which in turn affects her confidence. A fearful and unconfident midwife fosters the same such emotions in the woman she is attending, for both sentiments are "infectious" (Kirkham 2009:123). On the contrary, Fisher et al. (2006:73), suggest that particular to the Western Australian sample of their study, the "professional intimacy" intrinsic to the midwifery model of care actually lessens women's overall fear of childbirth. This concept (i.e. providers presumably unintentionally affecting women's birthing experiences) was further analyzed by Vedam et al. (2009), who found that patients often adopt the opinions of their provider in relation to birthing plans and locations. For this reason, Howell-White (1997) suggests that women should develop their own opinions regarding the birthing experience, as related to their personal beliefs and expectations, prior to selecting a provider. This implication is based on Howell White's (1997:925) findings that "women who define childbirth as 'risky' and requiring technical and medical intervention are more likely to select an obstetrician, while those who define it as 'natural' or 'normal' are more likely to select a Certified Nurse Midwife."

The proposal inferred by Howell-White (1997) that a particular model of childbirth might be right for one woman but not another leads to a discussion of how fear and opposition amongst healthcare providers affects inter-relations of providers with respect to the needs and/or desires of their specific patient populations. Adams et al.

(2011:473) conducted an integrative literature review analyzing the “attitudes and practice behaviors of mainstream maternity care professionals towards complementary and alternative treatments.” In their study, alternative therapies refers to the use of complementary and alternative medicines including but not limited to herbal therapy, massage therapy, acupuncture, movement therapy, aromatherapy, and meditation (Adams et al. 2011). They (Adams et al. 2011) found that 65% of midwives “perceived alternative therapies as effective in stimulating the body’s natural healing powers” whereas only 19% of obstetricians agreed with this statement. Adams et al. (2011) attribute this divergence to the general lack of understanding and respect relative to complementary and alternative medicine expressed by obstetricians in their particular sample. They go on to conclude that midwives approach such conventions as means to reduce intervention, a practice the researchers believe healthcare professionals could benefit from, given a better platform for communication amongst all maternity care providers and their patients (Adams et al. 2011).

Kirkham (2009:123) takes this issue back to a basis of fear, proposing that dichotomous thinking is a “defense mechanism” rooted in the inherent challenge to competency and confidence faced by all facets. Rothman (1982:86) paraphrases Dick-Read, the English obstetrician often credited for thrusting the childbirth movement into the limelight with his 1942 book *Natural Childbirth*, stating that “if fear can be eliminated, pain will cease.” To eliminate such fear, Walsh (2010:486) proposes “an integration of traditional embodiment theories, mediated through compassionate, relationally focused maternity care, especially when labor complications develop.” According to Walsh (2010:492), this would entail maternity care providers aligning

themselves within the interest of the childbearing women they serve rather than with their respective vocation, ultimately coming to understand “team as including the woman” and perhaps one another. It is this sort of reform that Walsh (2010:497) deems necessary to break down the barriers constructed throughout history and enable providers to “offer so much more than just their clinical skills.” Jowitt (2010:2) reasserts this point, referencing the fact that transfer births are often unpleasant for all parties as the current contexts of childbirth practices and perspectives “show[s] up most at the slippery slope between normal and potentially abnormal, the very point at which a midwife should refer.” This leads to impending complications that often impulsively distress the midwife-doctor relationship from the get-go, resulting in a woman in labor being roughly transitioned to a new care provider (Jowitt 2010). This cycle only perpetuates fear in childbirth, once again evidencing the notion that patients indirectly catch the brunt of the childbirth dispute.

Some tangible applications of the suggestions made by both Walsh (2010) and Jowitt (2010) (i.e. collaboration amongst maternity care providers) are in existence. In her article, “The Good Guys: A Happy Little Secret,” Nichols (2008) explores several instances in which she, as a midwife, and obstetricians have voluntarily sought the advice and wisdom of one another. The “happy little secret” she contends is “that there are doctors throughout the world who either are already practicing in ways congruent with the midwifery model or are eager to learn how” (Nichols 2008:43). Contrary to the inherent dichotomy set forth by Fielder et al. (2004), Nichols (2008:44) holds that “doctor and midwife truly can speak the same language,” a phenomenon which Jowitt (2010:2) regards as the “ideal collaboration between art and science.”

Policy in Midwifery Regulation

As of 2010, the U.S. Department of Health and Human Services estimated that the United States is home to more than four million live births annually (Macdorman, Menacker, and Declercq 2010). Ninety-nine percent of these births take place in a hospital under the care of a physician, though an estimated 40,000 (i.e. 1%) take place out of the hospital (Macdorman 2010). What's more, physicians attend 90% of total births, while CNMs attend 8.6% and non-nurse midwives attend 0.6% (Davis-Floyd and Johnson 2006). These statistics, evidencing the persistence of midwifery (despite small numbers) since its re-emergence in the latter half of the twentieth century, have made maternity care providers and their practices a critical topic of debate amongst policy-makers.

Midwifery is currently regulated on a state-by state basis and to varying degrees. According to Hafner-Eaton and Pearce (1994:1-2), state legislatures base their laws on “safety, cost, freedom of choice, quality of the care experience, and legality,” with the ultimate goal of striking “a delicate balance between the legal and medical responsibilities of protecting the public’s health and the individual’s right to privacy and choice.” In other words, they are “concerned with the criteria of fit-for-purpose and fitness-to-practice” (Fealy et al. 2009). The diversity of factors involved in decisions about midwifery regulation has led to a lack of uniformity amongst the states, in part due to variation in types of midwives as well as a lack of conclusive, empirical evidence regarding the relative safety of such practices (Fealy et al. 2009). With respect to the latter, Durand (1992) and Wax et al. (2010) independently compared the outcomes of

home births and hospital births. Durand (1992) analyzed the outcomes of 1,707 midwife-attended births, which took place at the Farm Midwifery Center between 1971 and 1989, and 14,033 physician-attended births, which took place in hospitals across the nation in 1980. The study suggests that for low-risk pregnancies, midwife-attended home-births are indeed comparable in safety to physician-attended hospital births, as there were no significant differences between the Farm group and probability sample with respect to fetal death, labor complications, or Apgar scores (Durand 1992). In fact, it was found that those that birthed at the Farm required significantly less assistance during delivery (Durand 1992).

These findings contrast to those of Wax et al. (2010), whose research consisted of a meta-analysis of 12 prior studies, which were performed and peer-reviewed in developed Western, first-world nations and which aimed to report on maternal and infant mortality relative to intended site of delivery. The researchers found that with respect to their sample, planned home-births, though associated with fewer medical and maternal interventions than hospital births, were correlated to approximately 33% more neonatal deaths. Based on these findings, the researchers conclude that, “less medical intervention during planned home birth is associated with a tripling of the neonatal mortality rate” (Wax et al. 253). Obviously, the conclusions drawn by Durand (1992) and Wax et al. (2010) are conflicting, thus representing yet another complication regarding understandings of maternity care and its providers as a whole.

