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Midwives Practice CAM: Feminism in the Delivery Room

Judith T. Shuval, MA, PhD, and Sky E. Gross, MA

This article focuses on midwives who practice complementary and alternative medicine (CAM) in Israel. After qualifying as nurses in mainstream biomedical institutions, these midwives have, at some point in their careers, opted to study a variety of CAM skills and practice them in hospital delivery rooms in Israel. The authors explore the relationship of selected elements of feminist ideology to the epistemology of CAM midwives. Seven context-specific themes are viewed as central to their epistemological stance: rejection of the medicalization of birth; a strong belief in the “naturalness” of childbirth; rejection of the overuse of technology; empowerment of women; nostalgia and reverence for the past; centrality of intuition, feeling, and emotion; and active advocacy. In-depth, semistructured interviews were carried out during 2004 to 2005 with 13 midwives. These narratives provided empirical material for a qualitative analysis. Evidence is shown to demonstrate the unique feminist quality of the core beliefs of the CAM midwives.

Keywords: midwives; Israel; boundaries; feminism; complementary and alternative medicine

Among nurse midwives who are trained and experienced in mainstream biomedicine, there are some who, at one point or another in their careers, have opted to study a variety of complementary and alternative medicine (CAM) skills and to practice them in hospital delivery rooms in Israel. We will refer to this population as CAM midwives. This article focuses on the feminist quality of the norms and values that underlie their professional ideology. We seek to demonstrate the congruence of selected elements of feminist ideology to the epistemology of CAM midwives in Israel.

The research reported here is an additional link in our work on the interface between biomedicine and alternative medicine in the health care profession. Earlier articles have dealt with physicians and nurses who, after completing their biomedical socialization, have entered into the practice of one or several CAM fields. We have been interested in the negotiative processes of boundary crossing and “boundary work,” which take place when alternative practitioners work within the organizational context of biomedical institutions (Gieryn, 1983, 1999). Our principal focus has been on modes of behavior, resolution of apparent conflicts among different epistemologies, and patterns of interaction among actors in settings in which biomedical and alternative health care are provided by the same individual. All these studies have been carried out in Israel (Lifshitz-Milwidsky, 2007; Mizrachi & Shuval, 2004; Mizrachi, Shuval, & Gross, 2004; Shuval, 1999, 2001, 2006; Shuval & Mizrachi, 2004; Shuval, Mizrachi, & Smetannikov, 2002; Smetannikov, 2007).

From the Department of Sociology and Anthropology, Hebrew University of Jerusalem, Jerusalem, Israel.

Address correspondence to: Judith T. Shuval, MA, PhD, Department of Sociology and Anthropology, Hebrew University of Jerusalem, Jerusalem, 91905 Israel; e-mail: msshuval@mscc.huji.ac.il.
Midwifery in Israel

The midwives included in the present study are all qualified nurses (registered nurses) who have completed an additional 1,000-hr training course in midwifery. The midwifery course is taught by qualified practitioners from Israeli medical schools, combining theory with clinical experience. It includes supervision of the trainee in at least 50 births. It focuses on the obstetrical model of care as taught in biomedical contexts. Successful completion of the course involves passing a government-administered examination, which provides the midwife with a license to practice. At the end of 2004, there were 1,215 licensed midwives in Israel. They constitute 10% of the nurses with specialized training and 4.2% of all the nurses. In the course of this article, the term midwife refers only to nurse midwives.

There are about 150,000 births a year in Israel. Almost all the births take place in hospitals—a condition for the woman to receive a maternity grant from the government (the equivalent of about $300 for a first birth and $100 for subsequent births). This policy was established by law in 1954 to encourage women to deliver in hospitals. In effect, it almost eliminated the non–nurse midwives because such persons, lacking biomedical training, are unable to obtain jobs in hospitals. In 2002, there were only 290 planned homebirths (Tel-Oren, 2002).

In the obstetrics department, most hospitals have at least one rotating nurse midwife working in a section set aside for early labor. This midwife examines the woman and fills in her chart before she is admitted to the labor ward. After admission, most hospitals have separate labor rooms for each woman. The woman is placed in a bed, attached to a fetal monitor, and an intravenous routine is started. Vaginal checks occur at about every hour. When there is a 4- to 5-cm cervical dilation, the woman is encouraged to take an epidural analgesia injection containing a combination of local anesthetics and opioids, which provides relief from the pain of labor as well as anesthetizes the lower part of the body below the point in the spine where it is given. In 2003, 39% of the women received epidural anesthesia. The routine tasks of midwives include rupture of membranes when deemed necessary by a physician, attachment of fetal monitoring devices, injection of intravenous fluids, and delivery in lithotomy position (i.e., lying on the back with knees bent and elevated above the hips with the thighs apart) (Cohain, 2004; Israel Midwives Association, 2005; Israel Ministry of Health, 2004; Reches, 1978; Slome, 2004; Tel-Oren, 2002).

