

Midwifery in American Institutes of Higher Education: Women's Work, Vocations and the 21st Century

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Abstract

Midwifery is one of the universal professions. At the end of the nineteenth century, midwives in the United States were disenfranchised from the mainstream. A concerted effort was waged by male physicians to characterize midwifery practices as unscientific while simultaneously preventing midwives from obtaining formal education. Although midwifery in the United States continued, it was limited to an apprentice model, and viewed as a vocation exclusively for women and without the need for education, especially at the college or university level.

In the 1920's a model of nurse-midwifery, based on the British system, emerged and was taught in independent schools. It was not until mid-century that programs were subsumed into schools of nursing within colleges and universities. By the turn of the twenty-first century, programs are taught on the graduate level. Although this has enabled mainstreaming of education, this movement has meant midwifery faculty is increasingly challenged to possess excellent skills in practice, education and research, to be productive scholars within the institution, and to educate millennial students who seek financial security instead of a calling. In addition, the position of midwifery within nursing often obscures its unique role and diminishes both the power of the profession and its faculty. Among the new issues for midwifery academicians are increased technology, increased curricular content and an increasing number of male candidates for this traditional woman's work.

The History of Midwifery

Midwifery is universal and ubiquitous. Research on the size and shape of the human pelvis have found that, in comparison to other primates, most human births require another being in attendance, or what is termed obligatory midwifery.^a In addition to physical support, midwifery has been characterized as a social role throughout recorded history, regardless of culture or time.^b Birthing women received care from other women. At an unknown point in the cultural evolution,

^a Rosenberg, Karen and Trevathan, Wenda. "Birth, Obstetrics and Human Evolution." *British Journal of Obstetrics and Gynecology*. 109, no. 11 (2002): 1199-1206

^b Brucker, Mary C. "History of Midwifery" Parkland School of Nurse-Midwifery in affiliation with The University of Texas Southwestern Medical Center
http://www.swmed.edu/home_pages/parkland/midwifery/txt/mdwfhstxt.html (original pages now inaccessible; cited on several other webpages)

some experienced women became the designated wise women to attend birth, and also often were viewed as general healers in the area.^c Thus, the profession of midwifery began.

Biblical recognition of midwifery included several verses,^d recounting the experiences of two Hebrew midwives who refused to kill male infants in defiance of the King of Egypt . Other verses in the Bible,^e note midwifery attendance at birth, implying that it was well accepted and an expected societal function. In Greek and Roman times, midwives were viewed as respected, autonomous care providers for women. During this time qualifications to practice began to emerge, often requiring the midwife to be of a mature age and having had previous births herself. Because of the inherent role of reproduction and sexuality, midwifery was assumed to be “women’s work”, although important work.

The profession of midwifery continued without major changes throughout the centuries. In Europe midwives routinely used herbs and potions, as forerunners of today's modern pharmaceuticals. The midwives of these centuries taught their successors, as other healers did, primarily through the use of an apprentice model. For many midwives this was the best form of succession planning, while for others, unfortunately as Cushman in her Newberry Award winning children’s book state, occasionally sought someone who “gave her cheap labor” and an apprentice too stupid and scared to be any competition.^f

Midwifery in the United States

Native American tribes had their own midwives and early colonists imported midwifery as an extension of European practices. During the trans-Atlantic passage of the Mayflower, midwife Brigit Lee Fuller attended three births. Midwives filled a clear, important role in the colonies, as described by Laurel Thatcher Ulrich in her Pulitzer Prize winning book: *A Midwife's Tale: The Life of Martha Ballard Based on Her Diary 1785-1812*.^g Midwifery was viewed as a respectable profession, even warranting priority on Massachusetts ferry boats and certain midwives established reputations that resulted in women specifically seeking their services.

^c Brucker, Mary C. and Reedy, Nancy Jo. “Nurse-Midwifery: Yesterday, Today and Tomorrow.” *MCN* 25, no. 6 (2000), 322-326.

