HISTORICAL ISSUES
in
Implementation of the Licensed Midwifery Practice Act

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I wish to thank the members of the California Medical Board, and Drs. Shumacher and Joas in particular, for inviting me to speak at this hearing on implementation of legislation for the licensing of non-nurse-midwives to practice in the State of California.

That invitation was extended, even with the understanding that some of the things I had to say might make obstetricians, on the one hand, and midwives, on the other, uncomfortable, and that it might end by endearing me to neither. The only commitment I made was twofold: first, to stay focussed on the central issue before us: the welfare of the women and babies of the State of California, and hence, given the power of our State, of the Nation. The second is that I would be honest, with history, with myself, and with you. It is my hope that the insights I now share with you, both from my life and from more than twenty years research and contemplation on medicine, midwifery and their emotionally-charged history, will offer you new perspectives on implementation of this important law.

I am, at least now, a slow-thinker, examining and re-examining, ever-turning the kaleidoscope of history and of life to study the patterns and configurations which have brought us to our current point in time.

For twenty years, and centuries of history, I have watched midwives and men play out their drama on the stage of medicine and society, like some peculiarly discordant and un-ending interpretation of Bolero, which is uniquely colored by the ambient culture in which that drama appears. And I have wondered when, and under what circumstances, obstetricians and midwives would ever really come together in the interests of this world's women, babies and families.

Even as this legislation was going though the California Legislature, I was still struggling to understand their drama, listen to their hearts, comprehend their arguments, and view them within context of the history of medicine, the history of American medicine, in particular, as well as within context of the complex dynamics impacting relationships of men and women both within and outside of medicine at this pivotal moment of the human experience. Above all, perhaps, I was struggling to exorcise any of my own private demons regarding women and men, physicians and midwives, in order that I find that quiet, centered place within myself that would, I hoped, bring some balance and insight to this most difficult subject in American medicine.

THE CENTRAL ISSUE

What is at issue here? The immediate issue is how the new non-nurse-midwifery legislation will be implemented into practice. The greater issue is who will control American medicine, midwives or physicians. American physicians recognized, at least by the early part of this century, that whoever controls birth, controls medicine. ***The essential question before us in implementation of this particular legislation, which creates a true medical rather than domiciliary model for the licensed practice of non-nurse-midwifery, is whether it will serve as a pathway to separate midwifery from both medicine and nursing as a completely independent, self-regulating discipline.***

This is the central issue. But before I present my thoughts on this subject, it is only fair for me to step back with you in time, and share with you a little of the personal existential journey which shapes and structures my remarks.

My mother, Margaret Olga Novak, was born in 1914, the first child of her parents, Laura Nimskern and Joseph Novak, Sr. She was born while they were living in a community of immigrants, on the Lower East Side of New York City. Unlike many babies of her era, she was born in a hospital. The first of five brothers, Robert Novak, born four years later, came into this life from another immigrant community, Coytesville, New Jersey, to which they had move after my grandfather became a scenic artist at The

Metropolitan Opera House. Then only 22, she and my grandfather were on the upwardly mobile path to realizing the American dream by moving from the Lower East Side of New York to a suburb of New Jersey on the Palisades.

My grandfather was estranged from another branch of the Novak family, which was already making a name for itself and creating a medical dynasty in the field of obstetrics and gynecology during the first half of this century, but they all shared their faith in the American dream of personal freedom, as well as the belief that American medicine, within context of American democracy, was in process of creating the greatest health care system in the world. My grandfather's first act after their move to New Jersey was to build a flagpole for the American flag, which was hoisted every day before he took the long trip to New York City, where they (or at least, my grandmother) had left behind their god.

That god was Dr. Marion Sims, the American gynecologist whose tenacity, along with that of the three stoic young black women upon whom he performed countless surgeries, had led to development of a successful surgery for vesiculo-vaginal fistula. Among Sims' many other accomplishments, was the creation (undertaken over the objections of many women), of the first hospital where women might go to be treated for cancer, ovarian cancer, in particular. As a young girl I listened to my grandmother's stories of American obstetrics and gynecology, which were to her a no greater miracle than the Constitution of the United States. Doubtless they influence everything I say here today.