Among midwives in Israel, interest in CAM developed in the context of changing values and norms in other health professions and in different segments of the society. Midwives practicing CAM at the start of the 21st century represent a small, marginal group among midwives in Israel. As in other developed societies, they have been influenced by increasing exposure to Eastern spirituality and to postmodern values, which have raised pertinent questions about the ability of science and technology to provide answers to human problems including illness (Coburn & Willis, 2000).

Midwives’ growing interest in CAM may be seen by their enthusiastic participation in courses in CAM geared specifically for midwives. A number of these have been held in the past 5 years in six different hospitals in Israel, in some cases under the sponsorship of the hospital administration. In the curriculum of a 108-hour course for midwives in alternative health care techniques offered at an elite Jerusalem hospital in 2004, the following subjects were presented by expert practitioners in each field: shiatsu, reflexology, imaging, natural...
childbirth, naturopathy, Paula technique, reiki, touch therapy, aromatherapy, herbal medicine, Chinese pressure points, and body movement during labor. Most emphasis was placed on reflexology, reiki, imaging, and natural childbirth (more than 10 hours of instruction for each). In the above-mentioned hospital, the course was partially subsidized by the hospital, and all midwives were encouraged to participate in the course (Cohain, 2004; Israel Midwives Association, 2005; Israel Ministry of Health, 2004; Reches, 1978; Slome, 2004; Tel-Oren, 2002).

**Feminism and Alternative Midwifery**

Rushing (1993) has noted that nurse midwives in the United States and Canada have sought legitimation for their practice through a juxtaposition of science and feminism. The initial study of the empirical material gathered for this article led us to consider those midwives who incorporate CAM techniques into their practice as a special category of feminists (Davis-Floyd & Davis, 1996). In Klassen’s terms (2001a), their views may be seen as postmodern and “post biomedical”: They do not deny the usefulness of biomedicine, but they challenge its hegemony via alternative systems of knowledge and practice. Much of the ideology that lies behind their approach to birthing is anchored in a set of beliefs and values that are related to ideas and theories that are essentially feminist and parallel those of feminists who advocate home birthing. This distinguishes them from the majority of nurse midwives who generally show few overt signs of active feminism in the work context.

Midwives’ feminism does not relate to prominent feminist issues such as wage equality, conditions of work, occupational advancement, or gender gaps in status and prestige. As a wholly feminine occupation, midwifery is not seeking to gain entry into more prestigious occupations traditionally dominated by men. Indeed, the “semiprofessions,” traditionally categorized as women’s work, have not been a major focus of interest for the dominant feminist movement (Bernhard, 2003; Lewin, 1977).

**Methods**

In our effort to investigate the congruence of selected elements of feminist ideology with the epistemology of CAM midwives in Israel, we decided to use qualitative methods in the form of in-depth interviews with a small number of midwives engaged in CAM practice.

In seeking to locate this population, it quickly became apparent that there was no comprehensive list of such practitioners. Using informal sources of information and snowball sampling methods, we located the subjects who were located in many parts of the country. We soon found that many practice more than one form of alternative care.

The study population consisted of 13 midwives, all of whom have experience working in hospital delivery rooms in five different hospitals in Israel. Most are currently employed in such settings whereas a few have recently retired. All of the interviewees were first contacted by telephone and asked if they would consent to an interview of 1 to 1½ hours. Anonymity was assured. None refused. Under these stringent conditions (anonymity and informed consent), there is no requirement in Israel for an institutional review board approval for this
type of research. One of the authors (SEG) set up an appointment and an interview was scheduled in hospitals or in the interviewee’s home. At the end of the interview, each person was asked if she could provide names and locations of other midwives who also use CAM methods. Interviewing was terminated when ongoing analysis of the findings showed that saturation had been attained. The field work took place during 2004 to 2005.

After a careful study of the written material available and informal observation in the delivery rooms of several hospitals, an interview guide was designed. The interviews were informal and semistructured in terms of this guide. Subjects covered a wide array of topics relating to the midwife’s individual background and training, motivations, experience in practice, and modes of negotiating among different health practice cultures. The interviews yielded a rich set of informal narratives. All were taped—with the agreement of the interviewees—and were subsequently transcribed into systematic computerized records.

The analysis was based on grounded theory as developed by Glaser and Strauss (1967) and by more recent scholars (Miller & Fredericks, 1989; Strauss & Corbin, 1999).

Intensive reading and rereading of the texts led to the identification of the principal themes relating to the core beliefs of the CAM midwives. In the course of the narrative interviews, the midwives spoke freely and were keen to help us in understanding their stance with respect to these ideological positions.

The interviews enabled us to make sense of the social context of the practice settings; these findings are summarized at the beginning of the “Findings” section below. We then present the seven feminist themes that emerged from the narratives and finally a selection of the midwives’ in situ remarks relating to each of the themes as empirical evidence for their adherence to what we have defined as the principal components of the midwives’ epistemology.