^d Exodus 1:15-22

^e Genesis 35:17, and 38:28

^f Cushman, Karen *The Midwife’s Apprentice*. New York: Harper Trophy. Page 11, 1995.

^g Ulrich, Laurel Thatcher *A Midwife's Tale: The Life of Martha Ballard Based on Her Diary 1785-1812*. New York: Vintage, 1990.

Attending births was not the only role for most practicing midwives. Often these individuals were required to examine women who had been raped; and often they had the unenviable role of attempting to identify the father for an unmarried woman's baby. Baptism was a major ecclesiastical responsibility. Some midwives were blamed for reproductive loss and congenital anomalies and punished for being witches who used black magic that supposedly caused these poor outcomes.

During the early years of the American Republic, the apprentice model of training still predominated with a few exceptions. In 1765, Dr. William Shippman, Jr. of Philadelphia initiated a formal tutoring course for midwives.^h Several other such programs were mentioned over the years, including a proposed school of midwives within a hospital in 1817 by Dr. Thomas Ewell of Washington DC. The hospital affiliation was based on European models of the time, although the school never was opened.

Health Education in the 19th And 20th Centuries

The scientific nature of nineteenth century education promoted an explosion of knowledge. In Europe, hospitals moved from being strictly charitable facilities administered by religious groups to becoming local societal institutions, often associated with emerging schools of medicine. In these schools discoveries such as Pasteur's theory of infectious diseases, the link of hygiene to puerperal fever found by Semmelweis and Lister's writings on antiseptics were taught. In some regions hospitals also had schools of midwifery, wherein midwives taught midwifery students; whereas others had physicians as the professors.ⁱ Florence Nightingale opened the first nurses' training school in 1860 and many others quickly followed throughout Europe.^j

Nursing and medical education tended to mirror the European patterns. However, without national oversight, individual states and locales were found to be duplicating efforts without any clear plan. In 1910, Abraham Flexner produced a report for the Carnegie Foundation in which he documented the large number of medical schools and a wide variation in quality. For example, 14 independent medical schools were found in Chicago alone. In large part because of the

^h Carr, Katherine Camacho and Brucker, Mary C. "Midwifery education today". *The Nursing Clinics of North America*. 37, (2002), 803-18.

ⁱ Whitehead, Barbara J. *Women's Education in Early Modern Europe: A History, 1500-1800*. New York: Garland Publishing. 1999.

^j Cook, G.C. and Webb, A. J. "Reactions from the Medical and Nursing Professions to Nightingale's 'reform(s)' of nurse training in the late 19th century." *Postgraduate Medical Journal*. 78 no. 916 (2002):118-123.

Flexner report, not only did many medical schools close, but local and professional regulations regarding academics in medical education were developed and implemented. Among the schools closed were relatively new programs that had been admitting women and the six programs in the country specific for African Americans. A consequence of the Flexner report was that medical education became the domain of upper middle class males who possessed the basic education required for admission and the funding to pay for it.^{k 1}

Nursing also developed in its own way. Florence Nightingale espoused nursing as a separate profession, but in concert with the view of women at the time, it tended to be seen as a subordinate profession to medicine. When Nightingale arrived in the Crimean theater and discovered scores of wounded, she and her colleagues refused to provide any care until she received a physician's order to do so. The Nightingale oath includes a clear reference to loyalty to physicians.^m It is not surprising, therefore, that as American medicine became almost exclusively upper class male-dominated, nursing became the opposite; namely, an option for lower to middle class women seeking another choice rather than clerical work or teaching. Schools of nursing in the United States provided staffing for hospitals in the form of student nurses who provided uncompensated care for patients at all hours of the day or night under the rationale of necessary training.

During this time, midwifery education generally remained on an informal level with the apprentice model continuing. This model enabled skill and knowledge to be passed from generation to generation, but lack of a formalized system of education limited the information provided. Thus, midwives became isolated from the scientific approach as well as specific innovations and discoveries. Restriction of access to knowledge and lack of formal education was a challenge of paramount importance to the profession of midwifery, but not the only obstacle for practice in the early 20th century.