Whenever we went to New York City for the symphony or opera, we stopped at the statue of Dr. Marion Sims, which had been moved to the edge of Central Park, across from the New York Academy of Medicine, in 1936. Living today, a century since Dr. Marion Sims and others discovered a way to repair the fistulas caused by protracted parturition, the modern American woman can have little comprehension of the desperate lives of those women of previous generations who were afflicted with this dreadful disorder, and still are in those areas like northern Nigeria, where young girls marrying as early a ten and twelve may have the vagina cut (the ***gishiri*** cut) by untrained midwives, which can create a tear between the vagina and bladder.

My grandmother, herself, as part of woman's work, had attended many lying-ins, and was possibly more skilled than most, as she was frequently called as a simple birth attendant. She was unique in that she would only attend a lying-in at which a physician was present as the primary caregiver. As a result of her experience, American obstetrics and gynecology meant to her, not only freedom from the apprentice-trained midwives of their East European immigrant communities, but also the entire medical science of women's health.

She saw in that science women's redemption from the endless cycles of pregnancies, births, and gynecological disasters at the hands of inadequately trained midwives. She saw in it some relief from the pains and hazards of multiple childbirths, too frequent to be consistent with sustained good health, and often too unwanted to make of their parents caring and loving mothers and fathers. She saw in the new science of obstetrics and gynecology a safe place in a hospital where a woman might give birth, away from the crowded living conditions, the tuberculosis, the smells of cooking, and the requirements of little children and aging relatives, or husbands who placed marital demands within days, or sometimes hours after birth.

Those were the conditions she had observed in the Lower East Side of New York City, and they were the conditions of the poor elsewhere until modern obstetrics and gynecology changed that life for millions of women.

Her fight, which took the form of numerous letters to authorities in medicine, public health and the New Jersey Legislature, supported the new science of obstetrics and gynecology. She saw nothing special or empowered about women with inadequate training bringing the children of other women into the world. She had only her own experience to go on; [despite some compelling studies, even then, regarding the safety of homebirth]* what she had seen were were the disasters of inept deliveries and the tragedies of mothers and babies who could not be delivered,

or who were delivered too late. Her major concerns were the gynecological complications of inferior midwifery.

*Omitted from the oral presentation, as noted by midwife Tosi Marceline.

Although she never said so directly, my grandmother seemed to intuit that ***in order to solve the problems of difficult births and other complications of pregnancy and childbirth, men had to take birth out of woman's province, the home.*** Consistent with that view, she had her children in a hospital, in order that she might serve as material for the medical students.

My grandmother expected American medicine to keep its promise–made early in the century at the time physicians were eliminating midwives from practice–that every expectant mother would receive good prenatal care, and every American baby would be well-born. Although she was only one of millions of American women, there were countless others like her who supported the new science of obstetrics and gynecology. They wanted their pink and blue bundles and their clean, hygienic nurseries, and American obstetrics and gynecology would never have developed as it did without their support. So imagine my surprise when I grew up and learned from the feminist literature that men had stolen birth away from midwives.

My grandmother actually considered herself luckier than many of the women of her time. She and her family lived comfortably in a large Victorian house. She always had live-in or day help for the house and her growing family. With some assistance from new contraceptive techniques, she had been pregnant only 12 times during her long and loving marriage to my grandfather, despite an unusually late menopause. Eight children were born live and lived to adulthood.

Until the end of her life, Laura Nimskern Novak never gave up her belief that the new science of obstetrics and gynecology was something that had never been offered through the folk-lore, anecdotal wisdom and oral-apprentice tradition of midwifery: during her time, this new scientific medicine was already offering women an organized, readable compilation of knowledge about women, their anatomy, physiology, endocrinology, the diseases that afflict them, and the ways they can keep themselves well during the cycles of their lives. From her view, it was that body of rational, scientific, transmissable knowledge which would ultimately allow women the opportunity to receive education equal to that of men, to find out who we truly are as people, and above all, to be freed from the endless tragedy which consumed the life of fertile married women of her time, when millions of women in this country and elsewhere could still expect to be pregnant or nursing an infant every year of their life from marriage to menopause, unless death intervened.

