Midwives Deliver

Midwives monitor, comfort, encourage, and educate, as well as deliver, for less than the cost of doctor-assisted childbirth in a hospital

by Aurelia C. Scott

It's easy to miss the building, set back as it is on a quiet street behind hundred-year-old cottonwoods. It looks like many of the houses in Taos, New Mexico—single-story, adobe-brown, rambling into a lopsided V shape as rooms were added for an expanding family. Then you pause, noticing the handcarved wooden sign that hangs near the driveway's entrance. It's a stork bearing a diaper-wrapped bundle in its beak. Below the stork is the legend: "Northern New Mexico Midwifery Center and Birth Cottage."

If you go inside on this particular Tuesday and walk down the longest part of the V, you'll find Tina Earl settled into an easy chair in one of the center's two birthing rooms. Two-week-old McKenna Earl nurses at Tina's breast, oblivious to the midwife who is wrapping a cloth tape measure around her head; this is McKenna's first formal checkup, and she is doing fine. Actually, says the midwife, "she's perfect."

Until nine months ago, Tina had always assumed she would give birth to her first child in a hospital. Then she visited the midwifery center for one of the free pregnancy tests they offer. "I liked it here," she says. "The midwives made me feel comfortable. When I asked, they said that my husband could help deliver the baby, and I wouldn't have to lie down if I didn't want to. They even said they would come help me have the baby at home. My husband thought that sounded great, but I liked the rooms here at the center."

Two weeks ago, McKenna was born in one of the center's birthing rooms, instead of the hospital Tina had always pictured. At the moment of birth, Tina left the room's wide double bed and sat on a birthing stool, which looks something like half a toilet seat set on three legs. Leaning back against a midwife's supporting legs while another midwife wiped her brow, she delivered baby McKenna into her husband's waiting hands.

In coming years more women may have the opportunity to choose the

Midwife Elizabeth Gilmore holds one of her deliveries, 11-month-old Onaayo Thomas, the daughter of midwife-apprentice Lori Clinchard.

PHOTOGRAPHY BY ALEXANDRIA KING

type of midwife-assisted childbirth that Tina chose. As part of its health reform package, the Clinton Administration is proposing to train and recruit midwives, nurse practitioners, and physician's assistants to work in rural states. For less than the cost of specialists and hospitals, these allied-health professionals can provide underserved rural Americans with the primary care that most people need most of the time—broken bones mended, flu shots administered, and babies born.

The Administration's proposal reflects America's renewed interest in midwifery—the art of women assisting women during childbirth. Before World War I, most American women gave birth at home with a midwife and family members in attendance. Doctors were called if a problem arose. While it disappeared in urban areas in the 1920s, this social form of childbirth remained the norm for rural women well into the 1940s. After World War II, though, homebirth and the attendant midwife virtually vanished in the United States.

In large part, midwifery's ebb resulted from Americans moving to the cities, away from their hometowns, families, and local midwives. Attitudes about pregnancy changed as well. What was once seen as a moderately safe experience became, according to one Boston obstetrician, "a complicated and delicately adjusted process, subject to variations from the normal which may be disastrous to the mother or the baby, or both."

By 1940 most Americans decided that such a complicated process required a specialist who could—and often did—intervene, not a midwife who used patience, massage, and warm baths. Midwives were told to leave their work to the professionals. Some states, like Massachusetts, completed the move from midwifery by making it illegal.

Despite its effective banishment, midwifery persisted in pockets of the most rural states, such as Georgia and Alabama. And midwives have always practiced in northern New Mexico's isolated, mountainous counties. After all, doctors are expensive and the hospital may be two valleys away; yet babies are going to be born. It's better to at least have the midwife, whom you've probably known from childhood.

A painting by Taos artist Betty West brightens the wall at the midwifery center behind new mom Sandy Walcutt and her three-week-old son Gabriel.

How Do You Find the Midwife You Want?

Every state now has a midwifery association. Most states register or license midwives as they do other health care providers. (In New Mexico, for example, the Public Health Department and the New Mexico Midwives Association developed rigorous education programs for midwives, who are required to take license renewal tests every other year.) National testing and certification are available. And new midwifery training programs have been established in New Mexico, Washington, and Florida.