Findings

Structural Characteristics of the Midwives’ Practice

All the midwives interviewed in this study worked routinely in delivery rooms of public hospitals in Israel, either full-time or part-time. A small number also offered prenatal care within the context of the hospital program or privately. Thus, most of the alternative care provided by midwives is given within the context of a hospital, an obvious biomedical institution. In this respect, they differ from nurses practicing CAM, whose main locus of alternative care is in a territorially separate, non–biomedical setting, generally under private settings (Shuval, 2006).

The midwives’ training in CAM was obtained in short-term courses offered in a variety of settings and of differing quality. Some courses take place under the auspices of one of the schools for CAM practice; others are offered by experienced practitioners in hospital settings as described above.

As noted, all uncomplicated births are delivered by licensed midwives in hospitals, that is, 80% of all births. The midwives and their support personnel constitute the active staff of the delivery rooms. Physicians are generally situated in adjacent locations and are summoned by the midwife only when needed. This structural differentiation unambiguously defines the physician’s domain as one of “pathology,” whereas the midwife’s territory is formally
limited to “uncomplicated,” that is, healthy, nonproblematic births. When there is no “real”
medical problem, physicians play no active role in the delivery.

The alternative fields of practice used by midwives include a variety of CAM practices
noted above, but focus on techniques used during labor and childbirth: reflexology, reiki,
imaging, and natural childbirth.

On arrival in the delivery room, a woman in labor is assigned to an attending midwife.
Those midwives interested in using alternative methods and minimizing the use of an epidural
perceive every arrival as a potential client. Some claimed they could sense, on first meeting
a woman, whether she was open to acceptance of CAM methods during labor. CAM mid-
wives are always careful in obtaining informed consent for use of their methods and in
responding to requests for conventional procedures during labor—if the woman is unwilling
to continue with alternative techniques.

CAM midwives are well aware that physicians differ in their views regarding alternative
medicine and its application to women in childbirth. Many doctors are known to be adamant
in their opposition and hostility to alternative care, whereas others hold different views with
regard to the various forms of alternative practice, ranging from extremely negative to posi-
tive with varied levels of approval between the two poles (Shuval & Mizrachi, 2004).
However, the fact that many obstetricians in Israel favor natural childbirth provides impor-
tant legitimation to one of the central tenets of the midwives’ beliefs and serves as a major area
of consensus for physicians and midwives. Interviewees noted that some of the physicians—
although not present in the delivery room—were well aware of their use of alternative meth-
ods and efforts to minimize the use of an epidural in the interest of promoting a completely
natural birth. Thus, introduction of alternative methods by the midwives is neither clandestine
nor fearful; they report doing it with confidence even in the presence of physicians.

At the same time, CAM midwives are aware of their legal and moral responsibilities and
of the possible consequences to them and their career if they fail to comply with the doctor’s
instructions. They are therefore extremely cautious and circumspect in introducing alterna-
tive methods when they know that a specific doctor objects. Several emphasized the gradual
process of persuading physicians over time and avoidance of conflict. Part of their strategy
is to make sure to obtain the woman’s consent. They all accept the premise that life-threatening
conditions always call for biomedical intervention.

Midwives who work in hospital delivery rooms in Israel provide a unique example of the
autonomous introduction of alternative techniques into a biomedical setting. In the relative
freedom of their separate practice setting, midwives are able to exercise initiative and inde-
pendence in introducing these methods to predisposed consumers. Their confidence in
doing this is bolstered by the virtual presence of physicians nearby—who are on call in case
of need. At the same time, they relish their autonomy, which is fully legitimized by the
medical community; their autonomy is expressed in the deliberate allocation of the vast
majority of uncomplicated births to their care. They are qualified and licensed biomedical
workers—a status that endows on them the authority to judge the appropriateness or inap-
propriateness of procedures used during labor and birth. In a new birthing facility set up at
an elite hospital in the Tel Aviv area, one midwife stated proudly:

There are no doctors around . . . we midwives run everything . . . . You don’t even feel that the
doctors are in the vicinity . . . it’s a wonderful feeling!
The Feminist Ideology of CAM Midwives

Scrutiny of our empirical findings led us to suggest that the CAM midwives adhere to a set of interrelated ideas that may be viewed as an epistemological stance composed of selected elements drawn—explicitly or implicitly—from the broader context of feminist ideology. However, it appears that the midwives have focused on a specific set of feminist concepts, which are meaningful in the context of their work. Their feminism is context specific to their occupation; there is no evidence to suggest that these beliefs spill over to create a more general feminist stance among them. Neither is their closeness to certain elements of feminism necessarily an explicit or conscious choice. One thinks of Scott’s (1998) suggestion that homeopathy may be considered a feminist form of medicine because it addresses more social issues than does biomedicine and also because it addresses the mind–body duality, which has been at the center of interest of recent feminist activists. It would seem that the midwives who incorporate CAM into their work seek to emphasize the uniquely female contribution of their practice. This is seen in their emphasis on “female qualities,” for example, emotions, feelings, meaning of experience, individual support, and care rather than cure.

The principal components of the midwives’ epistemology are given below.