As we come here today, a century from the time she came to this country from Austria-Hungary as a young girl, the men and women of American medicine have kept a great share of their original promise to the women, babies and families of this country. But we are here today because there are still miles to go before we sleep.

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When I completed my studies in history at Columbia University in New York City, I went on to Yale to undertake a special program in anatomy and other medical subjects preparatory to what I expected to be a career studying the anatomical works of Leonardo da Vinci. I was formulating my plans to study with Dr. J.B. de C.M. Saunders, a British-trained physician, Renaissance scholar and former chancellor of the University of California, San Francisco, who was a specialist in the work of Leonardo and Vesalius, when the women's movement intervened.

The quiet student who had wanted to study the apolitical anatomical drawing of Leonardo with Dr. Saunders, arrived at UCSF graduate school instead raging about the violence of men, technology, war, the patriarchy, paternalism in medicine, and the persecution of midwives, particularly in American medicine. In the 1970s in San Francisco, I had plenty of support for my position; I could always count on a cheering group of women to tell me I was right when I hammered away at men about patriarchal medicine or the persecutions of midwives and other women healers under the **MALLEUS MALEFICARUM** from the 15th century on.

In the six years I studied in San Francisco with Dr. Saunders, and worked as a clinical research associate on the UCSF staff, I brought that rage down on his head and the head of every other patriarch or patriarchally-influenced physician, male or female, in UCSF medicine. Dr. Saunders hung in. In tutorials on medical subjects and medical history, which sometimes lasted six hours, he forced me to confront myself as often as he forced me to confront history. As he loaded me down with books after every session, he demanded that I read around my subject; he sent me to England to study at the Wellcome Institute in the History of Medicine, and talk to physicians and midwives working under National Health. Even after completing my doctoral course work he urged me to wait to write my dissertation. Instead, he suggested that I study the alternative care movement and what he still called "lay midwifery" by living where both were flourishing. I chose Taos, New Mexico. He never told me what to believe, but he did tell me, "be fair." Both he and my grandmother are gone now, so except to the extent that we are all somehow connected in this universe, neither knows the conclusion of my own existential quest on the subject of midwifery.

As I watched the changes in health care, women's lives and the greater society from 1986 through 1993, I did so from Taos, New Mexico as Director of New Mexico Health Issues, a small research and health resource information service. During this time, as I witnessed the conflictive midwifery drama being played out locally between a strong-minded obstetrician and an equally strong-minded non-nurse-midwifery center, and as I read more widely on the socio-political philosophy of independent midwifery, my entire perspective on the women's movement, on midwifery, and its history, was to become transformed.

MAJOR COMPONENTS OF THE MODERN, AMERICAN NON-NURSE-MIDWIFERY AGENDA

During my years in New Mexico, I began to recognize that there is a cohesive modern non-nurse-midwifery Agenda in the women's movement. It begins with the assumption that women are uniquely qualified to deliver babies, even without any education at all. To the extent that basic qualifications for the practice were adopted in New Mexico for licensing as a non-nurse or apprentice-trained midwife, these qualifications had been developed and eventually placed into law through the cooperation of physicians and nurse-midwives practicing within and outside of the State's Department of Public Health with non-nurse-midwives from the alternative care and women's movements. These regulations did not arise from the early 20th century, apprentice-trained midwives of the Hispanic culture.

After midwifery died away and was then revived with growth of the women's, alternative care and paraprofessional movements, prospective non-nurse-midwives were responding to the demands of greater professionalism and more structured training throughout the health care industry, as well as to the organizational efforts of the American College of Nurse-Midwives, which was first chartered in New Mexico and eventually recognized by the American College of Obstetrics and Gynecology in the 1970s.

A second part of this Agenda centers on the quasi-religious role of the non-nurse-midwife; according to this view, the midwife who practices in certain areas of the country outside the law, is responding to a higher law, often described as the law of the Mother Goddess, to take care of sister women in childbirth and provide access to care that has been denied by patriarchal, mainstream medicine, especially to the poor.