As of 2012, CNMs are legal in all states and CPMs and/or CMs are licensed, certified, registered, or permitted in 26 states, 11 of which allow for Medicaid reimbursement (Midwives Alliance of North America 2012). In four states, midwifery is

neither regulated nor prohibited, whereas in 11 other states it is legal by judicial interpretation or statutory inference, the latter of which generally excludes midwifery as a practice of medicine thus legally protecting midwives from laws against practicing medicine without a license (Midwives Alliance of North America 2012; Hafner-Eaton and Pearce 1994). In the remaining nine states as well as in the District of Columbia, midwifery is prohibited (Midwives Alliance of North America 2012). In these nine states, many midwives continue to practice, which Davis-Floyd and Johnson (2006:184) maintain is “not out of a quest for money and power, but out of moral imperative they feel to keep the home-birth option open to the women in their communities.” These women, working in an illegal status, risk prosecution for practicing medicine without a license as well as criminal negligence in the event of infant mortality or injury (McKendry and Langford 2001). In contrast to these few adamant midwives, issues with regulation have, in fact, led to the demise or relocation of many midwifery practices. In one example, Tutt (1999) eloquently reflects on her decision to stop working as a midwife:

The whole situation reminds me of a long, hard labor, like my firstborn. Midwifery has been in second stage for a long, long time. Midwives and consumers have been working really hard to support this birth, but everyone knows, pushing is hard work and we're tired.

In light of these variations, many midwifery supporters are still working to legalize and regulate their practice in many states. At the national-level, organizations such as Citizens for Midwifery (CfM) work to provide state-level groups with the support and information they need to gain legal recognition (Davis-Floyd and Johnson 2006). Major setbacks to such organizations tend to revolve around compromises laid out by the state to which midwives are not willing to conform (Davis-Floyd and Johnson 2006). For

example, some states add clauses that require midwives to formally practice alongside physicians whereas others restrict them from attending certain births (e.g. VBACs, breeches, and twins) (Brodsky 1997; Davis-Floyd and Johnson 2006). In Mississippi specifically, Mississippi Friends of Midwives, a state-level organization, presented a bill, introduced by Mississippi Legislature (2012) as House Bill No. 207, which sought the following:

To provide for the licensure of persons engaged in the practice of midwifery by the State Department of Health; to provide definitions; to create the Mississippi Licensed Midwifery Board to advise and assist the Department in its duties under this act; to prescribe the qualifications for a license to practice midwifery and a temporary license to practice midwifery; to provide for biennial renewal of licenses; to prescribe fees for licensure and renewal; to prescribe the grounds for which the Department may suspend or revoke a license; to provide for exceptions to the licensure requirements; to provide for penalties for violations of provisions of this act; to require license holders to submit annual reports to the Department; to amend Section 73-25-33, Mississippi Code of 1972, to remove from the definition of the practice of medicine the exception for females engaged solely in the practice of midwifery; and for related purposes.

This bill passed the house on February 9, 2011 by a vote of 70 to 49, was referred to the Public Health and Welfare Chamber of the Senate of February 14, 2011, but ultimately failed to be signed into law (Mississippi Legislature 2012).

Given that Mississippi is among the poorest states in the country – and that midwifery is less expensive than obstetric care – at first glance the lack of enthusiasm for the profession of midwifery in the state may seem counter-intuitive. The government is constantly trying to reduce spending, particularly in relation to health-care reform.

According to Blevins (1998:58), such reforms should address the cost effectiveness of the “medical monopoly,” a conundrum defined as “an oversupply of specialists who rely heavily on government funding for training while, at the same time, licensure laws and Federal reimbursement regulations restrict non-physician providers from entering the

healthcare marketplace.” Blevins (1998) goes on to argue that a consequence of such a monopoly is the limitation of consumer choice, which not only imposes high costs but also restricts people’s rights to make decisions relating to their personal healthcare services. In reference to midwifery specifically, Blevins (1998) asserts that state prohibition of midwifery is rarely based on empirical evidence but is rather a reflection of the tendency of society to accept medical dominance. Brodsky (1997:60), like Blevins (1998), encourages state legislatures to challenge this trend, adding that “based on an average saving of \$3,000 per midwife-attended birth...insurers could save \$2.4 billion annually if 20% of American women used midwives.”

Medical Attitudes Towards Midwifery & the Regulation Thereof

The current medical community in the United States remains torn on the issue of midwives and their place in women’s health, albeit it is a far cry from the racial and sexist driven prejudices that dominated eighteenth and nineteenth century medical stances against midwifery. The American College of Obstetricians and Gynecologists (2010) has repeatedly reiterated its “long-standing opposition to home-births.” Their stance is one not reflected by similar organizations in other industrialized countries, such as Britain’s Royal College of Obstetricians and Gynaecologists or The Netherlands’ Royal Dutch Medical Association (Macdorman et al. 2010). Also in contrast, the World Health Organization, American College of Nurse-Midwives, and the American Public Health Association all support home-births for low-risk women (Macdorman et al. 2010). Specifically, the American Public Health Association (2004) cites the success of the midwifery model in other parts of the world, where home births are not only considered a

safe approach to birth, but an advantageous one. Additionally, the Association's statement goes on to reference the United States' high spending on healthcare yet prominent "gaps in maternal and child healthcare access" (American Public Health Association 2004). Finally, it encourages collaboration within the scope of autonomy amongst physicians and midwives, advises state legislatures to provide both legalization and regulation of midwifery practices, encourages other health organizations to support midwifery, and suggests that public programs such as Medicare and Medicaid ensure that the midwifery model is accessible to all persons (American Public Health Association 2004).

Specifically addressing individual healthcare professionals' views of midwifery, McCarthy (1996:31) quotes a New York physician's belief that "midwives have to realize for their own protection and the protection of patients that we have to have a true collaboration." The quoted physician continues, saying "we respect what their opinion is, but the buck stops [t]here" (McCarthy 1996:31). In contrast, Brodsky (1997:60) quotes another doctor as saying "we physicians have something to learn from midwives about the approach to low-risk women." What's more, in a study that assessed the midwife-doctor relationship relative to doctors' willingness to provide backup support to midwives in the event of complications, Blevins (1998) found that many refused. Blevins (1998) notes that the premise of this refusal was largely related to malpractice in addition to the variation of healthcare professionals' views on the subject with regard to particular geographical regions (Blevins 1998). Finally, another study aimed at specifically assessing healthcare managers' perspectives on nursing and midwifery practices found that a large majority supports the development of such practices relative

to both a cost-effectiveness and quality-of-care analysis, assuming the cases are low-risk (McKenna, Keeney, and Hasson 2009).

Inconsistencies in healthcare professionals' views on midwifery have not been well defined, thoroughly researched, or analyzed. Furthermore, the recent floor debate of HB 207 before the Mississippi House of Representatives evidences a range of opinions as portrayed by representatives of midwifery, policy, and obstetrics, the latter of which voiced opposition to the bill (Mississippi Friends of Midwives 2011). This gap in the literature, coupled with the current political debate in the state, suggests a need for new, up-to-date research on healthcare professionals' attitudes towards midwifery and regulation in Mississippi.