The Midwives Alliance of North America, founded in 1983, is the official registry of midwives in the United States. Abby Kinne, the alliance's membership director, can provide you with the names of midwives in your area and the telephone number of the midwives association in your state. Her address is PO Box 127, Raymond, Ohio, 43067; call her at (513) 246-3892.

Elizabeth Gilmore, Director of the Northern New Mexico Midwifery Center, offers the following questions for you to ask the midwife you call. They may help you decide if she is the right midwife for you and your family.

- Why did she become a midwife?
- How was she trained?
- Does she work alone or within a network of midwives?
- Under what circumstances would she transfer you to a doctor or ask for a second opinion?
- How would she research the answers to medical questions that she can't answer from her own knowledge?
- Does she express confidence in the ability of mothers to guide their own care? And does she seem to want to educate and inform parents as much as possible?
- Does she place her clients' interests first and believe that a mother's welfare and comfort are paramount?
- Does she encourage you to speak with her other clients?

Finally, as you would with any kind of health care provider, ask yourself if you like her. Does she make you feel comfortable?

In addition, midwives have often been willing to accept whatever a family could offer as payment—an important consideration in cash-poor rural areas. Take Erlinda Gonzales' grandmother, for example. In Las Vegas, New Mexico, perched high on the eastern slope of the Rocky Mountains, Gonzales recently brought 60 years' worth of handstitched quilts to be documented for a cultural history project. "Ah," she nodded, when asked how she learned her craft, "I learned from my grandmother in Bernal. She was the midwife there, you see, and people paid her with eggs or meat or sometimes cloth. She had all these different pieces of material from everybody, so she taught me how to quilt."

Midwifery's recent reemergence from backcountry isolation has been spurred by statistics showing most pregnancies and deliveries to be normal—they need monitoring, not surgical intervention. A shortage of obstetricians in rural areas and long distances between regional hospitals have also pulled midwifery back into the mainstream. More rural families are beginning to demand access to the benefits of local, family centered health care—care that includes home birth and midwives.

Two licensed midwives and a host of midwife trainees staff the sunny, plant-filled rooms of Taos's Northern New Mexico Midwifery Center. Midwife Elizabeth Gilmore founded the nonprofit birth center in 1982 with the active encouragement of the county hospital. Hospital physicians and nurses donated start-up equipment, including an examination table, and say they agree with Gilmore that most births are not medical crises. Since the center's founding, Gilmore has helped with the birth of more than 1,250 babies. With her strawberry hair braided around her head in the fashion of an earlier era, Gilmore doesn't look like a trendsetter. Yet, as a nationally certified, licensed midwife in rural America, Gilmore is in the vanguard of proposed changes to the health care system.

Inside the center's rambling building, slipcovers drape couches in floral print; corner rocking chairs encourage visitors to rest beside stacks of donated children's toys; and bookcases spill over with wellness and infant-care books. All the rooms—examining room, birthing rooms, meeting room, kitchen, and office—are peopled with images of mothers and children.

In the reception room, photographs of dazed but happy moms, dads, and infants color the heavy wooden ceiling beams. Thank you letters frame the midwives' posted licenses. And just to the right of the front door two bumper stickers are offered for sale: Midwives Deliver and Midwives Do It Gently.

An air of casual purpose prevails in the center. Women with bellies to the fore push the center's turquoise door wide and enter with the side-to-side roll of those in their ninth month. New mothers arrive for postpartum checks holding pristine baby carriers before them like gifts for the midwives. Still more women wander in with toddlers in tow. These last have come, as often as not, to sort through cabinets of children's clothes donated by the community and available to families in need.

Midwife apprentices handle the center's clerical tasks: Lori Clinchard (left), Carla Poindexter (right).

The midwives at the center, like all other licensed midwives in the United States, serve low-risk, healthy women for whom normal labor and delivery are expected—85 to 98 percent of expectant mothers, depending on which demographics one studies. For these women, the midwives provide complete prenatal, delivery, and postpartum care in the home and at the center. When specialized and expensive tests such as ultrasounds are needed, the midwives refer their patients to a consulting physician. And at any sign of a problem—from persistent maternal fever to fetal distress—midwives also consult with physicians.