**Theme 1: Rejection of the medicalization of birth.** Although the medical establishment has turned birth into a potentially pathological event, CAM midwives insist on viewing the process as normal and natural (Davis-Floyd & Davis, 1996). Many obstetricians adhere to a pathology-oriented view, emphasizing the risks and danger of pregnancy, which often require active medical intervention (Evenson, 1982).

The notion of resisting the medicalization of birth was originally led primarily by feminist activists seeking bodily autonomy for women. Pregnancy is, in most cases, not experienced as illness and has in itself, on a phenomenological level, few elements of risks (Young, 1990). Various social groups are, in fact, responsible for projecting ideas of risk, danger, and illness onto the pregnant body and the process of birth. The medicalization of birth is strongly opposed by many midwives who are convinced that childbirth is not usually a medical condition (Klassen, 2001b). However, these views are especially strong among midwives in alternative practice, who see this stance as both self-serving and misinformed (Weitz & Sullivan, 1986).

**Theme 2: A strong belief in the “naturalness” of childbirth.** Birth is viewed by CAM midwives as a natural process, which should be allowed to take its course with minimum intervention. The use of epidurals and other medical procedures should be avoided as they are seen as interfering with the natural course of events. The time sequence and developmental process of a birth is dictated by the individual woman’s needs and should be allowed to proceed at its own pace with minimum intervention. The natural process permits women to “experience the whole of birth—its rhythms, its juiciness, its intense sexuality, fluidity, ecstasy, and pain” (Davis-Floyd and Davis, 1996, p. 240). It is viewed as “natural” to consider the individual as an inseparable whole in which physical and emotional needs are intimately related; one set of needs cannot be considered without dealing with the others. But the biomedical approach focuses essentially on the physical–biological process paying less, if any, attention to the emotional needs of women during childbirth.
Theme 3: Rejection of the overuse of technology. Biomedicine tends to emphasize and encourage the use of sophisticated technology. This orientation is prevalent in delivery rooms where women are immediately connected to a monitor where their progress can be carefully supervised and controlled. High-tech manipulation and technical control are strongly rejected by midwives in alternative practice as these are thought to render the woman invisible and inaudible. Davis-Floyd and Davis (1996) describe the “technocratic model” of birth as the core paradigm underlying contemporary obstetric practice, which results in depersonalization of women (Davis-Floyd, 1992). Under this model, authoritative knowledge (i.e., the knowledge on the basis of which decisions are made and actions are taken) is vested in machines and in those who know how to manipulate and interpret them. The predominant use of these machines during birthing is symbolic of how our culture emphasizes machines over bodies, technology over nature. Obstetrical procedures may be viewed as rituals that convey cultural core values to birthing women, and separate the birth process into a set of identifiable and controllable segments that transform it into a mechanistic process. From this viewpoint, linking women to these technologies gives them an illusion of safety (Davis-Floyd & Davis, 1996).

CAM midwives seek to help women to distance themselves quite consciously from the reach of the technocratic model during their birthing experience. They feel that drugs, needles, and the distant interpretation of lines on a graph depersonalize women; they are poor substitutes—in the view of CAM midwives—for the warm exchange of breath and sweat, of touch and scent, and emotions that characterizes birth (Davis-Floyd & Davis, 1996).

Theme 4: Empowerment of women. CAM midwives believe that the birthing experience is empowering for women and should be used to provide an imprinting experience of control over their bodies. The issue of control is strong in the context of birth: Who holds the authoritative knowledge? What is this authoritative knowledge: scientific techniques or intuition, womanly feelings? Who should make the decisions? (Hays, 1996). Indeed, the feminist literature on pregnancy has noted the conflict between “haptic” knowledge, which is essentially sentient, and “optic” knowledge, which is biomedical. The claim is made that women’s feelings can be fully expressed only when the former type of knowledge is not controlled by the latter (Browner & Press, 1996; Duden, 1993; Haraway, 1991; Shildrick, 1997). CAM midwives highlight the meaningfulness of giving birth; its uniqueness in the human experience is emphasized and extolled as a profound event with wide-ranging implications for the woman herself and for her child. They see birth as a display of women’s special power to bring forth life (Klassen, 2001a) and as a central symbol of autonomy (Evenson, 1982).

Theme 5: Nostalgia, reverence for the past. The past, when things are thought to have been simpler and more straightforward, is viewed with nostalgia and longing. CAM midwives regret the passing of a less sophisticated time, when life is thought to have been less complicated and when births took place in the home in a warmer, more supportive, and less threatening environment than the contemporary hospital. A similar trend has been noted by Tovey and Adams (2003) in their research among nurses using CAM in their practice.

Theme 6: Centrality of intuition and emotion. CAM midwives emphasize the centrality of emotions and intuition in the childbirth process. Their approach may be viewed in terms
of “indeterminate” knowledge as defined by Jamous and Pelouille (1970): The indeterminate (I) component refers to knowledge that is not entirely rational, is partly intuitive, and is located in the domain of individual interpretation and judgment. By way of contrast, these authors speak of the “technical” (T) component of knowledge, which focuses on rationality and logic.