CHAPTER III: METHODOLOGY

Research Setting and Sample

The subject population included all healthcare professionals who work in childbirth areas, specifically Doctors of Medicine (M.D.s), Doctors of Osteopathic Medicine (D.O.s), Nurse Practitioners, and nurses in labor and delivery. Being that the purpose of this project is to analyze healthcare professionals' views on the regulation of midwifery in Mississippi, the research setting was particular to professionals currently practicing or with experience practicing within said state. A maximum of 20 subjects over the age of 18 was sought. Subject recruitment entailed both direct contact from the researcher and snowball sampling from initial interview contacts. Participation was strictly on a volunteer basis; subjects received no financial or other form of compensation. Benefits consisted solely of being able to discuss their opinions of the topics presented herein in a confidential setting.

A total of eight subjects ultimately participated in the study. All participants were Doctors of Medicine and 75% (6) were specially trained in obstetrics and gynecology. All had, at some point in their careers, been the primary attendant to a birth, though only 63% (5) had attended 175 births or more in the twelve months prior to their respective interview. Seventy-five percent (6) of the sample was females; twenty-five percent (2) was males. They represented an age range of less than thirty to greater than fifty, the mean age being approximately forty years. Their individual backgrounds as healthcare professionals ranged from a minimum of two years to a maximum of forty-three years; the mean was fifteen years. Half of all participants had experience working in states

other than Mississippi. All respondents identified a religious affiliation. A full summary of the demographic portion of the information sheets is presented in Appendix B.

Direct contact

Several local Obstetrics and Gynecology clinics list their faculty, staff, and contact information on their respective websites. Using these listings as a guide, letters (see Appendix C) briefly explaining the study herein and asking whether or not he/she would be interested in participating in a relevant interview were addressed to each physician and mailed to the central address of his/her respective clinic. Additionally, the same letters were addressed and mailed to the office managers of said clinics. Being they have publicly listed their names on websites, addressees were public figures and thus easily known and contacted. The healthcare professionals who responded to the requests for participation were briefed about the research and, if the person agreed to an interview, a meeting time and location was determined per the prospective subject's preference.

Snowball sampling

Additional subjects were recruited through snowball sampling, meaning that initial participants recruited further subjects from among their acquaintances or, in this case, colleagues. In such cases, prospective subjects contacted the researcher and data collection continued as described herein.

Procedures

Persons who agreed to participate were met at the time and location of their preference. Before any data collection began, individual participants were briefed about the study and given an opportunity to ask questions. Additionally, they were reminded of

their right to withdraw participation at any point in the process with no negative consequences. Thus, those feeling any significant discomfort or stress as well as those that found the time commitment noncompliant with their schedule and/or wishes were permitted to discontinue participation. Subjects were also made aware of the option to not answer a question by simply asking the researcher to skip the question or move on to the next topic. Upon agreement to continue, subjects were presented with a consent form (see Appendix D) to approve, sign, and return to the researcher. Additionally, the researcher signed a separate but identical consent form to be kept by the subject. Data was derived through both information sheets (see Appendix E) and semi-structured interviews (see Appendix F). It was collected over the course of a three-month period (December 2011-February 2012). Prior to data collection, the project was formally reviewed and approved by the University of Southern Mississippi Institutional Review Board. All data collected was held confidential, only accessible to the primary researcher and project advisor, Dr. Amy C Miller, as was disclosed to subjects in the consent form (see Appendix D).

Information Sheets

After providing informed consent but prior to interviews, subjects were asked to complete a brief information sheet (see Appendix E) regarding their stance on the practice and regulation of midwifery as well as some demographic information. No name or identifying information was placed on the information sheets, but rather an interview number assigned to the participant beforehand.

Semi-structured Interviews

The primary data-gathering tool was a series of in-depth, open-ended interview questions. The interview guide (see Appendix F) was designed as to elicit healthcare professionals' views regarding midwifery practice, particularly in relation to the regulation thereof in the state of Mississippi, per the purpose of this research. Questions focused on respondents' perspectives on the midwifery and medical model of care, maternal health in Mississippi, regulating midwifery (principally with respect to HB 207), and their experiences with alternative care providers, specifically midwives and doulas. The researcher allowed the conversation to flow naturally but did not pry for information. Each interview lasted between twenty and sixty minutes, depending on the time available and length of responses offered by the subject. All interviews were digitally recorded on the primary researcher's personal recording device and subsequently transcribed (at which time they were deleted from the recording device) and analyzed following the interview. Care was taken to ensure the resultant transcriptions did not contain personally identifiable information linking particular responses to respective interviewees.

Analysis

Following data collection, all documents (i.e. consent forms, information sheets, and interview guides containing notes and annotations) were secured in individual re-rope folders labeled "Confidential" then placed in a secure file, along with a master list matching interview numbers to the subjects' actual names, at the researcher's home. Data were pulled, frequencies were found for pertinent data, and emergent themes and trends were analyzed using the primary researcher's technology only. Upon completion

of analysis, all materials were transferred to a locked file at the office of Dr. Amy Miller, advisor to this research, to be stored for five years, at which time consent forms, information sheets, interview guides, and the master list matching interview numbers to actual names will be destroyed. Only the anonymous, digital copies of the transcriptions will be saved indefinitely. It should also be noted that given the professional status of the population sought, extra care was taken to avoid exposing any connection between an individual and the opinions/findings expressed. Not only were names, addresses, etc. excluded, but also subjects' place of employment, hometown, and other potential identifiers.

CHAPTER IV: DATA AND ANALYSIS

This chapter aims to present and describe themes that emerged from subjects' responses to both questionnaires and semi-structured interviews. Topics are analyzed in the following four categories: (1) lack of familiarity and understanding (2) cultural influences (3) many facets of fear and (4) collaboration with limitations. Conclusions drawn from these themes are discussed in Chapter V.

Lack of Familiarity and Understanding

None of the healthcare professionals in this study were familiar with the current legal status of midwives in Mississippi or, more specifically, with House Bill 207. As discussed previously, House Bill 207 was a 2011 legislative bill that proposed all non-nurse midwives be required to become CPMs as certified by NARM or a successor organization. The lack of awareness regarding this bill is representative of a larger trend, as many expressed ignorance relating not only to the regulation thereof, but also to the practice of midwifery in general. When asked about the potential benefits of midwifery, one physician said “I personally don't know the training that midwifery entails—and that's really ignorance on my part, but I don't know what's required of them.” All study participants similarly expressed a general lack of knowledge regarding the qualifications of midwives; one specifically attributed this to a lack of uniformity amongst midwives (i.e. the many different types), whereas others acknowledged they either did not know the existing types of midwives or were unfamiliar with the specific requirements associated with respective types.

Only four of the eight (50%) interviewed had any experience with midwives. When discussing the circumstances surrounding these experiences, two stated that they were indirect, as he/she only took over a midwife's patient in an emergent situation (i.e. after transport from a home-birth to a hospital setting). In the words of one physician, "I don't really count that as working 'with,' because I wasn't a team member with [the midwife]—it was more of a rescue." The same physician went on to state that such patients tend to arrive at the hospital "in a mess...with a midwife who tries to counsel [the physician] on what needs to be done." In turn, if the physician "does something different than what the midwife is suggesting," patients often side with the midwife while questioning the physician. The interviewee described this experience as "very frustrating," with the biggest concern being a patient who "just doesn't think I am there to help." Ultimately, both physicians who had experience working with midwives in emergencies related negative opinions of midwifery in general.

