

**THE ROLE OF MIDWIFERY CARE IN URBAN SETTINGS:  
MITIGATING DISPARITIES AND EXPANDING ACCESS**

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A Thesis  
Submitted to  
the Temple University Graduate Board

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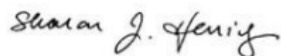
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## ABSTRACT

Midwifery has existed for thousands of years, and midwives have been providing care to women and birthing people in both medical and non-medical settings. Physicians specializing in obstetrics and gynecology and midwives are both able to care for pregnant women and birthing people, but do so in differing ways. When examining the distribution of women's health providers across different areas of the United States, there seems to be a disparate number of midwives in urban areas. Given the rising maternal mortality rates in the United States and focus on equitable care and expanding access to care, I sought to explore the role of midwifery in urban settings, and midwives' role in mitigating adverse outcomes in vulnerable populations. Amidst time spent in numerous maternity wards within the same urban area, I've noticed different versions of how midwifery care is implemented, as well as distribution of this care. This thesis will discuss the role of midwives generally, and how midwives are integrated into care in urban settings. I will then discuss the geographic imbalance of midwifery care, how midwives can and do assist to mitigate health disparities, and how midwives improve maternal and neonatal health outcomes. Lastly, I will discuss how patients in urban settings view midwifery care and my view and recommendations on what the future of midwifery care should look like integrated into urban settings.

## **DEDICATION**

To my incredible medical school friends,  
who have supported me and each other  
for the last four years.

I can't wait to see all the wonderful  
things we all do!

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## CHAPTER 1: INTRODUCTION

### The Role of Midwives and Types of Midwives

Midwives have been providing care to women and birthing people since the paleolithic era (40,000 B.C.) (International Confederation of Midwives 2022). The reputation of midwives has changed over the years, as midwives were seen as high-class professionals in the early 2000s B.C. In the late B.C. period, midwifery went from being an empowering, scientific profession to being integrated under the hierarchy of male-dominated medicine. In the early AD era, midwives were in fact seen as witches and were burned to death. Historically (and still today), midwifery has also differed geographically. In China, midwives tended to practice techniques that align with Eastern medicine. In Thailand and Chile, midwives were originally primarily treating the underserved. In Africa, midwives have been the primary providers for birthing people for hundreds of years. In the early United States, many enslaved women were trained as midwives and treated both African and white birthing people until the late 1800s (Rooks 2022). At this point, medical obstetrics began to take over, and white male doctors took control (Chakraborty 2018).

Despite differing roles for midwives over time and across the globe, the International Confederation of Midwives (ICM) shares a common definition (American College of Nurse Midwives 2017). A midwife is defined as a licensed, registered individual who has completed a midwifery education program that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education. Furthermore, the ICM defines midwives as a

“responsible and accountable professional who works in partnership with women [and birthing people] to give the necessary support, care and advice during pregnancy, labor and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.” The ICM endorses that midwives have a crucial role in health counseling and education, not only for the woman or birthing person, but also within the family and the community. In terms of setting, the ICM states that a midwife can practice in the home, community, hospitals, or clinic.

### *How Midwives Differ from Physicians*

As previously mentioned, medical obstetrics began to take over in the late 1800s. By the early 1900s, births were equally divided between midwives and obstetricians. However, in the following years, physician births would become the norm, as childbirth was now being seen as pathologic (Chakraborty 2018, Jenkinson 2017, Rooks 2022). Around the same time, the Flexner Report, a report on American medical education, was published. The Flexner Report set the stage for modern day medical education, which included implementation of teaching hospitals (Flexner 1910). In obstetrics, this translated to the isolation of midwives, and increased training for obstetricians on birthing patients. Teaching hospitals particularly attracted a patient population that was Black and poor, thus the report has not only been criticized for the ostracization of midwifery, but the perpetuation of systemic racism (Duffy 2011). About ten years later,

in 1921, the Sheppard-Towner Act was ratified. Originally aimed to promote improved maternal and child health, the Sheppard-Towner Act led to the creation of many additional maternal-child health centers and decreased infant mortality rates. However, this act ultimately reinforced hierarchies of race and socioeconomic status and contributed to the decline of midwifery in the United States, as individuals encouraged physician-led hospital-based birth (Coleman 2014). Despite these barriers, midwifery re-invented itself as nurse midwifery in the mid 1900s with the implementation of certified nurse midwives (CNMs). In the post-World War II era, CNMs were called on by the very same hospitals that ostracized them to assist with the high volume of births occurring. While physicians continued to focus more on pathologic birth and intervention, CNMs focused on the patient's birth experience (Jenkinson 2017). These experiences included family-centered birth, patient education, mother-baby rooming, and breastfeeding. All midwives, not just CNMs, tend to practice obstetrics in the aforementioned way—with more emphasis on the patient experience, support, and physiologic birth (Ellmann 2022). In terms of education, obstetricians complete a bachelor's degree, a medical degree (MD or DO), a residency (four additional years of training), and must pass a universally administered board exam. Midwifery education differs depending on the type of midwives, which will be discussed below.