Midwifery practice in the United States suffered from the general xenophobia and isolationism of the times. Immigrants began to be seen negatively as large numbers came to the US shores with the foreign-born population of the United States increasing from 2.2 million to

^k Flexner, Abraham. *Medical Education in the United States and Canada*. Boston: Merrymount Press, 1910.

^l Hudson, Robert P. "Abraham Flexner in Perspective: American Medical Education 1865-1910," *Bulletin of the History of Medicine* 46 (1972):545-561.

^m Wilson, G.R. "From Loyalty to Advocacy: A New Metaphor for Nursing." *Hastings Center Report* 14 no. 3 (1984): 32-40.

14.2 million in the years from 1850 to 1930.ⁿ Feelings against immigrants grew so strong that in the 1920, immigration quotas were instituted. Among the individuals who were immigrants, were midwives. These women were of the same ethnicity and familiar with the women's specific cultures. These midwives were particularly suspect, particularly as all immigrants were often viewed as inferior to native-born Americans.

Even native born midwives discovered that their practices were changing. Births moved to hospitals. The reason for this movement has long been discussed with various causes suggested such as easy availability of analgesia/anesthesia, the financial interest of physicians in hospitals and lack of home-based domestic care when such workers found additional options during World War I economy. As births moved to the hospital, physicians became the health care provider for most affluent women. Midwives were left with a disproportionate number of poor women, either immigrants or not. These underserved women tended to live in rural areas or in inner cities; both sites of poor sanitation and lack of other services that negatively influenced their general health status.

By the turn of the 20th century, physicians were engaged in active discussion about a "midwifery problem", asserting that midwifery care was associated with poorer outcomes for women and their infants. Of the perinatal statistics available, midwifery attended births often did demonstrate poorer statistical outcomes than physician attended deliveries, although that was not universal, and none of the statistical analyses of the time discussed the disparity of types of clientele. Although the concern about the women and babies was publically stated as the reason for the midwife problem, Kobrin suggested economic impact as another central issue, identifying the desire by physicians to move women's care to the hospitals.^o

To address the "midwife problem" two major solutions were proposed. Formal education of midwives was suggested in a manner similar to medicine or nursing. As with nursing, midwives were women and the suggested education would be through formal schools taught in affiliation with hospitals and by physicians. The second major proposal was the one adopted, and that was an active program of eradication of midwifery through restrictive legislation and consumer health education as to its dangers. The latter was suggested in order to promote public

ⁿ Campbell, J. Gibson and Lennon, Emily "Historical Census Statistics on the Foreign-born Population of the United States: 1850-1990" *Population Division Working Paper 29* (1999):

<http://www.census.gov/population/www/documentation/twps0029/twps0029.html> . Accessed 8/30/09

^o Kobrin, Frances E. "The American Midwife Controversy: A Crisis of Professionalization." *Bulletin Of The History Of Medicine* 40 (July/Aug 1966):350-363.

health of the nation. Due to the success of this approach, midwifery in the United States almost ceased to exist.

Birth of Nurse-Midwifery in The United States

Although midwifery began to vanish from some regions in the US, a few hardy midwives continued to practice, but their numbers dramatically diminished. In 1915 it was estimated that 40% of all births were attended by midwives, but only 10.7% in 1935 and of these, more than 50% of the women were nonwhite. Closure of the few formal midwifery schools and decrease in numbers of midwives from whom apprentices could learn, appeared to herald the death knell of midwifery in the United States.

However, a modern midwife was on the horizon. Mary Breckinridge was a woman of means, from a prominent US family that included a US Vice President, US Attorney General and an Ambassador to Czarist Russia. She was well-educated and well connected with a personal history of reproductive/child losses that spurred her desire to help others, especially in the area of maternal and child health. While in her early 40's, Mary Breckinridge reflected on her life and volunteered to help France in their post World War I recovery. There she met British Nurse-Midwives and realized that their skill set could be of value for US women. She was so convinced of the advantages of the role that she successfully completed a formal program in England and in 1925, with several adventurous British Nurse-Midwives; Mary Breckinridge moved to an area of Appalachia in her family's home state of Kentucky and formally founded the Frontier Nursing Service (FNS).