In contrast, the two other interviewees who cited experience working with midwives had done so under non-emergent circumstances. In one case, the physician did not work with the midwife in the capacity of midwifery, but rather in a situation where the midwife was working as a nurse in a hospital setting. In the other case, the physician also only had experience with midwifery in a hospital setting; he/she spoke of two different instances in which the midwives were in fact working as midwives (i.e. actively managing laboring patients) to non-emergent, non-transport patients in hospital systems. With regard to those particular experiences, the physician stated the following: "I felt they were very appropriate; it was something I would have personally chosen to be part

of if I were a patient.” Accordingly, the physicians who had worked with midwives in non-emergent situations related good experiences.

In terms of doulas, the same four interviewees who referenced experiences with midwives also had experiences with doulas, though in varying degrees. Interestingly, one of the two physicians who related overall negative experiences with midwives spoke relatively high of doulas, saying that “sometimes the husband or significant other is not enough and somebody like [a doula] is especially helpful for [a woman] who wants a natural delivery.” It should be noted, however, that this particular physician only had experience working with one doula, albeit on several different occasions. The other of the physicians who felt negatively towards midwives had worked with many doulas and had the following to offer:

There are several doulas in town and I think one of them is very good and actually does a very good job at being neutral in supporting not only the patient, but also the medical staff. And then there are some that I just would not have paid money for—that’s just my personal opinion.

Finally, of the two physicians who cited positive experiences with midwives, one had worked with two doulas, “one on several occasions and another on more rare occasions.”

Of those experiences, the interviewee said the following:

Those were good experiences. I have to admit, in the beginning, maybe it was a little bit tentative as far as them encroaching upon our medical decisions and those sorts of things. But I’ve very rarely found it to be a bad experience, particularly in cases of more experienced [doulas].

On the contrary, the physician quoted as saying midwives’ hospital-based care was something she would have “personally chosen to be part of” as a patient, did not feel the same towards doulas:

I have very limited experience with but have been around [doulas]. I think that most are okay, but I wouldn’t personally choose it. I think that the problem is that

the patients sometimes rely on the doulas a little more than their doctors and I feel that the doctors are ultimately the most qualified attendants. And that's my problem with doulas.

As made apparent, the physicians in this sample generally based their opinions regarding midwifery and alternative birthing practices as a whole on their specific experiences.

In regard to experience working with midwives and/or doulas, it is also of note that, specific to the population of the sample who had attended 175 or more births within a year of their respective interview, eighty percent (4) referenced at least some experience with midwives as well as doulas, whereas the other twenty percent (1) had no experience with either. Furthermore, of those who had no experience working with midwives, three expressed an interest in doing so if the opportunity presented itself. To quote one physician, "yes, I would love to see what they do;" another was "neutral" on the subject.

Another emergent theme relative to lack of understanding had to do with varying ideals about why women might seek the services of midwives and/or doulas. One physician thought it might be a gender-related issue, saying "I could see where women in labor might feel more comfortable with another woman." Considering this, it is interesting to note that half of the sample felt that it is 'rarely' or 'never' true that "women are naturally better at caring for others than men are," whereas the other half were either 'neutral' on the subject or thought that such a statement is 'sometimes' true (see Appendix G). Two other doctors thought that, rather than gender, perhaps it is related to levels of education; when speaking of doulas, one offered the following:

The more educated woman, someone who is more interested in having a natural childbirth (i.e. lack of intervention, continuous monitoring, and medications—and preferably doing it without an epidural and augmentations such as pitocin), is certainly going to be more likely to seek out the assistance of a doula—that

population and perhaps those persons who have had positive experiences in the past or have heard [positive stories] from their friends.

This reiterates the view that a doula is “especially helpful” to someone desiring a natural delivery. However, this same stance was not reciprocated with respect to midwives, as the physicians tended to associate their usage with a less-educated population.

Specifically, one physician expressed the following:

I don't really understand patients' perceptions of why [a midwife attended home-birth] is a better way to deliver. I'm just curious, in Mississippi [relative to the other states I've worked in], why do they think that is the way to go? Why are people so against hospitals? Why are they so willing to trust a midwife as opposed to a doctor that could potentially save [their] lives? I just think it's a weird thing; I don't know what it is about Mississippi and the patients and what they think about doctors and hospitals. I think the level of education is different; very few people I know [in other states I've worked in] would trust an unlicensed person to deliver their baby at home. They would want a natural delivery—which I'm all for—but these people are okay with doing it at home with no—or very little—monitoring.

Overall, the physicians related a great deal of obscurity with regard to midwives as well as women who choose to utilize midwifery services. Subjects were unknowledgeable about the training and regulation of the various forms of midwives, perhaps because their professional experiences seemed to overlap with midwives only on rare occasions.

Cultural Influences

Building upon the notion that midwifery and its usage is related to population and, more specifically, the education level amongst particular populations, many interviewees brought up larger trends associated with cultural contexts of maternity care. In comparison to other parts of the world, three different interviewees mentioned that, with respect to developing countries, many women do not have access to healthcare and, in

such cases, “a midwife is better than no one.” It is for this reason that they believed organizations such as the WHO support planned, midwife-attended home-births for low-risk women.

Furthermore, when asked about the discrepancy between other developed countries that employ the midwifery model more commonly while maintaining comparable or lower rates of maternal and infant mortality than the United States, physicians suggested a range of possible causes. Concerning the relationship of education to the practice of midwifery, one physician suggested that the populations of such countries are usually “more educated” as a whole. As such, these populations are “generally healthier and don’t have all the co-morbidities that make [women] high risk.” Another physician, who offered the following, echoed this population-based theory:

In this country, we have had a slight rise in maternal mortality; that is because we’re taking care of a much higher risk population than perhaps we did in the 1960s or 1970s or simply in the past. Our patients are older; our patients are not as healthy; they are not taking care of themselves; they are a lot bigger as a group—obesity is a big problem. So, I think when you take all of that into consideration (i.e. the population in the United Kingdom not being quite as unhealthy as that in the United States) maybe they are just better suited for it.

In contrast, others reasoned that it has less to do with the population and more to do with the said countries’ respective healthcare systems:

I think maybe it’s [related] to how their medicine is. If you have social medicine and, as such, you don’t have these outrageous malpractice lawsuits and settlements, then people and organizations are more lax about that (i.e. alternative birthing practices). I don’t think they have five million dollar settlements for babies with cerebral palsy in Britain whereas, unfortunately, that is the case here.

Others simply stated that perhaps it is the “constant threat of a lawsuit” or, similarly, “there is not as much [legal] pressure there as [we experience] here.” What’s more,

another interviewee suggested that as a result of the American healthcare system, it is financially disadvantageous for the government to support midwifery. In his/her words:

I think you also have to think about financial aspects and such. In the long run, it's going to be cheaper for the government/state/whatever to fund care for these populations and catch the high risk [situations] early rather than later, [in which case they are] spending all this money on babies in the NICU and such for things that could have and should have been caught [early on, by a physician].

