

Midwifery: Thriving Amidst Chaos



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Presented at ACNM's 50th Annual Meeting

As a profession, we have been serving women in the United States for over 80 years and the American College of Nurse-Midwives is celebrating its 50th anniversary as our professional organization. We have accomplished much and we should take the time this year to celebrate and reflect on these accomplishments as they are the source of our passion and continued commitment to the women and families we serve, as well as to our cherished profession of midwifery. Truly, we have come a long way with babies!

However, we all recognize that in the last 10-15 years we have seen tremendous change in our profession, as well as the overall health industry. I refer to the "health care industry," as Mary Kroeger, CNM often labeled it. We both concluded that the term "health care system" is an oxymoron. The health care industry is focused on productivity and cost control and is anything but systematic.

Healthcare financing with managed care, the information explosion in science and technology, the composition of the healthcare workforce, the economy, the domestic and global priorities of our administration, changing demographics, and the increased complexity of the health care system are some of the forces of change that have had a tremendous impact on all of us. While productivity, cost control and efficiency have become increasingly important, a quality chasm in health care delivery has developed.¹

The very safety of care is in question and medical error frequently "feeds the fires" of litigation, while reasonable tort reform seems to remain as an elusive goal. In addition, far too many Americans are without access to health-care including timely prevention and screening, diagnosis and treatment, resulting in continued and increased disparity in health status, especially for racial and ethnic minorities. We know this is true when we assess maternal and

infant mortality and morbidity for whites and non-whites in the United States. We know this is true when the poor and uninsured or underinsured use the emergency room as primary care provider. In short, the health care system is in a period of disequilibrium and chaos.

If one applies quantum and chaos theory to this situation, we can expect that this will impact the entire system, as we are all interconnected and interdependent in ways we cannot even articulate.² According to chaos theory, the period of instability and flux will lead to a period of accelerated change, followed by stabilization, and then once again destabilization. I believe that the current period of instability and accelerated change can be used to benefit our profession and women's health care. It is paradoxical to think that this upheaval and disorganization could result in positive change.

"We must lead the revolution in practice, education and research related to midwifery and women's health. In order to do this, we must not lose heart."

In this tumultuous environment where the Cesarean section rate is out of control, the cost of liability insurance has skyrocketed and it seems like we are constantly being forced to compromise our autonomy and our values to practice midwifery (not obstetrics), we must grasp every opportunity to lead the revolution in health care. We must lead the revolution in practice, education and research related to midwifery and women's health. In order to do this, we must not lose

heart. We must not be immobilized by our problems; instead we must rekindle our passion to ride out the inevitable storms. Most importantly we must hang onto our basic principles, the hallmarks of midwifery, and develop a clear vision of where we are going and why.

Kennedy's work has clearly identified that it is our belief in normal that defines us as midwives practicing midwifery and separates us from other care providers practicing obstetrics.³ If you believe that birth and other life transitions are normal, then supporting, facilitating and studying "normal" would be the primary focus of our work.

Interventions would not be routinely applied to all, but personalized based on individual needs and circumstances. Yet, we find ourselves in a depersonalized system that routinely applies technology to improve outcomes. This is the major source of angst for most of us. As Becker said, "our art is our life" and the midwife is a human instrument to help a woman and her family get what she needs, while respecting her choices.⁴ Midwifery and obstetrical practice have been affected by a culture of fear and risk aversion, as well as the lure of technology and the illusion of control of natural processes. This period of instability and change has deeply affected our collective psyche and we must recommit to our foundational belief in the normalcy of birth.

Here's a test to find out whether your mission on earth is finished: if you are still alive, it isn't (Richard Bach). For sure, our mission is not yet finished. It is obvious to most of us that today's model of health care delivery is failing to serve a large percent of the population, consuming more and more resources every year, is distributed unevenly, has varying standards of quality and causes thousands of unnecessary deaths annually. We as midwives do not want to continue to support this system as it implodes, but we are part of it, and must continue to participate in it. However, we must not let it immobilize us or opt out of the

continued on page 9

President's Pen

from page 3

profession we love. We must devote energy to creating a new vision, a powerful and clear one to inspire and unify us in the path forward.