Mary Breckinridge envisioned FNS as a prototype of a service that could be replicated and to that end spoke widely and wrote about it.^P Using her social and political connections, she disseminated information about statistical outcomes that rivaled the most expensive care; even though, as she noted, the women and infants were in one of the poorest areas of the country, especially during the Great Depression. Mary Breckinridge used her own education wisely in developing FNS, keeping statistics and hiring well; and in her autobiography she discussed eventual development of an educational program for the nurse-midwives. However, for FNS, the educational route remained through the British venue for most of the first 15 years of its existence.

^P Breckinridge, Mary. *Wide Neighborhoods: A Story Of Frontier Nursing Service*. New York: Harper, 1952.

Ironically at approximately the same time Mary Breckinridge was considering caring for vulnerable women, another group was faced with the same challenge. However, instead of Appalachia, this population of women was found in New York City. Yet the nurse-midwifery model was also suggested as a potential system. In 1931, the Lobenstine Clinic instituted a formal program that was designed to educate nurse-midwives to care for disadvantaged New York City women. This program was totally independent of FNS and continues to survive, although it has evolved over the years. Today it can be directly traced to the State University of New York Downstate (SUNY Downstate) Nurse-Midwifery and Midwifery Programs.

In 1939, FNS was faced with loss of their valued British Nurse-Midwives as these professionals desired to return to their native land as it entered into World War II. Therefore, FNS began its educational program, Frontier School of Midwifery and it, too, continues. FNS, like SUNY Downstate, began as programs that awarded a certificate, not a degree. In 1969, FNS began offering the first family nurse practitioner program (FNP) in the United States. The FNP certificate program caused a subsequent change in the name of the school to Frontier School of Midwifery and Family Nursing (FSMFN); a name that remains today.

The Movement from Certificate Programs to Degree Granting Programs

As noted above, the early nurse-midwifery programs issued certificate for education. For example, Loebenstine and Frontier programs initially were autonomous certificate programs and all other nurse-midwifery programs can be traced to them. The first university affiliated program also was a certificate program, Flint-Goodrich School of Nurse-Midwifery that forged a relationship with Dillard University (New Orleans) in 1947. The next year, the certificate program at Catholic Maternity Institute affiliated with Catholic University School of Nursing, forming a longer affiliation, access to an educational degree and the prototype for several other programs over the years. A program at Johns Hopkins was begun in 1956 and for years offered either a certificate or a Master's degree in Public Health (MPH).

During the 1970's the numbers of nurse-midwifery programs doubled, with an increasing number moving into nursing programs and offering graduate degrees. In the 1980's a nurse-midwifery doctoral program was offered at Rush University in Chicago. Certificate programs often affiliated with large medical schools or obstetrical/gynecological departments within a

medical center such as Parkland Memorial Hospital in Dallas or the University of Southern California.

Although certificate programs continued into the 21st century, their numbers decreased as more programs opened in nursing programs with graduate degrees attached. Moreover, several states and facilities began to require a minimum of a master's degree for practice, even though no clear evidence of practice differences between certificate graduates and master's graduates were published. Groups of nurses, such as nurse practitioners, clinical specialists and nurse anesthetists began to mandate graduate education earlier than the midwives, who will not require such until 2010. However, it is of note that nurse-midwives have the highest percentage of graduate degrees compared to the aforementioned groups, in large part because of the predilection of midwives and nurses to pursue education in a sequential fashion due to outside responsibilities such as families and fiscal responsibilities.