The “I” component plays a central role in the professional orientation of CAM midwives. Davis-Floyd and Davis (1996) refer to a “deeply embodied” kind of knowledge that defies rationality or logic. As the CAM midwife is opposed to a linear, mechanical epistemology, she prefers to use intuition as a basis for action. This provides for an alternative “logic” or way of thought. In terms of cognitive research regarding the human brain, the left hemisphere belongs to analytical (male) logic, whereas the right one would favor Gestaltic perception and thought (female) (Kandel, Schwartz, & Jessel, 2000; Springer & Deutsch, 1993).

Such an approach is different from what we would expect from the biomedical encounter (Davis-Floyd & Davis, 1996). The language of instinct, invoking both animality and spirituality, acts as a powerful legitimator of birthing decisions that are often in opposition to the ways preferred by medical experts (Klassen, 2001b).

Theme 7: Active advocacy. Listening to the CAM midwives’ narratives, one cannot but be impressed by the special passion of their rhetoric. They do not view their doctrine passively but seem to feel a deep obligation to disseminate it among others. This is expressed in their enthusiasm and zeal for the ideology they have adopted and by their dedication to spreading it. Many CAM midwives have adopted a mission-like approach, which seeks to disseminate the word of their holistic values and their unique praxis regarding childbirth (Davis-Floyd & Davis, 1996). Indeed, they view it as their obligation to propagate their doctrine among pregnant women, obstetricians, and other midwives who have not yet been informed or persuaded of its many benefits.

Narrative Evidence for the Feminist Ideology of CAM Midwives

Theme 1: Rejection of the medicalization of birth. Not all of the CAM midwives express their objection to the medicalization of childbirth in an explicit manner; most midwives prefer to convey their convictions indirectly, through an expression of concern with the importance of natural childbirth and the overuse of technology.

The following are examples of direct statements on this theme:

Monitoring the baby’s progress has turned into a search for pathologies . . . which in most cases are not there, or go away by themselves.

It makes no sense to assume that every birth is a high risk . . . every woman does not need to be on the monitor . . . midwives can determine if there is a risk . . . 85% of births are completely normal and need no medical intervention.

As hospitals symbolize the heart of biomedicine, the location of childbirth within its confines may be viewed as the quintessence of medicalization. An advocate of home births emphasized the dysfunctions of hospital birthing:
Giving birth is a healthy act... it has nothing to do with pathology, and therefore should not be carried out in a hospital—unless there is clear evidence of a problem... Putting a woman in a place like a hospital is a bad idea to begin with... it puts her in a public place with rules and regulations that ignore her personal needs for privacy, family, and emotional support.

**Theme 2: A strong belief in the “naturalness” of childbirth.** The belief in natural childbirth is a dominant theme that is common to all the midwives interviewed. If there is one central tenet that serves as the heart of the CAM midwives’ practice, it is this belief, which was repeated in one form or another in almost all the interviews.

Giving birth is a healthy phenomenon, part of the natural flow of life... interference in this normal process, which is common to all living creatures, can only have negative effects.

A natural process is an ideal, primordial goal... the body knows what to do.

Birth is a primitive process and should remain natural... we are animals... it has nothing to do with logic.

Pain in giving birth is natural, but is neither “good” nor “desirable” in itself. It can be eased considerably by a variety of alternative methods so as to allow the natural processes to progress at their own pace. An epidural should be used only if the woman feels that the pain is unbearable.

Let nature take its own time... I object to speeding up labor; it’s better not to use epidural to reduce pain but rather massage and other techniques that are not invasive or drug-based... bodies are not machines.

Midwives who do not practice CAM are criticized for their “biomedicalism” and for failing to adhere closely enough to the natural order in childbirth.

Midwives [who do not practice CAM] have learned a lot of medical techniques... they need to get back to nature, to touch the natural process.

A belief in the centrality of mind–body “holism” is expressed in the following remarks:

There is a unity of mind and body... the body is not a machine.

Giving birth is a most profound moment when body and mind and soul come together.

**Theme 3: Rejection of the overuse of technology.** Our findings point to the fact that midwives are virtually unanimous in their objection—sometimes expressed in heated tones—to the overuse of technology in the birthing process by physicians.

Interfering in the natural process with pain killers reduces the unique, dramatic experience to a technical event.

Drugs interfere in the process and should be avoided... you never can know what effects they will have on mother or baby. Alternative methods cannot do any damage.
Epidural is the opium of hospitals . . . it is used as a “silencer” to keep things quiet, unemotional and under control.

**Theme 4: Empowerment of women.** Childbirth is viewed by CAM midwives as a form of empowerment of women. A natural birth is a great accomplishment and serves to give women a sense of achievement and power.

The midwife looked deep into the eyes of the woman and said triumphantly: “you did it!” . . . in order to give her a sense of triumph, of having done a splendid and wonderful thing.

When giving birth, a woman should be free of inhibitions—to scream, soil herself, weep . . . she should be able to act totally natural, animal-like, uninhibited . . . her body knows what to do . . . she should ignore all social norms and constraints on how to behave.