### *Community vs. Hospital Based Midwives*

As previously mentioned, nurse midwifery first gained momentum about seventy-five years ago. The midwives in practice prior to that are what would now be referred to as “direct entry midwives.” CNMs first must become registered nurses (typically through

a bachelor's degree or accelerated program after a bachelor's), then complete a master's program in nurse midwifery (an average of 3 years), and then pass a universally administered certification exam. As CNMs are nurses by training, their practice is typically clinic and hospital based, though they may practice in any setting, and are licensed in all 50 states (American Midwifery Certification Board, Midwives Alliance of North America 2018). Direct entry midwives include certified midwives (CMs), certified professional midwives (CPMs), and licensed midwives (LMs) in some states. These individuals have differing educational paths from CNMs and may practice in either hospital or non-hospital, (community-based) settings, depending on the specific type. CM's have very similar training to CNM's (bachelor's degree followed by a master's degree, same licensing exam) but are not trained nurses and are not licensed to practice in all 50 states. They also have a very similar scope of practice, as they may also practice in any setting, typically hospitals. CPMs make up most direct entry midwives in the United States and are the only type of midwives that require knowledge about and experience in non-hospital settings. Their education and clinical training focuses on midwifery in homes and birth centers, as they do not practice in hospitals. CPMs are also not licensed to practice in all 50 states and are credentialed by the North American Registry of Midwives, not the American Midwifery Certification Board like CNMs and CMs (American Midwifery Certification Board, Midwives Alliance of North America 2018). A third class of midwives exist, traditional midwives. Traditional midwives are exclusively community based, and do not undergo certification or licensing. These midwives believe midwifery is a social contract and that birthing people should be able to choose their provider regardless of legal or education status (Midwives Alliance of North

America 2018). Due to the emerging prominence of doulas as part of contemporary maternity care, it is important to distinguish that doulas are not a type of midwife. Doulas are not a primary maternity care provider, but rather are non-clinical individuals who strive to provide physical and emotional support to pregnant people throughout pregnancy and the peripartum period (Ellmann 2022).

### Models of Maternity Care and Impact on Maternal and Infant Outcomes

In this next section, I will discuss the different modern-day models of maternity care offered in the United States, and how these models of care affect maternal and neonatal outcomes. There are several models of care including what is perceived as the current conventional model, the laborist model, the midwife model, and the collaborative model. In the conventional model, an obstetric physician follows a pregnant person throughout pregnancy and delivery, but may or may not be available at the time of delivery depending on other clinical duties (Srinivas 2016). If able, the provider who knows the patient well, will be there for delivery. Introduced roughly fifteen years ago, the laborist model consists of a hospital-employed obstetric physician that staffs the labor and delivery unit without any competing clinical duties. Patients may see one provider in the outpatient prenatal setting and will have whoever is “on call” deliver their baby (Srinivas 2012, Srinivas 2016). The midwife model approaches childbirth differently than physician-based models by aiming to be more nurturing and hands-on, promoting individualized patient education and minimizing unnecessary intervention (Citizens for Midwifery 2014, Midwives Alliance of North America 2020). Midwives may provide continuous support for birthing people through pregnancy and the postpartum period,

while acknowledging a patient's life experiences and nurturing communication (American College of Nurse-Midwives 2020). Midwives may care for patients in both the outpatient and in the delivery setting and emphasize psychological and social well-being of the pregnant person, education, and minimal intervention. Lastly, the collaborative model of care consists of obstetricians, midwives, family medicine physicians, and nurses working collaboratively to take care of patients (Boston University Obstetrics & Gynecology, Chang Pecci 2012). In terms of outcomes, recent data has shown that compared to the traditional model, the laborist model may decrease adverse outcomes and result in lower rates of preterm birth and induction of labor (Srinivas 2016). Midwifery models have long been shown to have reduced morbidity and mortality, as the countries with the lowest rates of these adverse maternal and infant outcomes have well integrated midwife models (Midwives Alliance of North America 2020). The collaborative model has an increased emphasis on safety culture and de-emphasization of hierarchy, as well as improved patient satisfaction (Healthy Mother 2021). In discussing models, it is crucial to further highlight how physician-based obstetrics differs from midwife based maternity care. As previously mentioned, midwives traditionally avoid intervention while obstetricians practice induction and augmentation of labor, episiotomy, epidurals, and cesarean sections (C-section). A cornerstone of midwifery practice is positioning during labor, while physicians may be more likely to jump to intervention. While emphasizing psychological well-being of the pregnant person, midwives classically act as an additional support person for the patient and spend large amounts of time one-on-one. Conversely, physicians who have multiple other patients and competing clinical duties may check-in with laboring patients more sporadically

(Healthy Mother 2021). Additionally, midwives provide care across the childbearing continuum, with special attention to the postpartum period (Jefford 2019). The postpartum period, also known as the *fourth trimester*, has long been a focus of midwifery care with emphasis on breastfeeding, mental health, and birth recovery (Kitzinger 1975, Verbiest 2017). Only more recently has medical obstetrics acknowledged the paramount importance of the care after discharge from the hospital, while this has always been a fundamental aspect of midwifery care (ACOG Committee Opinion Number 786). While there is no right or wrong way to practice obstetrics, it is important to be aware of the differences in practice.