As certificate programs decreased in number, so did autonomous nurse-midwifery programs. The nurse-midwifery accrediting agency, first created in 1969 within the American College of Nurse-Midwives and today the separate group, Accreditation Commission of Midwifery Education, has long had a criterion that any program must have an affiliation with a school of higher education. Gradually it became apparent that a loose affiliation was no longer acceptable and formal relationships had to be established. This requirement most likely encouraged certificate programs to seek affiliations with local nursing programs since earlier connections with medical schools and hospital departments were less well organized. Public health schools, albeit affiliated with a few programs, often had organizational frameworks that did not lend themselves to affiliation. Nursing schools also often sought nurse-midwifery programs when grant opportunities were available. Statistics of care associated with nurse-midwives; local or state funding; and grant money from the United States Health and Human Services Division of Nursing were attractive to many programs. In addition, in recent years Division of Nursing funding has been denied to new programs outside of nursing and/or new certificate programs. Therefore, establishment of nurse-midwifery programs within schools of nursing such as Columbia University, Yale University, Emory University and University of California San Francisco became the most common type of educational program. Nurse-midwifery programs in prestigious programs promoted the growth of nurse-midwifery, but tied the profession into American nursing.

Close integration now dictates that changes within nursing education have profound effects on nurse-midwifery education. The most recent change in education has been the mandate by the American Association of Colleges of Nursing to have all Advanced Practice Nurses, a category in which they place nurse-midwives although not all nurse-midwives are pleased with such a placement,^q to have a doctoral degree if they graduate in 2015 or thereafter. To that end, many nursing programs are transitioning to a Doctor of Nursing Practice (DNP) degree program. One new nurse-midwifery program, Baylor University, has the first BSN to DNP curriculum without a master's option.

Two programs are outside the norm and award degrees in midwifery, not nursing. These programs are the SUNY-Downstate, the oldest nurse-midwifery program in continuous operation; and Philadelphia University that incorporated a previously autonomous certificate program, the Institute of Midwifery and Women's Health. Both of these programs award masters in midwifery, and there is speculation that they may offer future doctoral degrees in midwifery.

Education and Vocation in Midwifery

Another changing facet of midwifery education is that of the vocational aspect of the profession. Midwives have long been said to be "called" to care for women. This "calling" or "vocation" most likely was linked to some of the religious responsibilities of midwifery. Even today, Canon Law in the Catholic Church contains admonitions for the actions of midwives.^r Yet the concept of vocation can complicate the view of midwifery education to the extent that a degree-granting institute of higher education is viewed in opposition to training at a vocational school. However, that potential conflict may be explained in light of semantics.

The vocational issue that is more apparent than the linguistic one is the financial evolution of midwifery. No longer is midwifery just valued, now it is valuable. The average salary of a Certified Nurse-Midwife has been estimated to be more than \$89,000 annually and self employed midwives, especially with their own birthing centers may income produce into six figures.^s Today it is not unusual for prospective students to ask about future income when considering a multi-year educational endeavor. Nor is such a request unreasonable. Yet some

^q Rooks, Judith Pence. *Midwifery and Childbirth in America*. Philadelphia: Temple University. 1997

^r Ferraris, *Bibl. Can.*, V (Rome, 1889), s.v. *Obstetrices*; Taunton, *The Law of the Church* (London, 1906), s.v. *Baptism*.

^s . http://swz.salary.com/salarywizard/layouthtmls/swzl_compresult_national_HC07000229.html Accessed 8/30/09

current midwives continue to lament the admission of students who they believe do not have the heart of a midwife, or the calling.

Educational Innovations and Midwifery

Midwifery education has been the forefront of several innovations. From the 1950's to late 1960's, midwives coalesced into an early professional trade organization as well as distinct certification and accreditation groups that eventually became autonomous bodies. A self-organized group of directors of midwifery education program began to meet, primarily as a support group and for dissemination of information. This group continues to meet twice annually, and also has had an active electronic list serve for years.