Some midwives see the birthing experience as a trial that fortifies the woman’s inherent stamina; by passing the test, she demonstrates her strength and resilience to herself and to others. One interviewee used the example of the Israeli army’s tough traditional trek to *Masada*, at the end of which soldiers are given a special cap, a symbol of success in that trying test of endurance.

The pain makes you stronger . . . it’s like the trek to Masada . . . going up by cable-car is not the same as climbing by foot . . . you get a special sense of achievement that fortifies you for the rest of your life.

Thus, it may be said that CAM midwives adhere to a special type of feminism that focuses on the empowerment of women by means of childbirth. A natural birth is a great accomplishment and serves to give women a sense of achievement and power.

**Theme 5: Nostalgia, reverence for the past.** Many midwives express a nostalgic yearning for a past, which is viewed as simpler, more “authentic,” less superficial, and less encumbered by technologies. It is seen as superior to the present and imbued with greater depth and meaning. This stance parallels Tovey and Adams’s (2003) view that the current interest of these professionals in CAM can be viewed as a continuation or revival of earlier patterns, which focused more on emotional needs and patient-centered practice.

In ancient Egypt we know that midwives used touch methods to help against pain . . . and even now we are told by immigrant women who came here from Morocco that they gave birth with midwives who helped them with massage and herbal brews.

Years ago, when a woman began to feel her first contractions she got the children to bed, made up a big pot of soup . . . summoned the midwife . . . and had the baby right there in her own home . . . no problems . . . Yes, it’s true that 15 or so percent of the births may have complications . . . but why do we need to make such a big fuss over the normal ones?

Some midwives express a longing for the “good old days” when midwives performed a variety of tasks, which added up to a meaningful whole that stretched over the pregnancy period, the delivery, and the postpartum months. In those days, her expertise included knowledge and use of herbal products, massage techniques, positioning the woman for comfort.
and ease during labor, delivering the baby, and provision of support and help after birth in breastfeeding and infant care. In recent years, there has been an emasculation in the midwife’s role, which has been expressed in a process of task differentiation, with the transfer of many of her traditional responsibilities to other specialists.

Delivery of twins and shifting the position of the baby in the womb are done by doctors because they are seen as risky . . . use of aromatherapy and herbal treatments are done by doolas . . . yoga teachers and other specialists have taken over the preparatory tasks . . . baby nurses take over the care of the child immediately after birth . . . specialists in breast feeding and care of newborn infants offer post partum help . . . all we midwives can do is deliver normal births.

There is a widespread belief that the older methods of delivery were based on a warmer, kinder, and more compassionate approach.

In the past, babies were delivered by caring, gentle, considerate people who helped the woman feel support and love . . . in the hospital today there is so much paper work and technology that there is no time to be kind to the woman.

Contemporary methods of delivery and infant care are thought to be accompanied by numerous pathological effects, which were rarely seen in the past: allergies to non–breast milk, digestive problems, breast infections, fever after birth, loss of the bonding experience of breast feeding, and ill effects of drugs.

In Israel, rabbis, leaders of other religions, and charismatic figures offer health care based on a variety of traditional beliefs and practices and many focus on problems of fertility and issues associated with childbirth. Their modes of healing are based on the use of ancient texts, traditions, and claims of access to spirits or deceased figures; their practices may involve astrological formulas, oracles, interpretation of dreams, use of special water, blessings over a holy grave, or manipulation of sacred names and verses (Shuval, 1992).

Despite the frequently expressed nostalgia, midwives who use alternative methods were concerned to make clear their separateness and difference from these traditional practitioners.

We have nothing to do with people who use cards, talismans, holy water . . . what good does a rabbi’s blessing do? It won’t make you get pregnant!

What’s the use of visiting someone’s ancient grave? . . . I’m all for spirituality . . . but not everything can be included in complementary health care.

**Theme 6: Centrality of intuition and emotion.** The “I” component of care, which emphasizes intuition and emotions, plays a central role in the professional orientation of CAM midwives. The midwives emphasize the idiosyncratic aspects of each woman’s experience and tend to be critical of those physicians who are highly “T” in their behavior and practice and who emphasize rationalized, routinized tests and technically prescribed procedures. The CAM midwives highlight the drama, uniqueness, meaningfulness, spirituality, and miraculous quality of the context in which they work. Both the woman delivering an infant and the midwife herself are caught up in the drama and emotionality of the experience.
Giving birth is a deeply emotional experience that requires support and empathy. Every birth is different, individual . . . it’s never the same . . . and its success depends on the intuition of the woman and of the midwife . . . you can’t do it “by the book.” The womb is a bridge between different worlds . . . there is a crossing over a boundary . . . birth is a profound experience . . . a miracle.

A midwife who specialized in reflexology emphasized the “softer” aspects of reflexology as contrasted to the “aggressive” techniques used by some practitioners:

Some reflexologists use cold, “blunt,” overly structured techniques . . . whereas I prefer a warm, sensitive, individualistic, empathetic approach to patients.