#### *The Maternal Mortality Crisis and Access to Care*

Models of care cannot be discussed without addressing the rise in maternal mortality as well as barriers for access to care. Over the last thirty years, maternal mortality has increased in the United States, particularly among non-Hispanic Black birthing people (Centers for Disease Control and Prevention 2022, Petersen 2019). Structural racism is one of the culprits behind this disparity, as income and education level are not protective factors in improving outcomes (Crear-Perry 2021, Kennedy-Moulton 2022, Taylor 2019). The Centers for Disease Control and Prevention (CDC) recently reported that pregnancy-related deaths steadily increased from 7.2 deaths per 100,000 live births in 1987 to 17.3 deaths per 100,000 live births in 2018 (Centers for Disease Control and Prevention 2022). Even more disturbing is the fact that Black birthing people experience three to four times the number of deaths than white birthing people. Due to this rise, the CDC and many states have implemented surveillance

systems to assist in identifying contributing factors to rising maternal mortality with hopes for intervention and mitigation. In fact, the CDC's national Pregnancy Mortality Surveillance System identified that most pregnancy related deaths are actually due to preventable causes (Petersen 2019). Deaths are considered preventable if the state maternal mortality review committee determines that there was some chance of the death being averted by one or more reasonable changes to patient, community, provider, health facility, and/or system factors (Zaharatos 2018). This has been recognized by the American College of Obstetricians and Gynecologists (ACOG) and highlighted the need for increased concentration on access, quality, and safety in obstetrics (ACOG Obstetric Care Consensus Number 9). When it comes to accessibility of care, ACOG recognizes levels of obstetric care, to ensure that high-risk patients have access to adequate care with providers of appropriate training. In the 1970s, many states implemented a regional model of obstetric care in order to improve neonatal outcomes (March of Dimes 2010). For example, a pregnant person with a preterm infant would be transferred to a hospital with more multidisciplinary neonatal resources. The success of this model has promoted implementation of regionalized care to improve maternal outcomes, and has resulted in a classification system to establish levels of maternal care: basic care (level I), specialty care (level II), subspecialty care (level III), and regional perinatal health care centers (level IV) (ACOG Obstetric Care Consensus Number 9). Though not included in ACOG's classification, ACOG recognizes accredited birth centers, which often use a midwifery model of care as a crucial part of regionalized care. Accredited birth centers are freestanding facilities that provide peripartum care to low-risk birthing people and are not considered hospitals (American Association of Birth Centers Standards). Birth

centers typically offer midwife-led care and physiologic childbirth, and do not offer interventions such as epidural analgesia and cesarean birth. They may be owned by CNMs or CPMs, or a combination of both depending on the state. Their governing body, the American Association of Birth Centers (AABC) states that these centers should have relationships with higher level care centers in the event that the pregnant person or infant needs more complex care. While this will be discussed further, it is important to note that accredited birth centers provide obstetric care in underserved and rural communities, allowing for improved access to care. Without these accredited birth centers (and smaller hospitals), care gaps could widen and lead to increasing disparities (Hung 2017, Hung 2018, Kozhimannil 2017, Kozhimannil 2018).

### *Midwifery Mitigating Disparities in Care*

As mentioned, birth centers and the midwifery model of care have an important role in mitigating disparities in obstetric care by providing increased access to care. Expanding access to midwives is not only a way to reduce disparities in maternal health outcomes and improve experiences of birthing people, but also can decrease healthcare costs, which will be discussed later (Vedam 2018). Several studies have shown that integration of midwives is known to be associated with improved maternal health outcomes and lower rates of medical intervention in birth (Attanasio 2017, Dekker 2013, Julian 2020, National Academies 2020, Raisler 2005, Scarf 2018, Souter 2019, Vedam 2018). A study mapping midwifery integration into the health care system across the United States found that increased access to midwives was associated with higher rates of Spontaneous Vaginal Delivery (SVD), Vaginal Birth After Cesarean (VBAC), and