From another perspective, one doctor felt that though, yes, the discrepancy is likely related to the different healthcare systems, perhaps what one should infer from this is that the quality of care offered by the respective systems is different. The interviewee presented the following anecdote as an example:

Personally, my best friend from college was pregnant when living in England and she had somebody come and check on her—I guess it was a midwife—and the standard of care seemed to be much lower—like ‘how do you feel’ instead of checking blood pressure and such.

He/she went on to use this premise as rationalization for why in America, where healthcare is not socialized and thus less regulated by government and more bureaucratic, greater responsibility is left up to organizations such as the American Congress of Obstetricians and Gynecologists. Thus, ACOG is forced to be stricter and, “comparing apples to apples, just cannot support [midwifery].” Not all felt that it was indeed comparing “apples to apples,” however, as two physicians suggested that rather than the quality of care being higher in the United States, perhaps the quality of midwives in other countries is higher, a notion they both thought might be facilitated by stricter, more uniform regulations imposed upon midwives in other countries. One physician also felt that ACOG’s stance against home-births is a reflection of the organization’s traditional nature of being “very conservative” and then being “very emphatic on the position it

takes in terms of the guidelines it sets forth for practitioners”; as such, “it is active politically, in legislation, etc.”

In sum, all physicians understood and respected ACOG’s stance against home-births despite similar organizations’ relative support. What’s more, all related a cultural justification. In light of these revelations, it is also of note that, as shown in Appendix G, all physicians felt that the statement, “for a healthy woman with a normal pregnancy, hospital birth is safe,” is ‘sometimes’ or ‘always’ true. On the other hand, seventy-five percent (6) felt that the statement, “for a healthy woman with a normal pregnancy, home-birth is safe,” is ‘rarely’ or ‘never’ true, whereas the other twenty-five percent (2) believed it to be ‘sometimes’ true. This, along with their statements, suggests the physicians as a whole generally reflect the stance of ACOG against home-births. Considering the cultural contexts presented herein, it is likely more difficult for individual doctors to support home-births in theory or practice when their guiding organization does not. In the United States, such a position is seen as defiant, whereas this is not necessarily the case elsewhere.

Finally, on a local level, physicians related cultural influences on midwifery particular to its practice within Mississippi. When asked what immediately came to mind as the biggest healthcare challenge facing maternity in Mississippi, fifty percent (4) of respondents cited teenage pregnancy, twenty-five percent (2) spoke of lack of initiative as related to lack of early access (i.e. mothers not seeking care), and another twenty-five percent (2) spoke of financial and political issues that surround healthcare. They related all of these to an increased necessity for physician-based care in Mississippi as the first two scenarios present potentially high-risk patients whereas the theme in the latter was

that the under-insured patient population who depends heavily on Medicaid necessitates such care.

Many Facets of Fear

Most of the physicians in this study felt that childbirth is both a medical and spiritual event. Seventy-five percent (6) believed the statement “childbirth is a medical event” is ‘always’ true, whereas the other twenty-five percent (2) felt it was at least ‘sometimes’ true (see Appendix G). Moreover, fifty percent (4) felt the statement “childbirth is a spiritual event” is ‘always’ true, twenty-five percent (2) thought it was ‘sometimes’ true, and the remaining twenty-five percent (2) were neutral on the subject. As such, the physicians did not see ‘medical’ and ‘spiritual’ as oppositional but rather as coexisting, albeit with slightly more emphasis on the ‘medical.’

Not surprisingly, all respondents viewed pregnancy through the lens of the medical model. In the words of one physician, “potentially, pregnancy is a very dangerous condition; people die from this....I mean, I just don’t see how it’s not considered a practice of medicine.” In the words of another, “pregnancy can be seen as a natural state of disease because so many things can go wrong; for that reason, many doctors classify and treat it that way.” This idea of pregnancy being medical in the sense that it is, as one physician referred to it, “unpredictable,” was the major reason cited relative to why, as a whole, the sample felt that home-births were comparatively less safe than hospital births.

When asked about the relative benefits of midwifery-based and physician-based care, one physician put it most simply, saying “if you need a doctor, you need them; that’s all there is to it.” This same sentiment was clarified as follows:

I think that during an emergent time, a physician is great to have, because if you are at home and something happens, who is going to help you? By the time you hop in your car and come to the hospital, a lot of time has elapsed—and potentially you could have avoided the complications [that can be associated] with that. So I think that is why delivery in a hospital is better, per se, than delivery at home. Most home deliveries will go fine, but it’s that one in however many deliveries that go bad that you could potentially avoid. So, this day in age, I don’t know that home delivery is the safest thing.

Specifically to these “deliveries that go bad,” two different doctors cited that with respect to Mississippi’s relatively high-risk population, emergency intervention (i.e. caesarean or vaginal operative deliveries) is necessary in roughly thirty percent of all deliveries. It is during these “true emergencies” that the physicians seemed to agree “you need a specialist, you need them there right then, and you need them to know how to manage a team and get the baby out safely while still getting the momma whatever care she needs—very quickly.” One interviewee offered a personal anecdote:

I’ve seen completely normal pregnancies go wrong at the last minute and women end up needing C-sections. Like, for example, if a shoulder is stuck, that woman needs a C-section within two minutes or that baby and mother are at risk. In fact, just last month we had a resident lose her baby due to that exact thing; she just didn’t get a C-section quickly enough. And seeing that, I think, at the very least, it’s necessary [for women] to be in a hospital with access to emergent care.

Likewise, perhaps most succinctly, one physician expressed this same attitude, saying, “I see hospital birth like buying an insurance policy—most of the time you won’t need it, but if you do, well you do.” As a whole, all physicians attributed this fear of the “unpredictable,” even relative to seemingly normal pregnancies, as justification for the their view of hospital births as not only superior to, but also necessary over home-births.

As described, the physicians expressed a range of ‘fears’ they believe the inherently volatile nature of maternity care facilitates, whether it be on the part of the mother, the doctor providing care, or the agency as a whole. Many substantiated these fears with the high costs of malpractice insurance. Additionally, many alluded to this disposition as reason for why they became interested in medicine in the first place. Three interviewees felt it lent an avenue through which their medical knowledge would best allow them to “help people,” another three related that it fostered their love of science, and two believed the field of obstetrics, specifically, to be “a great combination of surgery and primary care.”

Collaboration with Limitations

Fifty percent (4) of the sample in this study felt that the statement, “midwives and doctors are equally qualified as birth attendants,” is ‘never’ true; the remaining percentage (4) feeling it is either ‘rarely’ or ‘sometimes’ true (see Appendix G). When asked to elaborate, most attributed this to the “superior and diverse care” they are able to offer as a result of “extensive education and training as physicians.” One physician referred to this as “state of the art,” while another explained as follows:

As physicians, not only have we had four years plus of education and training, but we’ve been exposed to a greater number of patients than midwives ever could have been, unless they’ve trained in a university situation. And as such, we’ve been exposed to so many more high-risk patients, so we’ve seen and continue to see so much more of what can go wrong in just an instant and completely change the outcome of a birth.