Theme 7: Active advocacy. Many of the CAM midwives feel that they have a mission, a “calling” to spread the message regarding the important contribution of their approach in improving the birthing experience: reducing fear, increasing a sense of achievement, and strengthening the relationship with the child. This orientation is accompanied in many cases by considerable zeal and passion.

This may sound presumptuous, but I feel I have an important mission . . . it’s like a religious feeling . . . this is not only a job . . . I have a “vocation” in my life . . . to let people know that there are alternatives available . . . women do not have to suffer so much in childbirth.

I feel a deep sense of mission . . . it imbues me with dedication . . . to help women overcome their fear . . . not to depend so much on painkillers . . . to strengthen their bonding with the baby.

In their zeal and commitment, some of the midwives criticized their colleagues who were less imbued with a sense of mission, referring to them as “bureaucratic” in their approach.

Many midwives (i.e., who do not practice CAM) have no real emotional commitment to their work . . . they don’t feel the experience of each woman as a meaningful one . . . all they want is to move the women along . . . it’s like a mass-production line . . . just get as many cases as possible through.

Midwives [who do not practice CAM] are busy with many women in labor . . . they rush around among them . . . they see separate, disconnected parts of the woman’s experience . . . but they never are able to see the entire process through . . . from beginning to end.

CAM midwives seek to convince women in labor of the effectiveness of their methods. In line with their respect for the autonomy of women during childbirth, CAM midwives report that they try to convince selected women, when they arrive at the delivery room, to try alternative methods during labor. At the same time, they made it clear that they never imposed their views if the woman did not consent. Furthermore, if—after trying alternative techniques—a woman insisted on receiving an epidural or a drug to encourage dilation, the midwife always agreed—despite her own beliefs that other alternative methods could be effective.
Discussion

The CAM midwives’ epistemology includes a set of axioms and values, which are congruent with selected elements of feminist ideology. Although there were few specific statements in the course of the interviews making this connection explicit, we have referred to a number of texts in the feminist literature, which discuss most of the ideological themes to which the midwives adhere (Browner & Press, 1996; Davis-Floyd, 1992; Davis-Floyd & Davis 1996; Duden, 1993; Evenson, 1982; Haraway, 1991; Hays, 1996; Klassen, 2001a, 2001b; Rushing, 1993; Scott, 1998; Shildrick, 1997; Weitz & Sullivan, 1986; Young, 1990).

There is no evidence that the CAM midwives are conscious or active feminists in the broader sense of the term. Their beliefs are context specific and do not go beyond the arenas of pregnancy and childbirth. We are unable to judge if there is a conscious awareness among them of the relationship between their epistemology and that of the feminists. What is reminiscent of some branches of the feminist movement is the quality of their beliefs, which are imbued with considerable zeal, passion, and a determination to disseminate them to a wide and heterogeneous public.

We have identified seven substantive themes, which together may be viewed as the CAM midwives’ epistemology: criticism of the medicalization of childbirth; an emphasis on natural processes in childbirth; objection to physicians’ overreliance on technology and drugs; empowerment of women through childbirth; nostalgia for the past when childbirth was a more meaningful experience and midwifery was a more broadly defined occupation; emphasis on the “femaleness” of childbirth, through highlighting of the emotional, expressive meaning of the experience; and a sense of zeal and mission to spread their message.

The first three themes (Themes 1 to 3) seem to be interrelated in the sense that they are all critical of the approach of wide segments of the biomedical profession to childbirth. The most explicitly negative statements are the most general ones referring to midwives’ overall rejection of the medicalization of childbirth (Theme 1). This type of statement is somewhat abstract in its implications. Remarks referring to Themes 2 and 3 are more frequent and are expressed, in one form or another, by almost all respondents. Because midwives’ work is essentially practical rather than abstract, it may be easier for them to concretize objections to medicalization in the context of “natural” processes and invasive technology.

CAM midwives also express their disapproval of the medicalization of childbirth in an indirect mode, through criticism of midwives who do not embrace CAM practices or accept its many benefits. It is probably less threatening to criticize other midwives than to criticize physicians. These colleagues are berated for their conformity to the requirements of biomedical obstetricians, who encourage use of epidural injections and interference in the natural developmental rhythm of labor. The CAM midwives also criticize the failure of such midwives to relate to the whole individual and her needs during childbirth. They disapprove of them for having no “real” emotional commitment to their work and failing to feel the meaningful experience of each woman. Like the obstetricians, they are only concerned to move the women along through the “production line.” It is typical of a feminist epistemology to reject the patriarchal and hierarchical approach of physicians and its acceptance by traditional midwives.
The notion of “empowerment” of women is drawn from the central tenets of feminism, where it has played a cardinal role throughout the movement’s development. It is transformed by the CAM midwives into a context-specific concept relating uniquely to childbirth. In their use of the concept, it is endowed with a special meaning, which is anchored in the essentially female experience of childbirth. The uniqueness of the birth experience and its exclusiveness to women are singled out as sacred, magical, and “a lifetime experience that is perfect, glorious, and unfrightening.” This empowering, imprinting experience is exclusively female and therefore endows the woman with a lifelong sense of achievement.