breastfeeding (Vedam 2018). This study also found that increased midwifery access was associated with lower rates of C-section, preterm birth, low birth weight infants, neonatal deaths, and overall obstetric interventions (Vedam 2018). Furthermore, states with the lowest integration of midwives (based on a midwifery integration scoring system) had the highest rates of Black births and neonatal deaths, highlighting that Black pregnant people have poor midwifery access when in fact this is the population that needs it the most (Vedam 2018). Additional research has also shown that midwifery care improves clinical perinatal health outcomes for Black birthing people specifically (Niles 2021). In addition to mitigating medical disparities, midwifery improves maternal satisfaction with the child-bearing process (Niles 2021, Sandall 2015). A study that surveyed many midwives found that the cornerstones of midwifery care are health-promoting, individualized, and narrative-based care which aim to diminish the emphasis on pathology driven care, efficiency, and intervention (Niles 2021). In addition to structural racism, barriers to comprehensive healthcare coverage in the United States also contribute to the disparities in maternal health outcomes. Despite higher spending costs than any other country on maternal health care with near universal access to emergency obstetrical care, the United States remains to have these rising rates of morbidity and mortality, especially among Black birthing people. Given that increases in intervention and spending have not led to reduction in morbidity and mortality, increasing midwifery presence in hospital-based obstetric care would (and has been shown to) provide more birth equity. This topic, along with additional barriers to midwifery care will be discussed in Chapter 3. In addition to midwives prioritizing narrative-based care, patients also value respect, autonomy, and patient-provider relationships. Increasing emphasis on these

tenets (through further midwifery integration) are an excellent way to improve outcomes (Niles 2021).

## CHAPTER 2: MIDWIVES IN URBAN SETTINGS

### My Personal Experience and Reflections

As a current fourth year medical student in a large urban setting, I have spent a fair amount of time in three different labor and delivery units in one metropolitan area. By no means does this make me an expert, but I have observed varying structures and behaviors and have spoken with attending obstetricians, resident physicians, and midwives about their goals and experiences. My first experience working with midwives was at an academic-affiliated community hospital, located in a high-income urban area. In the “workroom” (the place where all providers typically work between seeing patients), there were attendings, residents, and midwives. The physicians had patients, and the midwives had patients, each of whom their respective practices had followed throughout pregnancy. When new patients who had prenatal care elsewhere arrived, if they were low-risk, they would be assigned to a midwife, and if moderate or high-risk, to a physician. This hospital practiced a type of collaborative model of care—midwives would take residents to low-risk deliveries, midwives would ask attendings questions about concerning fetal heart tracings, and if midwife patients ever needed a C-section, they would first assist with a physician. My second labor and delivery experience was at a large academic medical center located in a low-income urban area (with over twenty-five percent of individuals living below the federal poverty level). At this hospital, midwives and physicians would work together to take care of *all* patients, both low and high-risk. If a patient had seen a midwife during pregnancy, they could ask for them to be involved in their care, but otherwise one cervical exam may be done by a midwife, and

the next by the resident. In the workroom, midwives, residents, and attendings would discuss all patients collaboratively, and occasionally if a resident was in the room with a patient during delivery and wanted a midwife's expertise with position changes or infant rotation, they were called in to help. That being said, the midwives were only present a few shifts each week at this academic urban center, in contrast to the community hospital where they were present nearly continuously. My final experience was at a second academic medical center, also located in a low-income urban area. In this setting, there were separate workrooms for attendings, residents, and midwives. While it's possible this was due to space limitations, it seemed to hinder natural collaboration. On my observation, the residents would take care of all laboring patients. One or two shifts each week, there would be a midwife on labor and delivery. The midwife would come into the resident workroom and ask which patients she could best support. The chief resident would let her know which patients were low-risk, and the midwife would assume care of one or two of them. The midwife would go back to her separate workspace, and typically be the sole provider for her patients. There was little collaboration between the physicians and the midwives, and only became apparent to me when midwives were concerned about fetal heart tracings and wanted to discuss C-sections. Of course, the culture and structure of every hospital is unique, but I personally found it interesting how within ten miles of each other, the integration of midwives varied substantially. The patient populations of these three hospitals varied greatly, with the community hospital having a low proportion of Black patients, the first academic hospital being about sixty percent Black, and the second academic hospital being over eighty percent Black. This begs the question, do Black patients have less access to midwifery care? While the outcomes are

important, I truly feel that patients being able to have the option for both physician and midwife care is crucial, especially through a collaborative model. Regardless of demographics or geographics, birthing people should have a say in who participates in their care.

### *The Balance Between Residents and Midwives*

Additionally, I wanted to touch further on my experience on the balance between residents and midwives. As I mentioned, some labor and delivery units are more collaborative than others. Midwives are less integrated in urban medical centers (to be discussed further), however, these urban medical centers are more likely to be academic or teaching hospitals that have residents. As stated by the Accreditation Council for Graduate Medical Education (ACGME), the governing body that sets standards for all residency training programs, obstetrics and gynecology residents must achieve certain competencies and complete a certain number of deliveries (as well as other obstetric and gynecological procedures) in order to graduate (Accreditation Council for Graduate Medical Education 2022). Residency programs are approved for a certain number of positions (and funded by the government accordingly) based on case logs from past residents and/or reported hospital volume of cases. Especially in urban medical centers where deliveries are more likely to be high-risk with higher rates of infant mortality, there are generally fewer low-risk deliveries (Meit 2014). From an educational and competency standpoint, obstetrics and gynecology residents are expected to become experts in both low-risk and high-risk (patients with medical and obstetric comorbidities, multiples, advanced maternal age) deliveries (National Institute of Child Health and