A third component of this Agenda centers on the polarizing of physicians-obstetricians and midwives; male physicians and obstetricians unsympathetic to midwifery are attacked as hostile aggressors who have taken birth away from women. A fourth component of this Agenda is the claim that male obstetricians are motivated by financial gain and a pathological desire to have power over women and exploit their bodies for men's profit. A fifth component of this Agenda is that midwifery is a separate, independent discipline which should not fall under the jurisdiction of either medicine or nursing, since normal birth is a non-medical event. A sixth component of the Agenda is that non-nurse-midwives, rooted in the customs and mores of the culture, are ideally suited to be primary birthing cargivers for immigrant and third-world

populations of this country.

A seventh major component of the non-nurse-midwifery Agenda is based on consumer-mandated health care delivery; that is, a belief that health caregivers should be regulated by consumers rather than the medical profession. Or to put it differently, the traditional role of the medical profession in setting standards of care, should be supplanted by consumer mandate.

As time went on, I was also to learn that an undetermined but significant percentage of certified nurse-midwives share these perspectives and had only trained for midwifery within the mainstream medical system to protect their economic futures. They, too, hoped to see the eventual separation of midwifery from both nursing and medicine.

THE ARGUMENT FOR INDEPENDENT MIDWIFERY

In the conversations I have had with non-nurse-midwives, there has been a prevailing theme relating to the independent practice of midwifery. That theme is summarized by Marsden Wagner, MD, who wrote for the World Health Organization for Europe the following defense of the independent practice of midwifery:

"It must be underlined at the very outset that midwifery is, always has been and must remain an independent profession with its own responsibilities if the health of mothers and children is to be not only promoted but protected. Midwives provide basic and essential services that are simply unavailable though any other system of the health and healing arts. Any legislation, or the interpretation and enforcement of any legislation, which attempts to eliminate, unduly restrict, or make midwifery a subservient profession is, per se, unreasonable, irrational, and arbitrary, and can be detrimental to the health , safety , and welfare of 90% of all pregnant women." (Informed Homebirth/Informed Birth and Parenting, 1991)

THE NORTHERN NEW MEXICO MIDWIFERY CENTER AND NATIONAL COLLEGE OF MIDWIFERY

There is currently a school for the training of non-nurse-midwives in Taos, New Mexico, with its own independent birthing center, which has worked actively with the Department of Public Health in New Mexico. The director of the center, Elizabeth Gilmore, a licensed non-nurse-midwife, founded the Northern New Mexico Midwifery Center from money she inherited and she wrote the State's licensing regulations for non-nurse-midwifery, which is regulated in New Mexico through the State Deparment of Public Health. The midwifery center enjoys a great deal of public support from their many followers in the alternative care and women's movements, as well as the greater community, both within and outside Taos. There is little question, at least in my own mind, that the midwives and their many supporters are seeking accreditation of that school to make it a center for the training of non-nurse-midwives from other states.

Described by one Taos midwife as a "college without walls," the National College of Midwifery in Taos, New Mexico, has intended to offer courses through the doctorate in non-nurse-midwifery, through residential and non-residential programs. In other words, a student from another state, including those states which do not currently license non-nurse-midwives, might be able to reside in her home state and undertake an apprenticeship with a licensed non-nurse-midwife, certified nurse-midwife, or physician in her state. Through this non-residential training program, the college would potentially be able to enroll thousands of women from around the country to study non-nurse-midwifery at different levels, and grant degrees to them ranging from an associate to a doctorate in midwifery.

The brochure, which has advertised the college as "recognized by the New Mexico Commission on Higher Education," fails to tell potential students and others, at least in the edition I have, that at the point the brochure was published a few years ago, "recognized by the New Mexico Commission on Higher Education" meant nothing more than informing the State that one is operating a school. This underscores the need for careful evaluation of out-of-state alternative education and training programs, which continue to be haunted by questions regarding curricula content and other issues.