Emphasis on intuition, feeling, and emotion (Theme 7) is the most explicitly “female” of the CAM midwives’ themes. These traits represent the quintessence of the traditional female and serve as a sharp contrast to “male” qualities such as rationalism, logic, control, analysis, and evidence-based medicine—all of which are perceived as “cold.” The “I” qualities of intuition, subjectivity, spirituality, emotion, and feeling celebrate the special femaleness of childbirth by highlighting the importance and centrality of a specific set of uniquely female characteristics.

We have noted that the notion of “active advocacy” provides a mission-oriented component to the CAM midwives’ ideology. Among the extremists, this borders on religious zeal and fervent belief in their importance and efficacy: a strongly held conviction, a sense of mission, and a “calling” to spread the word to as many people as possible. These include pregnant women and women in the labor room as well as obstetricians and other physicians. A daily arena in which CAM midwives seek to “sell” their methods is the delivery room, where every woman is perceived as a potential client.

Nostalgia and a reverence for the past provide a mechanism to distinguish the CAM midwives from the dominant biomedical orientation toward innovation, newness, and the latest scientific knowledge and technology. Visualizing the past as “better” and more meaningful provides legitimation for rejecting major elements of the present—especially in a biomedical context. Midwifery is essentially an ancient, traditional occupation, which has been modernized to acceptable biomedical standards; the CAM midwives accept this modernization, but seek to retain or return to certain of their earlier roots. This provides them with a special identity, which separates them from mainstream midwives.

Conclusions

In sum, the CAM midwives in Israel are able to act out their ideological stance in delivery rooms of biomedical hospitals where they enjoy considerable autonomy. As long as labor and delivery are deemed “uncomplicated” by biomedical criteria, the midwives are in complete charge. For the most part, the physician’s presence is virtual, that is, maintained through the monitor. Once they have obtained the woman’s consent, the CAM midwives feel free to introduce alternative techniques to control labor pains and reduce use of drugs, thus expanding the boundary of CAM legitimacy into the heartland of biomedicine.

The physician’s presence—virtual or real—in the close vicinity of the delivery room provides an unambiguous message indicating when CAM treatment must be terminated, that is, when the birth is “complicated.” Thus, the midwives’ use of CAM is contingent on the pathology of the case as defined by biomedical criteria.
The midwives engage in CAM inside biomedical settings with confidence and transparency. In this regard, they differ from non–midwife nurses (registered nurses) in CAM practice, who are extremely cautious in exercising their CAM skills inside biomedical institutions (Shuval, 2006). The CAM midwives have successfully crossed the organizational boundary of biomedicine and practice comfortably within it. Their self-assurance is reinforced by the full responsibility they carry for 80% of the births (which are “uncomplicated”). The findings show that there is some flexibility in the definition of “uncomplicated” and determined CAM midwives sometimes negotiate the boundaries of that condition. Finally, the fact that many obstetricians support the notion of “natural” childbirth provides them with legitimation for many of their CAM practices.

This research adds to our understanding of the boundary work at the interface between biomedicine and alternative medicine in settings in which the two types of health care are provided by the same individual. Working at the heart of the biomedical establishment—in delivery rooms—the CAM midwives provide a new perspective on the negotiative processes of boundary crossing and “boundary work,” which goes beyond the patterns previously observed among physicians and nurses. As a result of their legitimate location at the heart of the biomedical establishment and because of the explicit or virtual support of significant numbers of physicians, they are more able and willing than other CAM practitioners to introduce unconventional practices for women in childbirth.

Although the findings from this study are limited to Israel, the structure of health care delivery and many aspects of the broader cultural context in that country are quite similar to those in many other Western countries. Parallel research in other societies would be fruitful in learning about the generalizability of the findings to other social contexts.

References


Judith T. Shuval, MA, PhD, received her MA and Ph.D in sociology from Harvard University. She holds the Rose Chair in the Sociology of Health at the Hebrew University of Jerusalem, Israel. Her current research is on the interface between biomedicine and alternative medicine. She received the Israel Prize for the Social Sciences for her first book: Immigrants on the Threshold,” which presents a sociological analysis of the mass immigration to Israel in the 1950’s. She has served as Chair of the Israel Sociological Association and is active in the International Sociological Association as well as in the European Society for Health and Medical Sociology, which, in 2006, awarded her its prize for her life's work.

Sky E. Gross, MA, received her postgraduate degree from the Ecole des Hautes Etudes en Sciences Sociales (Paris) and is currently a PhD student at the Hebrew University of Jerusalem. Her thesis focuses on brain surgery and the relationships between biomedical and lay conceptions of the self. Her publication and research backgrounds comprises the relations between practice and knowledge, and include fieldwork into the collaboration of complementary and biomedicine practitioners in a hospital setting; an ethnography on a multidisciplinary neuro-oncological clinic; a historical study into psychosurgical practices; and a survey of practices of interdisciplinary consortia in EU research programs.