Human Development 2018). Of course, like with any educational course, there is a learning curve, and learners are expected to master the “simpler” content, i.e., low risk birth, before mastering the more “complex” content, i.e., high risk birth. Typically, there are not excess cases for other providers, including midwives, given that the number of residency positions is determined by the volume of cases. If programs have excess cases, they are able to petition the ACGME for additional slots, which leads to additional funding, and is fiscally advantageous for hospitals. From an economic standpoint, it is much more beneficial to hire additional residents if able, than advanced practice providers (APPs, including midwives, nurse practitioners, and physician assistants). For example, the University of New Mexico lost its accreditation for its neurosurgery residency program which had eight positions, each one with an annual salary on average of \$50,000. In order to compensate for the loss of manpower, the hospital had to hire twenty-three APPs, each making over double the average residency salary, costing the hospital over five times as much money (Carmody 2022). Residents are often overworked, working up to eighty hours a week, whereas APPs typically work more standardized hours, and may even get paid overtime. In the final chapter, I will discuss how we can mend this, resulting in midwives not only being providers, but also universally as an educational resource for residents.

### Where are the Midwives?

Switching gears, we cannot discuss midwifery in urban settings without discussing where midwives are practicing, both in the United States and abroad. Generally, the distribution of midwives is not uniform.

### *Geographic Distribution*

The geographic breakdown of midwives is not binary, i.e., all the midwives in urban areas or all the midwives are in rural areas. According to the United States Bureau of Labor Statistics, states with the highest employment of midwives are California, New York, Texas, Pennsylvania, and Massachusetts (American Midwifery Certification Board 2021, U.S. Bureau of Labor Statistics 2022). Previous research has found that the counties in the United States that have higher proportions of midwives tend to have lower populations, less hospitals, and be of lower income—suggesting that these areas tend to be more rural (Langwell 1980, Scupholme 1992). More specifically, in Arizona (a state that employs between one hundred-forty and two hundred-twenty midwives), midwives in rural areas tended to practice more comprehensive midwifery care (prenatal care, intrapartum care, and postpartum care) as opposed to in urban areas with higher proportions of physicians (Gordon 1993, U.S. Bureau of Labor Statistics 2022). Conversely in Colorado (a state that also employs between one hundred-forty and two hundred-twenty midwives), the majority of midwives reported practicing in urban, hospital-based settings, and is proposed to be a consequence of practice limitations that restrict midwife autonomy (Hastings-Tolsma 2015, U.S. Bureau of Labor Statistics 2022). In Europe and Canada, there tend to be more midwives in rural areas, whereas in India, midwives are well integrated in urban settings (Lisonkova 2016, Pricilla 2017, Winkelmann 2020). In Mongolia, there is actually a relatively even geographic distribution of midwives (Erdenee 2020).

## *Types of Practices*

Beyond geography, it is important to cover the actual types of practices where midwives are integrated. Types of practices include general hospitals (where labor and delivery units can be found), physician offices, private midwifery practices, outpatient care centers, birth centers, and health centers including federally qualified health centers (FQHCs) (Carter 2012, Frost 2019, U.S. Bureau of Labor Statistics 2022, Yellin 2021). There are higher numbers of midwives in physician offices and hospitals compared to outpatient care centers and health centers (U.S. Bureau of Labor Statistics 2022). However, birth centers likely contain the largest proportion of midwives and are considered to be the midwives' *domain* (Yellin 2021). There are over one hundred-thirty birth centers in the United States accredited by the AABC. The states with the largest number of birth centers are California, Texas, Colorado, Oregon, Florida, Washington, and Arizona (American Association of Birth Centers Find a Birth Center). Since we have already reviewed birth centers, I will mention midwives in health centers. Health centers may serve as a safety-net for low income and uninsured patients, with over ninety percent of health center patients having income below two hundred percent of the federal poverty line and over thirty percent being uninsured. Though these health centers are not hospitals or birth centers where people can give birth, midwives are increasing in numbers in these settings and assisting in providing primary and women's healthcare (Carter 2012). In fact, health centers have begun collaborating with birth centers in order to provide longitudinal, accessible care for underserved birthing people (Frost 2019). Community of Hope in Washington, DC is an example of this; providing accessible, equitable, family-

