

Midwifery in Athens, Georgia

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The story of the decline of midwifery that occurred primarily in the early 20th century is an excellent example of patriarchal models of science overtaking female-centered ones. Since then, male scientists and doctors have defined female experiences, such as childbirth and pregnancy, in terms that don't relate to many women's actual lived experience; thus childbirth is now fetus- and doctor-centered, nearly erasing the woman's role. Midwifery, in ancient times as well as today, is woman-centered and pays attention to her physical as well as emotional needs; this has easily been dismissed by doctors in modern times, however, by claiming that midwives aren't properly medically trained and that they do not have the expertise that male doctors can provide.

By looking at the recent history of midwifery, I hope to show the influence of the male medical establishment in its decline and link these historical processes with the current situation of midwives in this country. I will also explore the current situation of midwives in Athens, Georgia, including their relationships with local hospitals, doctors, patients and other related groups (including their advocacy and community work). Athens has not been exempt from the larger trend, in the South as well as throughout the country, of denigrating the position of midwives and making them seem to the general public as less competent than doctors. By connecting past patriarchal arguments with current demeaning views of midwifery – as well as celebrating the great work that midwives do in the Athens community – I hope to explore ways of granting midwives more medical authority, and thus give women more right to have a say in something as personal as their own pregnancy.

Although the major era of decline in midwifery occurred in the early 20th century, the medicalization of birth and regulation of midwives in America was to a limited extent

initiated two hundred years prior. In colonial American society hospitals and medical schools were being established, including a formal training school for midwives started by a male doctor; many midwives rejected this training, however, because of their belief that childbirth should be woman-centered and seen as a natural event that is guided by experience and intuition. During this period upper-class women began to utilize doctors when giving birth because of a growing belief that midwives were not properly trained and that, as women, they would be unable to learn new, superior medical techniques that male doctors were using; these medicalized procedures seemed to promise hope for lowering the death and illness rates due to pregnancy and were class-based due to their scarcity and cost.¹ Throughout the 1800s increasing numbers of middle and upper-class women used male doctors when giving birth, having long ago accepted the medicalization of birth as a state of disease and unnaturalness that necessitated the intervention of medical professionals. Meanwhile, however, lower-class women in immigrant enclaves and rural areas still used local midwives, with 50% of all births in 1900 being led by them.²

Although such negative views of midwives were already being propagated, and eventually led to their decline in the early 1900s, evidence from the time period suggests that using a midwife was actually safer than using a doctor. In a report from San Francisco in the 1890s a woman described how male doctors often used street clothes when delivering a baby which led to increased rates of infection; when midwives were present, however, stillbirths and maternal death from fever rarely occurred.³ Newly invented devices such as the stethoscope gave technology a certain authority and thus a

¹ Feldhusen, Midwifery Today website

² Ehrenreich and English, *For Her Own Good*, p.103

³ Jensen, "Politics and the American Midwife Controversy," p.20

new medicalized model of pregnancy – dependent on technology and the authority of male doctors - was able to overtake the facts of midwifery success. In addition, by insinuating medical students in charity hospitals to train on poor patients, doctors were eventually able to gain influence over poor women in the name of improving obstetrics and gynecology.⁴ It wasn't just the influence of doctors that led to the decline in midwifery, however. New federal requirements in the early 1900s that midwives be licensed and trained led to many women not being able to obtain permits and general demand for their services fell.⁵ The growing idea that childbirth was inherently dangerous led to the increasing demand for technological intervention such as the use of forceps,⁶ and midwives were not spared these new societal changes.

With the passage of the Sheppard-Towner Maternity and Infancy Protection Act in 1921, states were able to obtain funding from the federal government to train midwives so that they fell more closely in line with what medical professionals deemed safe. Nurses who were trained during an era that was obsessed with sterility and cleanliness taught midwives procedures that were deemed hygienic and instructed them to call a doctor when there was a difficult birth. With new requirements that tried to rid the tradition of women trusting in the experiences and abilities of other women in childbirth, the usage of midwives fell precipitously – from 50% to 15% between 1910 and 1930. Despite this sharp decline, many areas of the rural South were nearly untouched because the programs under the Act did not extend to those regions due to their remoteness; in these areas, lay midwives were able to carry on their traditional practices. In areas where midwives were encouraged by doctors and public health officials to adopt new practices