THE MODERN NON-NURSE-MIDWIFE*

The modern non-nurse-midwives of New Mexico, and elsewhere, however, bear little resemblance to the untrained East European immigrant midwives who so troubled my maternal grandmother and the physicians of her time. The typical lay midwife then was often uneducated, a seasoned woman of mature years, often a mother herself, who practiced within the community but without any extended or organizational support outside her immediate geographic locality. At this time, the early part of the century, the American medical profession and the profession of obstetrics and gynecology were still laying the organizational groundwork for the gigantic system of American medicine which was successfully to exclude midwives in most areas of the country from any participation in health care delivery to women and babies for much of this century.

Growth of the women's, alternative care and midwifery movements since the 1970s, has been paralleled by the growth of paraprofessionals performing, not only the tasks of frontier medical technology, but also many of the routine tasks which used to be handled by physicians and nurses earlier in this century. This modern fragmentation of health care delivery is currently displacing physicians more and more from their important central role in setting standards of care, a displacement which critics claim allopathic medicine has brought upon itself through over-rigidity, over-medicalization of life, over-technologization, over-specialization, and financial greed. Currently, there is a vast system of grassroots organizations with strong economic support for innovative changes in the health care system, and these mutually supportive organizations for environmental, health care and other reforms, have extended their support to the resurgence of non-nurse-midwifery. These grassroots organizations tend to "group" in mutual support for any major organization or group that is anti-establishment, much as members of a political party offer blanket support of a party's platform, even though they have little in-depth knowledge of specific, individual issues and candidates.

The revival of lay midwifery in the 1970s and current world-wide efforts to professionalize it as "direct-entry" or "independent midwifery," are in part motivated by a political need to further an independent prototype for the feminist cause within the health care industry. There are, of course, far more pragmatic motivations. As health care costs began to escalate at a geometric rate, more and more women have been uninsured, particularly the working poor. Even today, non-nurse-midwives may be the only caregivers to whom a woman can turn for sliding scale or free pre-natal and childbirth care, especially in rural areas such a Taos. This is usually not the case, however, and the woman or couple who choose to birth at home with a non-nurse-midwife are more likely to conform to ideological belief systems of the alternative care and New Age movements.

Unlike the untutored non-nurse-midwife earlier in this century, today's non-nurse-midwife has access to that body of information on women's health, which my grandmother foresaw would liberate women from their biology and physiology through a system of cognitive knowledge regarding women's health, including reproduction, birth, complications, and the importance of prenatal care. Re-emergence and subsequent development of non-nurse-midwifery after years of obstetrical science, extensive public health programs directed to maternal and child health, certified nurse-midwifery, and a world-wide telecommunications industry, has allowed grassroots organizations in women's health to work from an information and networking powerbase on independent midwifery that was unknown to their untutored forebears. Non-nurse-midwifery organizations such as MANA (the Midwives' Alliance of North America) promote cognitive knowledge, experiential learning, advocacy, and public education about birthing options and participate in an international network which mimics but qualitatively differs from that of mainstream medicine.

Many non-nurse-midwives practicing, or even in training, probably have more knowledge and experience in birth and reproduction than did fully-trained physicians at the early part of the century. Yet they are dependent, at every turn of their trade, on the technological developments of mainstream medicine, from gauze and maternal pads to IV lines, pharmaceutics, obstetricians, ambulance transportation, paramedics, and

hospital systems to which their patients are transferred under emergency circumstances. Since birth is one event which may change in the flash of a second from a normal process to a medical catastrophe, the midwife can never be truly free of the mainstream medical system which she not infrequently maligns. The role of the non-nurse-midwife advocating independent practice is therefore unique within the health care industry, for while she hopes to be self-jurisdating and self-regulating, she is critically dependent on mainstream medicine during emergency life-death situations.

The percentage of American women who opt for out-of-hospital birth with a midwife is still low, although it has grown steadily sine the 1970s, from 0.5-1% of total births, or from 26,000 to 37,000 between the years of 1974-1986, a trend that continues. (National Center for Health Statistics, Centers for Disease Control, Vital Statistics of the United States, 1986. Vol. I-Natality. Washington D.C., 1986.) Although non-nurse-midwives have often represented themselves as the best caregivers for poor, immigrant mothers, the women who choose to birth at home create a profile more compatible with the well-educated woman of the women's and alternative care movements, namely, over 30 years of age, above average in educational background, having a third child, and white. Most American women, given the choice, still choose to birth with physicians/obstetricians or physicians/obstetricians/certified nurse-midwifery teams. Women in new immigrant populations, particularly from poor, third-world countries, generally have a greater incidence of mid-high-risk pregnancies, necessitating physician caregivers.