I do not have all of the answers or know what our long range vision of midwifery or women's health care looks like, but I am hopeful that collectively we can articulate our vision for the future and develop specific recommendations to get there. We must lead the revolution. To start, I have asked the Board to initiate a Future of Midwifery Symposium, starting with a focus on midwifery education and practice. The Board has also recognized the need to restructure the organization in order to better respond to members needs and partner with members to solve problems as they arise, as well as incorporate member expertise across divisions and committees.

I do have some principles in mind to guide us in the meantime, including strengthening our **belief in normal, autonomy, partnership, and education.**² Our belief in normal can be strengthened in several ways: do everything you can to keep a woman's choice for a normal birth as a choice. For example, reclaim labor support (don't turn it over totally to the doula, nurse or partner), as it can be psychologically as empowering to you as to the woman; attend a home birth or out of hospital birth center birth; and model your passion for normal for your students. Make your birth stories heroic, positive stories, not depressing ones. Get rid of those fear-feeding books or less than helpful books and support those in line with your values as a midwife. Stop using risk labels such as high risk, low risk. It stresses the idea that all women are at risk. Let's change our mind set and use the optimality measures, an alternative approach to evaluating the outcomes of midwifery care. Optimality looks for the best possible outcomes and replaces the focus on risk and adverse outcomes, while normal is often defined as the absence of risk or poor outcomes.⁵ The optimality index as developed and presented by Aikens Murphy and Fullerton better reflects midwifery practice and philosophy.

Maintain your **autonomy** in practice. Recognize that our standards of practice do NOT require a signed agreement with an MD to practice. When negotiating, realize you cannot control every-

thing, but bring an attitude of commitment and cooperation, and do not compromise your principles. (Choose principles over profit, as Benjamin Franklin said). Participate in committees, bylaws revisions, and department meetings whenever possible. Watch your language and your state regulations. Are you a midwife, an advanced practice nurse or both, a provider, a mid level, or a non-physician? Autonomy is often related to your title. Are you an autonomous practitioner under state law? What happens when you apply for hospital credentialing? What happens when you are reviewed or disciplined? Address restrictions of your autonomy and get help from ACNM as needed.

Partnership is critical. Link your practice to education programs and researchers – that way we can help each other. Establish a relationship based on mutuality with other care providers and your consultant. Maintain your connections to other midwives in the community, in your state and nationally through ACNM. Know who your friends are and include nurse practitioners, other midwives, physicians, administrators, legislators, your friends, relatives and clients. We are always more powerful when acting together.

Basic and continuing midwifery **education** continues to be an important foundational element for competency. We know there are many ongoing challenges for our education programs. While we don't need to make everyone into a researcher, we do need be able to evaluate, apply or even debunk the evidence. We also need more research on normal processes, for example Joyce Roberts' research on normal labor and Leah Albers research on the management of the perineum, to name two of our paradigmatic midwifery researchers. These research findings need wide dissemination in both the scientific literature, such as the *Journal of Midwifery & Women's Health* and the popular press. We also need to be able to educate women even before they are pregnant and continue throughout pregnancy and parenting. The Centering model of pregnancy care is an example of education, social support and midwifery care that can enable us to make a difference in a cost controlled environment. Women need the real information about Cesarean, VBAC, epidural, and choices for labor support. Women believe they will avoid incontinence, that's its safer for them and the

baby, they will have less pain (no labor), have more control over the birth including timing and even have better sex! Education and informed consent for Cesarean and VBAC are sorely lacking and we can change that. ACNM has launched a campaign called operation REDUCE – Research & Education to Decrease Unnecessary Cesareans. This is a public outreach effort led by the American College of Nurse-Midwives and a network of like-minded allies to call attention to the rising Cesarean section rate in this country. Our primary aim is to compel the United States Congress to scrutinize this issue and examine the various factors underlying the rise in Cesareans in this country. Congress should be concerned about the direct and indirect costs associated with Cesarean section—one of the most frequently performed medical procedures in this country—and the impact the increased rate of surgery is having on publicly financed health care systems such as Medicaid.

We must continue to engage in coalition building with other women's organizations, and create a stronger public relations and marketing campaign than ever before. We must also direct our educational efforts toward our legislators. We need political action aimed at questioning technology in childbirth. We need to educate our legislators about the Cesarean epidemic and the decline in VBACs, which presents a clear and unnecessary danger to women and infants. I have asked Congress, on behalf of ACNM, to hold hearings on this issue and I hope you will also urge your legislators to get this on the national agenda. We must lead the revolution.

As Gandhi said – Be the change you want to see in the world. **Q**

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