The University of Mississippi program was a basic certificate midwifery program, although the credits were able to be applied to a graduate nursing program. In 1973, this program graduated the first class of midwives who were totally educated using a modular curriculum. Once a student demonstrated competency or mastery of didactic and clinical material, he or she progressed to another level or area. This program was supported by the United States Division of Nursing and the entire curriculum was disseminated to all other contemporary midwifery programs without restriction. However, due to time limitation for courses on semester or quarter systems, the modular curriculum never became the dominant method in nursing graduate programs, although some institutions incorporated various modules.

In large part due to the accreditation process, midwifery has maintained a dedication to assessment of competencies rather than accrual of credits or clinical hours as required by most nurse practitioner or other nursing programs. As the University of Mississippi demonstrated, midwifery students do not enter a program as a *tabula rasa*, but rather come with knowledge and talent so that education may take longer or shorter periods based upon both the individual and the volume/type of clinical experiences. Competency assessment occasionally has been difficult for midwifery to maintain in schools of nursing as it was so disparate from the other groups who used standard hours, but today there is an active movement among nurse practitioners to move to such an approach.

Midwives were not the first group to use distance education and programs such as Educational Program Associates (EPA) in California used such an approach for several years. In 1989, Frontier Nursing School of Midwifery and Family Nursing established a midwifery

program that was community based and exploded with students. Midwives who were eligible for faculty status but who often lived in areas away from a formal program, became clinical instructors for local nurses who wished to be midwives. Students came to the school periodically during their time of study, but primarily studied by distance, including using early forms of electronic communication. This program grew rapidly and maintains its autonomy, although it has evolved into a program that awards graduate degrees in nursing. Since its rebirth using distance technology, more than 1100 individuals have graduated. Today distance education on a graduate level is common, but the sheer numbers and influence of the FNS program cannot be underestimated.

Graduate nursing programs often require practice before admission. Some nurse practitioner groups have requirements for nursing practice for a specific minimum time period. Midwifery, even when contained within a nursing program, traditionally suggested labor and delivery experience. Today it is relatively common for individuals to obtain an accelerated degree in nursing in order to enroll in a midwifery program. Yale University was not the first program to attract such students, but has been accepting non-nursing students for more than three decades. Students complete the first year for their basic nursing, obtain an RN license and then complete their midwifery specialty.

Challenges for Today

As nurse-midwifery moved into nursing graduate education, advantages have included nursing grants, graduate degrees and a more mainstream presence. Challenges also exist with this move. Autonomous midwifery programs are few today and midwifery tends to be a small program in most nursing schools. Faculty are faced with devising a balance of teaching, practice and research to achieve and maintain advancement in these larger institutions. Often midwifery is viewed as the unusual or odd specialty in the nursing school since it has a separate accreditation process; competency requirements instead of credits or clinical hours; and students who often are seeking second degrees. Individuals become midwives in other countries because it is the mainstream; persons become midwives in the United States because they have seen the mainstream and wish to change it or provide alternatives. Therefore, these prospective students often do not fit the pattern of other students in nursing. Midwife educators are actively discussing these issues today.

Other challenges that are independent of the move to nursing or degree-granting institutions include the escalation of educational technology. Midwives have long taught how to attend a birth with a doll and a pelvis, but a \$40,000 simulator presents the opportunity to demonstrate a number of variations and deviations from normal. Classroom video/audio capture enables students to attend class from home via the web and review lectures as needed. However, educators must realize that technology is a method for teaching, not an end unto itself.

Another challenge inherent in midwifery is that it continues to be a “pink profession” or a woman-based discipline. Men who wish to work “with women” and be midwives comprise a small number. Admission to programs of men is not problematic, however, obtaining clinical experiences and future employment often poses issues since many women view the culture of birth and care of women as exclusive to other women.

In summary, after more than a century, nurse-midwifery today is entrenched in the health care educational system. The close ties with nursing have both positive and negative aspects. However, with the advent of health care reform, it may be anticipated that the midwifery profession complete with a long history of positive outcomes and financial savings, may be one of the more attractive options to Americans. The future of midwifery education is one that should be expected to grow; educational challenges articulated and met; and ultimately women provided the care they so richly deserve.