*[Some non-nurse-(direct entry, independent) midwives also hold nursing degrees, but received their midwifery training independent from a certified nurse-midwifery program.]

INDEPENDENT MIDWIFERY AND WOMEN'S OPTIONS FOR PRENATAL AND CHILDBIRTH CARE

Although part of the midwifery message is to increase women's options for childbirth, the real danger in the current political climate is that the options for American women will actually decrease if universal access to care seeks to reduce the over-all expenditure for health care delivery to women by transforming our current physician-based system into a midwifery-based system.

Should cost become the major derminant of health care delivery to women and babies under universal access to care, this will potentially further empower midwives to separate from medicine and nursing and become a truly independent, self-regulating discipline. This particular legislation, which creates a medical model for the practice of professional midwifery which is the equivalent to that of nurse-midwifery, will potentially empower those forces in ACNM and MANA who desire the autonomous practice of midwifery, to effect that transformational change under cost-containment provisions of universal access to health care and incremental midwifery legislation.

This was foreseen by New Mexico midwives in an article in the Santa Fe SUN published in January 1993. The article predicted successful passage of The New Mexicare Plan, a universal access to care bill then being introduced to the New Mexico Legislature, which displaced the central role of the medical profession in setting standards of care in favor of a health care system regulated by consumer mandate using approved gatekeepers. It was anticipated that cost-containment provisions under universal access to care would transform health care delivery to women and babies to an independent midwifery-based system, in which obstetricians became an endangered species. The legislation was also intended to shift the balance of power in the State from allopathic medicine to alternative medicine, a transition supported by the bill's gatekeeping system. The New Mexicare Plan was, however, defeated in the New Mexico Legislature, despite wide public support, especially from the aggressive alternative care, women's and New Age movements in Northern New Mexico.

POTENTIAL IMPACT OF INDEPENDENT MIDWIFERY

Under any independent system of midwifery, autonomous midwifery education, training and practice, will in turn transform ouRrentire system of health care delivery to women and babies from

its current model in which men and women receive their education and practice together, to a system in which the profession is dominated exclusively by women. Such a system will potentially permit midwives further to raise the risk level of midwifery-facilitated births and increase their practice in gynecology. In a system in which midwives, rather than physicians, call the shots, it is likely that more and more obstetricians, who handle high-risk pregnancies, will leave the profession due to the high cost of malpractice insurance and aggressive politicization of midwifery.

Is this what midwives want? In my view, yes, especially in the American Southwest, long the national hotbed of midwifery activity, where they hope to train California non-nurse-midwives and those from other states. There, the ultimate goal of some, if not all, dominant midwives is clearly for midwives to train and practice independently outside the jurisdiction of medicine or nursing.

Already, licensed, apprentice-trained, non-nurse-midwives in New Mexico are providing all the gynecological care that some women receive, a practice furthered by lack of access to affordable care in mainstream medicine. Some are serving as advisers and consultants for individuals and families doing their own home-births, usually for reasons of cost.

COGNITIVE KNOWLEDGE

There are valid questions that may be raised with respect to the role formal education and training on basic subjects such as anatomy and physiology, will actually play in self-regulated, self-determined midwifery programs. The impression of this researcher, is that the value currently attributed to cognitive knowledge is significantly posturing, in order to put forth the public image that will best advance the ultimate purpose of independent midwifery through incremental legislation. I say this because so many midwives have told me over the years that bringing babies into the world is something that midwives do naturally, and that their skills are superior to those of trained physicians and obstetricians.

At very least, the non-nurse-midwife appears to give conflicting or confused messages with respect to the value of cognitive knowledge. Here, too, her position is unenviable and unique, for in order to legalize her practice, and legitimate its world-wide acceptance, she must advance non-nurse-midwifery through a system she does not always understand, yet to which she is in many respects ideologically opposed. This is not the case in New Mexico, where the regulatory body, the Department of Public Health, has long supported and even, some physicians believe, protected non-nurse-midwives. There, the Department of Public Health has been described by one physician as "the most powerful arm of the alternative care movement." It is far more common for there to be vast ideological gulfs between the non-nurse-midwife and the mainstream system which evaluates and regulates her.