based care (Community of Hope 2019). While there are over one-hundred and thirty birth centers in the United States, some major urban areas are still lacking (American Association of Birth Centers Find a Birth Center). Philadelphia is one of those cities, and thankfully, the Family Practice and Counseling Network (FPCN) in Collaboration with the University of Pennsylvania's School of Nursing are working to remedy this (The Family Practice & Counseling Network). Due to rising maternal mortality rates, over ten years ago, the Department of Health and Human Services created the Strong Start Initiative, which had a goal to improve the quality of prenatal care for Medicaid recipients by providing additional services and to reduce costs during pregnancy, birth, and the infant's first year of life (Centers for Medicare & Medicaid Services 2022). Grant recipients to fund this initiative included almost fifty birth centers. The initiative demonstrated that low-income birthing people who were able to utilize birth centers had better outcomes and lower costs including lower risk of preterm birth, low birth weight babies, and lower C-section rates (Shannon 2019, The Family Practice & Counseling Network). The positive health and financial outcomes from this initiative align with the previous research (Chapter 1, Section IIB), that favor improved midwife integration (Vedam 2018). The FPCN's new birth center in Philadelphia aims to take the results of the Strong Start Initiative to specifically improve access to this population thereby improving outcomes (The Family Practice & Counseling Network).

## Who are the Midwives?

### *Demographics*

A demographic report from the United States in 2021 found that the average age of midwives was forty-nine years old, with over sixteen percent being over age sixty-five. Ninety-nine percent of midwives identify as female. Over eighty percent of midwives identify as white and over ninety percent as non-Hispanic or Latino. Approximately seven percent of midwives identify as Black, which slightly increased from the year prior. Over ninety-five percent of midwives primarily speak English, but over thirty percent also speak other languages (American Midwifery Certification Board 2021).

### *Racial Concordance and the Resurgence of Midwifery Among Birthing People of Color*

Perhaps this section should be titled *Racial Discordance*, given the fact that over ninety percent of midwives identify as white, and the majority of underserved birthing people are not. As previously mentioned, in the early days of the United States many enslaved Black women were trained as midwives. These African American midwives, known as “Grand Midwives” (previously “Granny Midwives”) took care of both Black and white birthing people (National Museum of African American History and Culture 2022, Rooks 2022). As obstetrics became medicalized in the second half of the twentieth century, “Grand Midwives” in common practice were phased out. As structural racism and implicit bias became keystones in society, Black healthcare workers in general (including obstetricians) were few and far between (National Museum of African American History and Culture 2022). Currently in obstetrics, approximately eight percent

of obstetrics and gynecology residents identify as Black, and approximately eleven percent of midwifery students identify as Black (Accreditation Commission for Midwifery Education and American College of Nurse Midwives 2019, Nguyen 2021). Given the rising maternal mortality rate and resurgence of midwifery among Black birthing people, both the ACGME and the American College of Nurse Midwives (ACNM) acknowledge the need for further diversity in providers in order to mirror the patient population. While not specific to pregnancy care, Black Americans report decreased trust in the healthcare system given years of mistreatment and abuse by healthcare providers (Kennedy 2007). Given midwives' alternative, more patient-centered approach to birth, this mistrust has led to an increase in demand for midwifery services among Black birthing people (Rafanelli 2022). However, this resurgence of midwifery care among Black birthing people may be attributed to multiple factors: improved outcomes in midwife births, increased sense of community, and distrust in physicians (Farzan 2022). Multiple initiatives to increase diversity among the midwifery profession exist (American College of Nurse-Midwives, Farzan 2022, Greenwood 2020, Wren Serbin 2016). The Black Midwives Alliance as well as Direct Relief and the National Association of Certified Professional Midwives have established scholarship funds to assist aspiring Black midwives (National Black Midwives Alliance, Rafanelli 2022). In fact, when looking at a cohort of almost eight hundred aspiring midwives of color, the strongest motivating factors for these individuals was to provide racially concordant care and reduce racial healthcare disparities. The main barriers to entering the profession identified by this group included cost, current racial discordance, and fear of exclusion of people of color (Mehra 2023). Given this information, the financial contributions of the

above organizations will hopefully start to close these gaps, but without government funding and expansion of loan forgiveness programs, scholarships can only go so far.

## CHAPTER 3: THE PATIENT PERSPECTIVE

### Patient Experiences with Midwifery Care

Despite discussing provider roles and outcomes, we have hardly touched on one of the most important aspects of maternity care—the patient perspective. Many birthing people have extremely positive experiences with midwives. A number of studies have previously examined this, many through surveys. Over the last twenty years, there have been five *Listening to Mothers* surveys, which were the first to investigate birthing people’s attitudes, beliefs, preferences and knowledge on a broad range of maternity topics. While all surveys are filled with a great deal of important data, I will specifically be highlighting patient’s attitudes and experiences with midwives. The first survey, done in 2002, found that midwives provided care to about ten percent of births in the study, but midwives received the highest ranking in terms of most supportive care compared to other providers (Maternity Center Association 2002). Additional studies have also found that midwifery care is associated with high maternal satisfaction (Shaw 2016). A follow up survey ten years later found that over fifty percent of birthing people who had care from a midwife reported that this care was supportive, compared with thirty percent of birthing people who received care by obstetricians (Declercq 2013). Specific birthing people surveyed stated that they would have chosen a midwife for childbirth had that been an option, but there were none available that were covered by insurance. Birthing people also commented that midwives protected the process of birth and were so grateful for the beauty of how they experienced childbirth. One of the most recent renditions of the survey, given specifically to birthing people in California, found that while majority of patients used an obstetrician for their prenatal care and births, over half of respondents