This view of doctors ultimately being the most qualified coupled with the previously described notion relative to the necessity of such care in many, often unexpected

circumstances engendered a variety of opinions on the ‘ideal legal status of midwives in Mississippi.’ One hundred percent (8) of study participants felt that some degree of regulation regarding the practice of midwifery in Mississippi is necessary; however, they varied greatly in the extent to which they believed such regulation should occur. When asked to rate their agreement with the statement, “I feel it is important that women have access to a variety of care providers, including midwives,” twenty-five percent (2) of the sample found it to be ‘always’ true, fifty percent (4) found it to be ‘sometimes’ true, and the remaining twenty-five (2) percent felt ‘neutral’ towards the statement. In dialogue, however, interviewees offered more candid responses; six respondents (75%) felt that midwives should be required to have some form of “medical background,” four of which specifically named “nursing” as a prerequisite. The other two respondents (comprising the remaining 25%) did not feel midwifery should have legal status in Mississippi.

Those who felt midwives should have formal, uniform medical training, whether it be in the form of nursing or direct entry midwifery schools, offered a number of explanations. One physician felt that it was simply necessary in order “to keep the lay midwives out there practicing in the community from putting people in danger, even if their intentions are good.” This view was reiterated several times, one participant saying, “it can’t just be a group some woman joins and learns the practice of midwifery—no.” Another believed that “there are certain biometric things that need to be checked on every patient—period—and I don’t see a midwife doing that as there are some things you just can’t do without a medical background.” This physician went on to say “even beauticians have to pass tests and be licensed; these midwives are messing with something much more high risk—they need to be regulated.” Additionally, of those

physicians who named nursing specifically, one felt that “a scientific background would enable the midwife to realize that, ‘hey, a blood pressure of 180/120 is dangerous for this particular woman, she shouldn’t be pushing’ ...a nurse would know that sort of thing.”

In addition to the medical background these physicians believed formal nursing training would provide, several also felt that such a background would enable midwives to better integrate into a working relationship with physicians, which all deemed obligatory. One physician recounted tension between midwives and physicians, stating that “attitudes happen on both sides and physicians are just not going to put up with that—but then again, they’re licensed.” All survey respondents except one (who was ‘neutral’ on the topic), felt that the statement, “it is possible for healthcare professionals and midwives to work together,” is ‘sometimes’ or ‘always’ true. However, all also felt that in order for this to happen, midwives’ must “know their limitations” and have a good working relationship with a physician to whom they are not only willing to “refer/defer patients to,” but also who they recognize as the “ultimate, most qualified attendant.” Put simply, “there could be a place for midwives, but midwives have to know their place.” In the view of one physician:

It would even be okay to supervise them from a distance—the doctor wouldn’t have to be physically present—but sometimes midwives are going to have problems and, in such instances, it can’t just be an ‘okay, we’ll call an ambulance’ situation; the midwife needs someone to talk to, to depend on.

Similarly, another physician believes this same sentiment further necessitates hospital births:

I think midwifery is potentially useful if it’s done in the hospital. So that if something happens that needs to be fixed it can be done and be done quickly [by a physician], instead of these people that come in from an hour away and arrive in a mess.

This evidences another recurring trend amongst the physicians, who, as a whole, expressed very different opinions of midwives and home-births, offering varying degrees of support for the former but unanimous opposition for the latter. Ultimately, they felt that midwives should have scientific backgrounds, work in collaboration with and sometimes under the supervision of physicians, and, accordingly, better adhere to the medical model of care, realizing and respecting the potential dangers of pregnancy and childbirth. One physician also thought that in addition to better adhering to the medical model in theory, “legalization should require midwives to go through the same qualifications and be upheld to the same standards of practice as physicians do—like we have to have CME (i.e. continuing medical education), malpractice insurance, etc.” Another interviewee also referenced these standards, adding “obstetricians are required to pay around \$100,000 for malpractice insurance.” In light of these many ideals, considerations, and recommendations, the physicians still expressed concern over the practice of midwifery regardless; one stated “if there was more regulation, fine, but I would still choose a M.D. any day.”

In comparison to those respondents who thought their might be a place for midwifery, those who felt the practice of midwifery should be illegal offered two different logics. First, one physician who is “just not ready for them in Mississippi” thought that if midwives gained legal recognition, physicians’ job security would be challenged:

That’s a complicated question because [with giving midwives legal status] you are also stepping on financial toes. We [as physicians] would like to protect our incomes, and if we have midwives that come into the hospital to deliver babies they are going to be cutting into those incomes and jobs.

The other physician, however, though in agreement with the overall conclusion (i.e. illegality for midwives), offered this rationalization:

I don't know that I feel that any of it [even nurse-midwifery] is appropriate, personally. Just because in working in labor and delivery, I've worked with nurses, many of whom have worked in the department for fifteen to twenty years, and still some of their judgment calls—though they have taught me a lot—are questionable at least. And that is just because they don't have the scientific background we do, they haven't attended the lectures we have, and they just haven't trained under experts like we have. [Because we have had those things], it is just more routine for us, and under such high pressures I think it has to be [routine] in order to make the correct decisions quickly. I think nurses do a lot with the philosophy 'it's always been done this way, this is protocol,' whereas we know why we're doing what we're doing.

All things considered, when asked their opinion on the statement, "I feel it is important that I actively 'support' the practice of midwifery in Mississippi," fifty percent (4) of respondents were 'neutral' on the subject, twenty-five percent (2) felt it was 'rarely' true, and another twenty-five percent (2) felt it was 'sometimes' true (see Appendix G). In contrast, fifty percent (4) felt it is 'rarely' or 'never' true that they should "actively oppose the practice of midwifery," the other fifty percent (4) being either 'neutral' on the subject or believing such a stance is 'sometimes' true.

In sum, the healthcare professionals' expressed an overwhelming lack of understanding of midwifery. Though some could see a place for it or, at minimum, tolerate it, all strongly believed that medically trained physicians are rightfully the primary birth attendants. The major underlying factor for this stance was the potential for childbirth to require intervention, particularly in South Mississippi, and the corresponding view that physicians are the sole care providers capable of managing such emergencies, an expertise afforded them by their extensive education and training requirements.

Interestingly, however, physicians were unaware of the education and training required of

midwives yet assumed on multiple occasions that midwifery standards are lower and thus midwives are not capable of providing quality care comparable to that physicians provide.

CHAPTER V: DISCUSSION AND CONCLUSION

Healthcare professionals in this study related an overwhelming sense of ambiguity towards midwifery. Though the literature suggests many doctors around the world collaborate with midwives, some even employing the midwifery model (Nichols 2008), it was not seen in this sample. Few healthcare professionals had worked with midwives and none had done so under planned circumstances or on a regular basis. Yet, all felt strongly about the advantages of the medical approach to childbirth over the midwifery approach. Fielder et al. (2004) suggest that the traditional rivalries between midwives and obstetricians have engendered a dichotomous relationship in which the two constantly feel compelled to defend their respective professions against the other; often in spite of little first hand knowledge or experience with said other. As such, much of the reasoning for physicians' views on midwifery was based on assumptions made about midwives and their education/training requirements. For example, more than one physician believed that midwives are under-qualified to manage childbirth because, presumably, they would not recognize a high blood pressure or be able to respond to a potentially emergent situation. However, certified midwives, even those without a nursing background, would be knowledgeable about vital signs and be trained to manage emergencies in a non-surgical manner or, at the very least, recognize an emergency and defer the patient immediately.