On the one hand, the non-nurse-midwife believes that women's ways of knowing and experiencing the world legitimate midwifery practice and contribute to a more meaningful, compassionate and affordable normal birth experience for mothers and families. On the other hand, she regards women's ways of perceiving, knowing and experiencing as being in conflict with man's cognitive, rational, technological approach. In professing the necessity for cognitive knowledge, the midwife undermines one of the essential messages of the non-nurse-midwifery movement, which is that women have been delivering babies successfully since the beginning of time without any help from "male knowledge," or to put it in the blunt terms in which it is often expressed, "without any help from men."

Even under circumstances where cognitive knowledge is genuinely appreciated and valued, we may expect independent, self-regulating non-nurse-midwives eventually to adopt a more informal, less cognitive approach to women's health. If midwives, rather than physicians, control birth under cost-containment provisions of projected universal access to care and become autonomous from medicine and nursing, midwives' less-cognitive approach will eventually threaten to devalue the cumulative wisdom of more than a century of men and women's combined clinical and research methodology, experience, and cognitive knowledge. This is likely to have consequences in American health care which reach far beyond the art and science of

childbirth.

I project this, not only because of my readings in the obstetrical, midwifery and feminist literature, but also because of my observations that the way obstetricians, on the one hand, and non-nurse-midwives, on the other, perceive and relate to the world as well as to women and childbirth, is generally very, very different at best, and diametrically opposed at its extreme. These differences are enhanced by contrasts in communication styles and core values and need to be studied objectively.

Although we, as women, kept childbirth as our separate, sacred province for thousands of years, we never developed the system of cognitive knowledge on reproduction, birth and women's health which, as my grandmother foresaw, would ultimately allow women to live free and healthy lives.

It is not enough to say that we did not do it because we were repressed or abused or living out most of that history in patriarchal societies. If we, as women, viewed the world through the same looking-glass as men, we certainly would have created the science of women's health at some point in time, perhaps through the religious orders, perhaps outside them.

We did not, and it was men who were to apply the rising science and technology to the problems of women. Even if one reads nothing but the cumulative indices in the obstetrical medical literature, one cannot avoid the meticulous thoughtfulness, tenacity, dedication and powers of observation and experience, that have gone into building the science and art of obstetrics and gynecology. In fact, the histories of midwifery, obstetrics and gynecology, may offer us some of our most important evidence that some, at least, of our abilities and thought processes are definitely sex-linked.

To be certain, men have over-technologized the experience of birth--that is the way men think, that is the way they are. They too have been living out their own mythic journey with respect to the womb, and sometimes cannot see that science and technology can have their own irrational applications. Over-technologization, however, while significantly impacting factors relating to women's satisfaction with childbirth, has generally been far less threatening to the welfare of women and babies than lack of cognitive knowledge of birth among midwives.

AMERICAN NON-NURSE-MIDWIFERY UNIQUE

There is, I believe, another real danger in any implementation of this law that would further the autonomy of midwifery and its separation from medicine and nursing. Non-nurse-midwifery in American medicine is unique, in that it was eliminated by the medical profession in the early part of this century. This distinguishes it from non-nurse-midwifery in European countries, such as Holland and Denmark, where non-nurse-midwifery has been integrated in the mainstream health care system for centuries. The battle to re-introduce midwifery to American health care, the role of non-nurse-midwifery in the women's and alternative care movements, and prosecutions of non-nurse-midwives, have all contributed to the highly political and emotionally-charged character of non-nurse-midwifery, which traditionally reflects the most radical and reactionary group in women's health and the women's movement.

A rise in the occult, pagan religions, irresponsible birthing, breakdown of the family, teen-age pregnancies out-of-wedlock (Teen-age pregnancies in the 1970s were actually higher; these pregnancies, however, were more likely to occur within marriage with economic spousal support and at a later teen age.), feminization of poverty, violence against women, and other social changes, have paralleled empowerment of non-nurse-midwifery. These phenomena need to be studied objectively with respect to their inter-relationships and what role, if any, midwifery plays as a causal factor.