⁴ Ehrenreich and English, *For Her Own Good*, p.104

⁵ Ladd-Taylor, "'Grannies' and 'Spinsters': Midwife Education Under the Sheppard-Towner Act," p.257

⁶ Litoff, "The Midwife Throughout History," p. 5

there involved varying levels of resistance. Molly Ladd-Taylor notes that midwives did not always passively accept the new laws, and in fact, “Midwives and their patients contributed to the direction of childbirth by choosing to follow some modern procedures while ignoring others, and by refusing to abandon traditional ways” that often involved “practices of religious and symbolic significance.”⁷

The fate of midwives in Georgia during the early 20th century was unique to the rest of the country due to the widespread usage of black “grannie” midwives and the aftermath of the government’s attempt to license them. There were approximately 9,000 grannie midwives in Georgia at the time, and in 1926 the attempt to license them led to many abandoning their practice. Although this is what the medical establishment ultimately wanted, there were no doctors to replace these women and it wasn’t until World War II that nurses trained as midwives were able to help women in a free maternity hospital. The situation was still dire for poor, rural women who needed assistance with birth, however, so eventually grannies that were still available were retrained to meet the demand for trained midwives. Often white nurses attended the training sessions and described how much they learned from the traditional ways of childbirth -- such as “the dignity of simplicity, the power of group thinking and a kindness to unmarried women”⁸ -- and the grannies adopted new methods that they found suitable. These training sessions ended after World War II, however, and with the ever-growing power of medical authority midwifery faded into relative obscurity again.⁹

⁷ Ladd-Taylor, "'Grannies' and 'Spinsters': Midwife Education Under the Sheppard-Towner Act," pp. 255-256

⁸ Jensen, “Politics and the American Midwife Controversy,” pp. 25

⁹ Jensen, “Politics and the American Midwife Controversy,” pp. 25-26

In recent years midwifery has been experiencing an upsurge in popularity, but there are still many restrictions on nurse-midwives that continue to place masculinist medical expertise over women's experience and intuition. The decline of trust in authority, and in medical authority in particular, during the 1960s and 1970s marked the resurgence of nurse-midwives being used by middle-class women who were often the most-represented class in the women's movement. The women's movement during this time period was instrumental in directing criticism against the male medical establishment, especially in terms of obstetrics, and in encouraging women to seek out more rewarding childbirth experiences by avoiding unnecessary medical intervention.¹⁰ Currently there are two categories of midwives in the United States: nurse-midwives and direct-entry midwives. The former is trained in both fields, while the latter train as midwives without first being a nurse. There are different levels of qualification with these midwives because laws governing them vary from state to state, but if a midwife is a Certified Professional Midwife (CPM) then a certain level of training is guaranteed. There are written as well as hands-on exams, and the midwives must have experience with home births and in birthing centers. The North American Registry of Midwives directs the CPM programs, with over 850 CPMs accredited in North America, and often the credentials gained through the program are the only way for a direct-entry midwife to attend a home birth.¹¹

In the Athens, Georgia community, only one of the two local hospitals offers midwifery services. Athens Regional Medical Center (ARMC) has had a Nurse-Midwifery Services program since 1977, and currently has seven Certified Nurse-

¹⁰ Rooks, "Nurse-midwifery: The Window is Wide Open," pp. 33-34

¹¹ "FAQs About Midwives and Midwifery." [Citizens for Midwifery](#).

Midwives (CNMs) that work in an in-hospital Birth Center. The nurse-midwives are available for many services including prenatal and postpartum care in addition to the normal labor and delivery services. Normal deliveries are performed independently, but if there are complications there is a back-up physician who “is available for consultation or referral” if needed.¹² According to Pat Nielsen, who was a nurse for nearly thirty years (spending much of this time in Athens) and is currently a doula as well as an advocate in the community, in practice the physician presence in a midwifery led birth is not overwhelming. The doctor is not in the room and oftentimes not even in the same building, and is usually reached by phone in the event of an emergency. This is encouraging in that the midwife and pregnant woman do not feel pressure from a doctor to perform any particular surgical or medical action that is not encouraged under the midwifery model of care and that independence is to some extent guaranteed.