The physicians' focus on measurements and the likelihood of 'required' intervention as well as the view that medical training/education is superior to not only midwives but also that of physicians in other countries likely stems from their American

schooling. As Glantz (2011:140) pointed out, “as one is trained, so one believes and practices, and in today’s teaching hospitals, [obstetric interventions] are at record highs.” Interestingly, Janssen (2009) found that midwife-attended home-births require less obstetric intervention (defined as electronic fetal monitoring, augmentation of labor, analgesia during labor, assisted vaginal delivery, cesarean delivery, et al.), lend reduced rates of adverse perinatal outcomes, are associated with fewer or comparable rates of perinatal death and, accordingly, become emergencies less often than physician-attended hospital births. These results suggest that midwives are in fact qualified to manage childbirth with outcomes comparable to those of physicians without the intervention. Furthermore, this theme is also reflective of Klein et al.’s (2011) view that the current generation, which was likely not practicing when midwifery re-emerged and challenged the medical model in the 1970s, is more supportive of interventionist methods and the necessity thereof than slightly older generations.

What Benoit (2010) refers to as the “historically hegemonic role medicine has played in maternity care provision” was also depicted in the physicians’ generally tolerable stance towards midwifery, provided that physicians are ultimately seen as the most qualified birth attendants. The healthcare professionals in this sample believed their educational background and vast experience with a variety of patients afforded them expertise over childbirth not shared by midwives. This view led most to conclude that if midwifery does maintain legality, regulation should include a physician overseer for all practicing midwives, preferably in a hospital setting. According to Benoit (2010:475), this is the very characterization of “professional dominance,” which is defined as “the way in which certain professions control the content of their work (autonomy), define

limits of the work of others (authority), and act as state-supported experts regarding the public's health (altruism).” Furthermore, the sample largely reflected the physician-view McCarthy (1996:31) referenced, ultimately concluding, “we respect what their opinion is, but the buck stops there,” suggesting that little has changed in the past fifteen years. As Reiger (2008:133) points out, these are not just “professional turf wars” but rather a defense of ideals fueled by the “depth and passion of those in maternity care...no doubt reflecting the intense emotional and social significance of birth itself.” The paper herein describes this in terms of the many facets of fear, whether they are relative to poor outcomes, challenges to the legitimacy of respective professions, or financial constraints associated with maternity care. It seems that the inherent isolation of midwifery from the traditional medical system has crippled inter-professional understanding within the two fields, despite their close relation to one another.

The physicians in this study inferred that the state of the healthcare system in the United States coupled with the high-risk population of South Mississippi further necessitates the medical approach, which in turn lessened the likelihood of them recognizing potential benefits of the midwifery approach. Ultimately, what they deemed the superior safety of the medical model outweighed other considerations. These cultural influences also shaped their opinions of women's right to choose as it relates to the notion that a particular model of care may be best for one person but not another (Howell-White 1997), as they felt that the specific population they serve exhibits relatively less proactive behavior with respect to their health. Accordingly, the doctors expressed the belief that they have an augmented responsibility to their patients and the health and safety thereof.

It is possible that ways forward can be established over time if some form of dialogue, preferably not dictated by emergent circumstances, could be established amongst Mississippi's maternity care providers. Several study participants acknowledged that midwifery is a "hot topic" amongst them, but their lack of familiarity with and understanding of the practice evidences the one-sided nature of such discussions. Obviously, speculation and stereotypes largely define physicians' views of midwives. This, coupled with their professional distance from and corresponding lack of intimacy with the practice of midwifery, shapes healthcare professionals' views on the regulation midwives. Discourse would hopefully stimulate a better understanding of midwifery on the part of physicians and, first and foremost, allow them to better collaborate with patients, ultimately providing a more cohesive front for the betterment of the woman. This could be achieved by incorporating education about the midwifery model and the status of midwives in the United States into medical education. Furthermore, focus groups designed to inform physicians on the education, training, and practice of midwifery and vice versa could better allow both parties to develop well-informed opinions rather than assumptions relative to midwifery. Perhaps this would lay the groundwork for a more informed, balanced debate on appropriate regulation for midwives in Mississippi, instead of an obstetrician versus midwife contest before the House, as was seen with respect to HB 207 (Mississippi Friends of Midwives 2011).

If regulation could be achieved within the realm of an agreement between midwives' stipulations and the many ideals of collaboration with limitations laid out by physicians herein, perhaps then the idea that midwives are in fact licensed and thus held to known standards of qualification would eliminate some of the obscurity relative to

their practice. However, the degree of limitation proposed by doctors suggests that one side or the other would have to compromise significantly for such a theory to play out. It was clauses brought about by such clauses that have, in the past, prevented many states from establishing regulation, despite advocacy for such from both midwives and physicians (Davis-Floyd and Johnson 2006).

Future research regarding midwives' opinions on analogous topics would make this study more relevant to the future of maternity care in Mississippi. Additionally, there is a need for unbiased, evidence-based research on the success of the midwifery model of care as it relates to birth outcome. Furthermore, though the opinions represented by this sample present reasonable diversity, they are certainly not generalizable to the views of individual healthcare professionals or Mississippi's healthcare professionals as a whole as the sample size was small and non-probability based. Subjects were drawn disproportionately from only three South Mississippi hospitals, so their responses are not representative of physicians from the respective hospitals as a whole. Furthermore, a more ample age range is called for. In sum, there is a need for a larger scale study with respect to both midwives and healthcare professionals in Mississippi.

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APPENDIX A: Table I

Table I: Summary of Types of Midwives					
<i>Type of Midwife</i>	<i>Acronym</i>	<i>Year Established</i>	<i>Education/Qualifications</i>	<i>Governing Body</i>	<i>Acronym</i>
Certified Nurse Midwife	CNM	1970	Training and licensure in both nursing and midwifery	American College of Nurse Midwives	ACNM
Direct-Entry Midwife	DEM	-	A professional midwife trained via apprenticeship or a college- or university-based program; requires no nurse training	American College of Nurse Midwives or North American Registry of Midwives	ACNM or NARM
Certified Professional Midwife	CPM	1994	A competency-based training program culminating with both a skills and written assessment	North American Registry of Midwives	NARM
Certified Midwife	CM	1994	A national certification for direct-entry midwives which requires passage of the same assessment and exam administered to CNMs	American College of Nurse Midwives	ACNM
Lay Midwife	-	-	No formal training or licensure	-	-

APPENDIX B: Table II

Table II: Information Sheet Demography						
Interview #	Age	Gender	Race	Religious Affiliation	Number of Children	Type of Birth Attendant Chosen for Child[ren]
1	50+	M	W	Episcopal	5	M.D.
2	45	F	W	Catholic	2	M.D.
3	46	F	A	Catholic	2	M.D.
4	37	F	W	Protestant	0	-
5	27	F	W	Christian-Baptist	0	-
6	29	F	W	Christian	0	-
7	43	F	W	Methodist	2	M.D.
8	43	M	W	Methodist	2	M.D.