HEALING THE QUARREL

Women and men, working together, are in process of making the birthing experience the best and most satisfying it can be for women, babies and families. The implementation of this important law must be undertaken with real mutual understanding of the differences that influence the commitment of both midwives and

obstetricians on the subject of birth.

I have found that midwives, in general, know very little of the history of scientific medicine, obstetrics and gynecology, except as presented in feminist writings. Many male obstetricians seem equally ignorant of, and insensitive to, important issues centered upon women's history, including woman's need to understand and control her own body and protect it from the ravages of over-technologization, particularly in the birth experience.

If this law is truly to serve women, babies and families, we must learn from one another by keeping non-nurse-midwifery education and training within the mainstream health care system. It is that system which must be constantly able to maintain its stability while it responds to innovative and qualitative transformative changes that deal with the great issues which haunt health care delivery, particularly with respect to women's health. Negative myths of the feminine, for example, may still be the most important variables in a diagnostic setting, even in an age of spectacular technological advances.

PARADIGM SHIFT AND THE MAINSTREAM HEALTH CARE SYSTEM

As we undergo a massive paradigm shift into the 21st century, society, as well as health science research and information data bases, are changing at a geometric rate which threatens the system of American medicine, with its historically slow-moving and conservative perspective on transformative change.

More than at any time in history, that system is being forced to confront its own inertia and resistance to change. Yet any body that regulates that system, and is concomitantly a part of it, including this Board, must of necessity be conservative, because its sacred trust is to protect human life.

Implementation of this important law, if we are wise, will allow us to create new frontiers in American medicine by using new techniques for resolving conflict between obstetricians and midwives, mainstream medicine and alternative care. In the past, the heavy hand of patriarchal authority has been leveled against midwives when men could not deal with the disorganization, appeal to the occult, disrespect for the law, lack of cognitive knowledge, and threat to life among midwives. Midwives have been equally intolerant of male insensitivity to women's ways of healing, and women's needs for wholeness in the birth setting as well as access to affordable prenatal and childbirth care. They have in turn responded to physicians with the typical passive-aggressive mechanisms of defense used by depowered peoples everywhere.

Historically, the polarized way in which women and men view themselves and one another, led to dreadful persecutions of midwives and women healers under the psychopathic document, THE MALLEUS MALEFICARUM, and at another point in time in America in this century, to the exclusion of midwives from the art and science of childbirth.

We must learn from our past, not repeat it, in the implementation of this law. To heal the wounds of centuries on this most difficult and painful subject in American medicine, we must all come closer together in taking shared responsibility for this tragedy. If this law is to work, both obstetricians and midwives need to deal with the dark sides of our nature as men and women which have polarized these practitioners on the subject of birth for centuries. They must begin to appreciate the other's point of view, for this law can only work if the quarrel between midwives and obstetricians can be healed.

In closing, it remains my concern that this legislation, if it allows for the training of non-nurse-midwives outside the existing health care system, will open the door for the eventual autonomy of midwifery. This will potentially make all of women's health a woman-dominated specialty, which centers on preservation of territorial rights rather than what is best for the women, babies and families of this Nation.

The greatness of American medicine has rested, in part, on the control of birth by physicians. Physicians and obstetricians, male or female, must continue in a true partnership relationship with the public and with midwives, if this law is ever to support its intended purposes. Effective

health care delivery depends, now, more than ever, on a system based on merit, in which caregiving teams work with shared knowledge, understanding, protocols, commitment, communication and respect.

I have great faith in the physicians, obstetricians, midwives, and women's advocates of this State, and this Nation, who have already accomplished so much on behalf of women, babies and families.

They put their trust in health care professionals, and this is a season in time, once again, for transformative change that protects public interests.

Thank you.

Note: Due to limitations of time and voice, parts of this address, particularly from the last four pages, were abbreviated in the oral presentation. Several **ad lib**, spontaneous remarks are not represented in this reproduction.