My interview with Pat Nielsen indicates that Athens is still quite conservative medically concerning what services are offered by midwives. In the late 1970s, when the midwifery program was opened at ARMC, services were primarily utilized by poor women. In fact it was basically an indigent care center for pregnant women because physicians did not want “those women” in their offices. This history is part of the reason that St. Mary’s hospital in Athens does not offer midwifery services – in the 1970s ARMC was called Athens General, and as a public hospital they primary served the poorest members of the community. The services started in that era have persisted to this day, and St. Mary’s has likewise persisted in not offering a midwifery practice. The midwives in Athens are constrained to working in a hospital environment, however, because CPMs, which are also known as lay midwives and can perform home births, are

¹² "Maternal Child- Midwifery Services." [Athens Regional Medical Center: Health Services.](#)

illegal in Georgia. Home birth does occur as an underground practice, but a midwife can get in trouble (under the excuse of practicing medicine without a license) for performing one; the mother does not get in trouble, however. Georgia only allows Certified Nurse-Midwives (CNMs), who are required to have physician backup and therefore must work in a hospital.

The issues with home birth in Georgia primarily revolve around insurance issues that doctors find troublesome to deal with because they can be so complex. For a midwife to perform a home birth they must have a physician present who would back them up in case of an emergency. Doctors cannot get malpractice insurance if they assist in homebirths, however, because it is so expensive. Not all insurance in Athens is so limiting, however. If ARMC accepts a certain insurance provider then the CNMs accept it as well. There is also a self-pay package if insurance does not cover the birth, and it is offered at a reasonable price (for middle to upper-class women, that is). CPMs are not covered by insurance agencies because of the “risk” involved with their deliveries, and the out-of-pocket expenses are enormous for women.

Ms. Nielsen described the perceptions of midwifery in Athens as still limited but growing in a positive way. Many people still see midwives as “granny hippie people” who are not formally trained or educated. According to her they don’t realize that oftentimes midwives perform the same lab tests with the same technology that physicians use, with the difference being that the focus is on the woman’s needs and desires rather than the doctor’s. People also have the misperception that if you use a midwife you have to have a natural birth, which is not the case. The goal for midwives is to provide the woman with sound information and allow her to make decisions that are best for her

situation, which doesn't necessarily preclude using technology. At ARMC a midwife cannot perform surgery or use forceps, and that is why there is physician back-up. Ms. Nielsen does not see this as an issue, however, because midwives do not want to be the ones performing surgery in the event that it's needed – it is not the focus or ideal of the midwifery model.

Although midwifery services at ARMC are adequate and generally positive, Ms. Nielsen feels that a huge step for midwifery in Athens would be the creation of a free-standing birthing center in the community. More progressive ideas about midwifery are slowly growing in the community, and many women are seeking out midwifery services and abandoning physician care. A lack of information about which midwifery services are provided in the community seems to be an impediment to their expansion, but Ms. Nielsen finds that when women use midwifery services they often recommend it to others and thus its popularity grows by word of mouth. A central place is needed for women to talk about issues and organize, because in her experience Ms. Nielsen finds that the more well-educated a woman is about her options the more likely she is to use a midwife. A good first step is for women to tell their physicians what kind of birth experience they want and be self-confident, but often this is difficult for women with little medical knowledge. This is where doulas in the community are helpful, because they serve as an advocate for women who are having medical as well as midwifery-based births. There are currently ten to twelve doulas in Athens, who are on call 24/7 for women two weeks before and after their due date. Some doctors do not allow doulas when delivering a baby, however, so exploring all options available is very important for women.

Although options in the Athens community for women who wish to avoid the medical model of pregnancy have expanded greatly over the years, there is still room for improvement. According to Ms. Nielsen, many doctors all over the country still see midwives as competition, especially over patients who have insurance. There are many people pushing for more alternative birth methods, though, including the creation of a center where water birth would be available. As more and more women choose midwives over physicians the conservative model of medicine and pregnancy in Athens will hopefully change to something more woman-centered and friendly for the community.

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