APPENDIX C: Subject Recruitment Letter

Dear Healthcare Professional,

My name is Alie Broadway and I am a student at the University of Southern Mississippi. As per the requirements of Senior Honors at USM, I am currently conducting research relative to the practice, regulation, and political context of midwifery in Mississippi. Given your status as a healthcare professional, I would like to interview you regarding your thoughts and opinions on midwifery regulation. Your responses will be kept completely confidential.

If you are interested in sharing your views with me (or simply would like more information regarding the study proposed herein) please contact me at alexandria.broadway@eagles.usm.edu or 601-297-6030. If you choose to participate, a meeting time and location will be set up per your preference; interviews last approximately thirty minutes.

Thank you!

Alexandria D Broadway

This project is under the advisement of Dr. Amy Miller, Associate Professor of Sociology and Chair. Furthermore, this project has been reviewed by the Human Subjects Review Committee, which ensures that research projects involving human subjects follow federal regulations. Any questions or concerns about rights as a research subject should be directed to the chair of the Institutional Review Board, the University of Southern Mississippi, 118 College Drive #5147, Hattiesburg, MS 39406-0001, (601) 266-6820.

APPENDIX D: Informed Consent

To Whom It May Concern:

My name is Alie Broadway and I am a student at the University of Southern Mississippi. As per the requirements of Senior Honors at USM, I am currently conducting research relative to the practice, regulation, and political context of midwifery in Mississippi. Your participation will involve an in-depth interview lasting anywhere from thirty to ninety minutes as well as the completion of a brief information sheet. Though your participation in this study is greatly appreciated, it is completely voluntary and you may discontinue your participation at anytime without penalty. Additionally, if you choose to continue with the interview yet feel significant stress and/or discomfort during the process, the interviewer will gladly skip the question and move on to the next topic.

All interview responses will be kept confidential; only the primary researcher and the research advisor, Dr. Amy Miller, will have access to the data. Please do not state your name or any form of identifier during the interview or place it on the information sheet. The interview will be digitally recorded then subsequently transcribed by the researcher. Once transcription is complete, the digital file will be deleted from the recording device. Furthermore, the consent form and information sheet will be secured in a locked file at the office of Dr. Amy Miller, advisor to this research. The digital, transcribed copies will not contain your name. All research materials will be securely stored for five years, at which point they will be destroyed.

If you have any questions or concerns regarding this study, please feel free to contact me through the Department of Anthropology and Sociology at 601-266-4306 or via cell at 601-297-6030. This project has been reviewed by the Human Subjects Review Committee, which ensures that research projects involving human subjects follow federal regulations. Any questions or concerns about rights as a research subject should be directed to the chair of the Institutional Review Board, the University of Southern Mississippi, 118 College Drive #5147, Hattiesburg, MS 39406-0001, (601) 266-6820.

You will be given a copy of this form to keep for your records. In conformance with the federal guidelines, we need your signature to show your consent to participate in this project. The University also requires that the date and the signature of the person explaining the study to you appear on the consent form.

Signature of the Research Subject

Date

Signature of the Person Explaining the Study

Date

APPENDIX E: Information Sheet

Interview Number: _____

INSTRUCTIONS: For each of the following ten statements, please circle the number that best corresponds to the way that you feel about it.

1. I feel it is important that women have access to a variety of care providers, including midwives.

1 2 3 4 5
Never True Rarely True Neutral Sometimes true Always True

2. For a healthy woman with a normal pregnancy, hospital birth is safe.

1 2 3 4 5
Never True Rarely True Neutral Sometimes true Always True

3. For a healthy woman with a normal pregnancy, home-birth is safe.

1 2 3 4 5
Never True Rarely True Neutral Sometimes true Always True

4. It is important that some degree of regulation regarding the practice of midwifery in Mississippi be signed into law.

1 2 3 4 5
Never True Rarely True Neutral Sometimes true Always True

5. Midwives and doctors are equally qualified as birth attendants.

1 2 3 4 5
Never True Rarely True Neutral Sometimes true Always True

6. It is possible for healthcare professionals and midwives to work together.

1 2 3 4 5
Never True Rarely True Neutral Sometimes true Always True

7. I feel it is important that I actively support the practice of midwifery in Mississippi.

1 2 3 4 5
Never True Rarely True Neutral Sometimes true Always True

8. I feel it is important that I actively oppose the practice of midwifery in Mississippi.

1 2 3 4 5
Never True Rarely True Neutral Sometimes true Always True

9. Women are naturally better at caring for others than men are.

1 2 3 4 5
Never True Rarely True Neutral Sometimes true Always True

10. Childbirth is a spiritual event.

1 2 3 4 5
Never True Rarely True Neutral Sometimes true Always True

11. Childbirth is a medical event.

1 2 3 4 5
Never True Rarely True Neutral Sometimes true Always True

Age: _____

Gender: _____

Race: _____

Religious affiliation, if any: _____

Number of children, if any: _____

The type of birth attendant chosen for the delivery of your
child/children:

APPENDIX F: Interview Guide

1. What is your position/background as a healthcare professional?
 - How long have you worked as a healthcare professional?
 - Have you worked in any states other than Mississippi?
2. What inspired you to become a healthcare professional, particularly one within your chosen field?
3. Approximately how many births (if any) have you attended in the past 12 months?
4. What immediately comes to mind as the biggest health care challenge facing maternity in Mississippi?
5. Have you ever worked with a midwife before? A doula?
 - If yes, what was it like? Could you describe the details behind this occurrence?
 - If no, would you ever consider working with a midwife or doula if the opportunity presented itself?
6. What do you think are the benefits of physician-care?
 - Do you think midwifery has its benefits too? If yes, what are these?
7. Are you familiar with the current legal status of midwives in Mississippi?
8. What do you think would be the ideal legal status of midwives in Mississippi?
9. Are you familiar with HB 207, the bill that was passed by the House but failed to be signed into law? If yes, what are your opinions regarding this bill?
10. The American College of Obstetrics and Gynecology does not support home-births, a stance which is not reflected by the World Health Organization, American College of Nurse Midwives, the American Public Health Association, or similar organizations in other countries such as Britain's Royal College of Obstetricians and Gynecologists and Royal College of Midwives, which all support home births; why do you think this is?
11. Is there anything else on the subject of midwifery and the regulation thereof that you would like to discuss?

APPENDIX G: Table III

Table III: Information Sheet Data Summary					
	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
	<i>Never True</i>	<i>Rarely True</i>	<i>Neutral</i>	<i>Sometimes True</i>	<i>Always True</i>
I feel it is important that women have access to a variety of care providers, including midwives.			**	****	**
For a healthy woman with a normal pregnancy, hospital birth is safe.				*****	***
For a healthy woman with a normal pregnancy, home-birth is safe.	*	*****		**	
It is important that some degree of regulation regarding the practice of midwifery in Mississippi be signed into law.					*****
Midwives and doctors are equally qualified as birth attendants.	****	*		***	
It is possible for healthcare professionals and midwives to work together.			*	*****	**
I feel it is important that I actively <u>support</u> the practice of midwifery in Mississippi.		**	****	**	
I feel it is important that I actively <u>oppose</u> the practice of midwifery in Mississippi.	*	***	***	*	
Women are naturally better at caring for others than men are.	*	***	**	**	
Childbirth is a spiritual event.			**	**	****
Childbirth is a medical event.				**	*****