In New Mexico, state law requires midwives to establish formal, working relationships with local physicians, and to alert those physicians when they encounter any of

a long list of prenatal, labor, postpartum, and newborn risk factors. Midwives in New Mexico, like midwives in most states, are also required to refer their patients for one physician visit during pregnancy, and to arrange for a physician who would intervene should problems arise during labor. American midwives, unlike some of their British and European counterparts, are not allowed to perform operative or augmentative procedures, which include administering drugs to induce labor and using vacuum extractors to pull infants down the birth canal more quickly. However, midwives in this country do use surgical equipment to cut and suture episiotomies, administer antihemorrhagic drugs, and perform full neonatal resuscitation when necessary.

In addition to pregnancy and childbirth care, the midwifery center provides birthing, parenting, and family support classes. It offers free pregnancy testing. And the midwives encourage women to attend their well-woman reproductive health clinics. All these services are covered by insurance and Medicare. Yet, says Gilmore, since neither insurance nor Medicare cover all the costs, and because she willingly treats women without any insurance, the center is managed on the proverbial shoestring. Those who can pay are charged $1,800 for center or home prenatal care and delivery. Clients who cannot pay trade for the services they receive: They plow the drive in winter, maintain the flower garden in summer, build bookshelves, and clean the office. To make up the seemingly endless shortfall, the center relies on donations and a lot of community goodwill.

"You're talking to the midwives?" people ask. "Well, they're wonderful."

Sitting with the sun shining through her halo of hair, midwife Gilmore smiles a Madonna-sweet smile and speaks so softly one must lean forward to hear her. "Life is fatal," she says. "No one can guarantee a perfect outcome; not in childbirth and not in the rest of life." And yet, emphasizes this mother of three, "labor is set up by nature to be successful. So our most important job as midwives is education. Women who know more, do better. We must teach women and their families to have confidence in themselves and in their ability to take charge of their own pregnancies and their own lives."

Thus mothers weigh and measure themselves; they help interpret test results; they monitor and chart the growth of their babies to be. Midwives urge mothers to bring family and close friends with them for checkups and educational meetings. And parents are encouraged to help deliver their own babies.

While Kelly Stebbins's first child was born in a hospital, her husband helped deliver their second child at the center. The difference between those two experiences has made Stebbins appreciate Gilmore's dictum that self-care is the cornerstone of a safe pregnancy. "I learned more (at the center) about being pregnant than I'd ever learned the first time," says Kelly. "They taught me so much, and they gave me choices, rather than just telling me how it would be. I guess you could say that they taught me to trust myself."

Women and their families are drawn to midwives for varying reasons. "Some are scared of hospitals," reflects Gilmore. "They want a more reassuring environment to have their baby. Others are willing to go to the hospital, but they don't have insurance and can't afford the fees. Some of our moms belong to special religious groups (that proscribe male doctors from caring for women or forbid the medical interventions so usual in hospital births). And, of course, lots of the women just want or need a safe home birth; we can give them that."

Three weeks ago, Cynthia Silva gave birth to her third daughter, Sophia, at home. While Cynthia and Joey's first girl, Gabriella, was born in one of the wide pine beds at the center, Sophia was their second child to be born at home.

Cynthia's description makes a home birth sound easy, even pleasant. "It's so much nicer to have a baby at home," she says. "You don't have to get dressed, go someplace else through who-knows-what weather, then get back in the car afterward when the only things you want to do are sleep and feed the baby. Instead, the midwives come to you."

Licensed Midwives and Certified Nurse Midwives

Licensed midwives are women who have received post-secondary and often graduate degrees in midwifery. After finishing their education, they take state exams and the national certification exam offered by the Midwives Alliance of North America. Certified nurse midwives are registered nurses who have received a graduate-level degree in midwifery. They are certified by the American College of Nurse Midwives.

There are two differences between nurse midwives and other midwives. Depending on the state, nurse midwives may prescribe a greater range of prescription drugs, such as antibiotics, than other midwives; they may also have more hospital admittance privileges, allowing them to work in hospitals with their own clients. Conversely, some states do not allow nurse midwives to work outside hospitals, barring them from helping with home births or working in freestanding birth centers.

Midwife MeLissa Bauer (left) talks with mom Jean McGowan, who holds onto her son Elijah.