said they would definitely want or would consider a midwife for a future pregnancy (Sakala 2018). Another survey is *Giving Voice to Mothers*, which was the first survey to specifically address patient mistreatment during childbirth. One in six women or birthing people reported experiencing mistreatment such as: loss of autonomy; being shouted at, scolded, or threatened; and being ignored, refused, or receiving no response to requests for help. Experiences of mistreatment differed significantly by place of birth: five percent of respondents who gave birth at home experienced mistreatment versus twenty-eight percent of respondents who gave birth at the hospital. Factors associated with a lower likelihood of mistreatment included having a vaginal birth, a community birth, a midwife, and being white, multiparous, and older than thirty years (Vedam 2019). Rates of mistreatment were higher among birthing people of color, birthing people of color with low socioeconomic status, and birthing people who had a Black partner, further highlighting the aforementioned role of racism in childbirth. Additional surveys including the Mother's Autonomy in Decision Making (MADM) scale and Mothers on Respect Index (MOR*i*) further highlight patient's autonomy, quality and safety during maternity care (Vedam 2017a, Vedam 2017b). The MADM survey, specifically assessing birthing people's autonomy during maternity care, found that MADM scores were highest among those cared for by midwives. This suggested that compared to physician-based care, birthing people who had midwife experiences had increased agency and autonomy in decision making. Additionally, the MADM study found that midwives typically spent thirty to sixty minutes with patients in each prenatal visit, whereas physicians spent less than fifteen minutes; and patient's sense of autonomy increased with more time for prenatal appointments (Vedam 2017a). The MOR*i* survey, specifically assessing birthing

people's experiences regarding disrespect and discrimination during maternity care, found that birthing people cared for by midwives were least likely to have low MORi scores. Birthing people who saw a midwife had higher scores (experienced less disrespect and discrimination) regardless of birth setting (home, birth center, hospital) (Vedam 2017b). Additional research has shown that patients report improved communication during childbirth with midwives and less use of medical jargon (Sanders 2021). Selected quotes in many of these surveys also highlighted positive midwife experiences, for example: "During my prenatal care I had the option to use my [doctor] or a nurse midwife that I met with on my first visit. I really like both, but chose the midwife because she seem[ed] to have more time to spend and was really helpful with resources and wanting to coordinate care with my outside therapist due to ongoing depression issues" (Sakala 2018). Furthermore, many positive "birth stories" are a result of midwife-based care, and patients share these stories publicly on the internet (The Midwife Center 2020).

### Barriers to Midwifery Care

The above discussion has shown that many patients have had positive midwife experiences or prefer midwife care, however this is not universal. Some patients do prefer physician-based hospital birth over midwife-based birth center birth. In one study, patients who preferred hospital-based birth were more likely to be Black, publicly insured, or nulliparous. Reasons for preferring hospital birth included insurance restrictions, family preferences, and more pain relief options (Kozhimannil 2015). Additionally, in the aforementioned *Listening to Mothers* survey done in California, one-quarter of respondents said they definitely would not want a midwife for reasons

including beliefs that doctors provide higher quality care and that doctors handle emergencies better. These reasons suggest a lack of knowledge about midwives and the high quality of maternal care they provide, and in fact, many patients did not know enough about midwives to have an opinion (Sakala 2018). A survey assessing college students' beliefs on midwifery found that the majority of respondents perceived childbirth as dangerous, that intervention is a necessity, and doubted the quality of midwife care (DeJoy 2010). In addition to preferences and misinformation, one of the biggest barriers to midwifery care is cost. As mentioned previously, *Listening to Mothers III* found that birthing people stated that they would have chosen a midwife for childbirth had that been an option, but there were none available that were covered by insurance (Declercq 2013). Classically, accessing care at a birth center with a midwife has not been affordable. Black Americans are two times more likely to be poor than their white counterparts, and Medicaid in most states does not cover birth center bills (Rafanelli 2022). According to the CDC, white birthing people are more than three times more likely to give birth in birth centers when compared with Black birthing people, and this is likely due to financial inability given studies show that both races would feel equally safe giving birth in such settings (Birth by The Numbers, Sperlich 2017). While this gap is in the process of being narrowed through the aforementioned birth center-health center collaborations, we still have a ways to go. Despite a number of barriers to midwifery care, birthing people are open to this form of care, and many prefer it. That being said, a patient should make the informed decision of who takes care of them, whether that be a physician or a midwife, and all patients should have access to information and all provider types.

## CHAPTER 4: CONCLUSIONS

### Improving Access and Recommendations

#### *Improving Access*

It is clear that midwives improve outcomes among birthing people and more specifically underserved and historically marginalized patients, many of whom live in urban areas. There is certainly a growing need for midwives nationally, particularly in these regions. Therefore, improving and expanding access to midwives is of paramount importance. There are a few important realms to consider that will be revisited and discussed in this section. First, as many urban medical centers are academic and have resident physicians, I make the case for the ability to improve midwives' integration when there is a limited number of deliveries. Second, given the success of birth centers and the rise of midwives in health centers, I discuss how we can normalize this and expand access further. Lastly, as midwives have historically been phased out due to the medicalization of birth, our country has adopted a narrative that refers to midwives as "medieval" or "strictly natural" (Illinois State University Staff 2013). In order to integrate midwives further into common practice, it is important to diminish bias.

#### Midwives in Medical Education

As discussed in Chapter 2, Section IA, it is fiscally beneficial to hire residents over midwives. But given that birthing people in this country continue to have horrifying outcomes, do we *really* need to prioritize profitability? What if instead of creating

additional residency spots, hospitals hired more midwives to cover the excess low-risk births? This would not only expand access to midwives in large academic medical centers, but also be extremely educational. Instead of residents learning only from attending physicians, what if midwives were standardized as part of their teachers? While attending physicians are certainly competent and capable, midwives truly are the *experts* in physiologic birth (Consensus Statement by ACNM, MANA, and NACPM 2013). As I mentioned from my personal experience, it was wonderful to witness midwives being an active part of the treatment team and mentoring trainees. Existing research also shows that when midwives are an active part of academic medicine, their clinical and teaching expertise are valued in medical education (Feinland 2010, McConaughey 2009). If midwives were a standardized part of graduate medical education, perhaps this would assist in improving access.

### Expanding Care in Urban Settings

In Chapter 2 Section III we discussed demographics of midwives as well as racial concordance. We explored the initiatives in place to expand education for aspiring Black midwives, as well as the collaborations between birth centers and health centers leading to expanded midwife care. If underserved patients are able to get their prenatal care in a health center, they can get looped into a birth center when the time comes for delivery. Experts have examined this model of care and found that this approach helps overcome organizational, financial, and cultural barriers while resulting in greater access to family-centered intrapartum care (Frost 2019). It is my hope that with cities like Washington,

DC and Philadelphia as models, additional urban areas will see the success of these collaborations, ultimately leading to improved maternal and neonatal outcomes.

## Reducing Bias

I have made my case for why increasing access to midwifery care would improve outcomes for historically marginalized birthing people in urban settings and we have a number of ways to implement this. But there are still negative biases towards midwives and towards underserved patients. How can we reduce these and finally move forward? Many biases towards midwives come from previously mentioned historical shifts and stereotypes including that midwives don't let patients have pain control or epidurals and that midwives are uneducated (Coleman 2014, Flexner 1910, Illinois State University Staff 2013, Princing 2018). Improved access to midwifery will only help to diminish these biases. From a patient perspective, providers have implicit biases that Black or low socioeconomic status patients are automatically high-risk, and therefore wouldn't be candidates for a midwife birth (Afulani 2021, Teleki 2021). A new law in California passed in 2019 (the California Dignity in Pregnancy and Childbirth Act) requires hospitals to offer an evidence-based implicit bias program for all of their perinatal care providers aimed to reduce pregnancy-related preventable deaths and associated health disparities (Teleki 2021). This training should not be limited to physicians and nurses, but also include midwives. Black midwives have previously provided incredible care to Black birthing people, and with the achievement of anti-racist midwifery care, we can diminish the existing disparities (Aseffa 2021, Grayson 2021). In terms of successful models of midwifery care, they do exist (Vedam 2018). While we know integration of

midwives is better, that being said, we still lack a sample model for this type of collaborative care model (McFarland 2020).

## Conclusions

Despite midwives playing a crucial role in maternity care for many years, our country has subpar midwifery integration and maternal outcomes. This narrative reviewed the roles and types of midwives, the various models of maternity care that exist, and the tragic reality of rising maternal mortality in our country. Through these lenses, we discussed my personal experience with models of care and midwifery integration in urban settings. We highlighted patients' perspectives on midwifery care, as well as the many barriers that exist to successful integration of this care. These barriers include but are not limited to: balancing resident physician education with midwife care in hospitals, cost of midwifery care and sparsity of birth centers in urban settings, societal biases towards midwives, and patient factors such as misinformation and lack of education. We discussed the framework for these barriers, ways we are improving, and ways we can improve further. Our healthcare system has many flaws, and inadequate distribution of midwifery care in urban settings is just one of them. Though given the rising maternal mortality rate in the United States (particularly among birthing people of color) and the positive outcomes associated with midwifery care (specifically *well-integrated* midwifery care) it is of paramount importance that we pay close attention to these barriers and solutions to overcoming them. Narrowing this gap will accelerate equitable, autonomous, and accessible care for all birthing people.

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