Making Midwives Legal

Childbirth, Medicine, and the Law

Second Edition

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To C. A.
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We are pleased to add *Making Midwives Legal: Childbirth, Medicine, and the Law* to our Women and Health Series. When Raymond DeVries's book (then entitled *Regulating Birth: Midwives, Medicine, and the Law*, Temple UP, 1985) first appeared a decade ago, it provided a way to help readers understand the debates erupting over the legal regulation of midwives. The issues raised by the book continue to be relevant both to scholars and to the general public. As the close of the twentieth century brings new concerns about the financing and regulation of health care, and as decisions about birth are increasingly negotiated not only between women and health care workers but between managed care companies and state legislatures, the place of midwives in the health care system continues to draw our attention.

DeVries's analysis highlights the dilemma of traditional midwifery in the United States in the late twentieth century. It documents the seemingly intractable contradiction that has troubled and continues to trouble this profession—namely, that in seeking to promote and strengthen legalized midwifery, proponents often create regulatory boundaries that stem its spread. Consequently, the regulations governing midwifery restrict some women's access to their preferred health care practitioner, while at the same time offering hope for a more humane health care system.

*Making Midwives Legal* thus remains a significant and relevant sociological work; in addition, it has become an important historical
work. In this edition Raymond DeVries gives us a new preface and epilogue. Together they update the book and provide some timely comparisons between the situations in the United States and in other nations. Students, scholars, practitioners, and general readers will find much to reflect upon as they consider the practice and regulation of midwifery in contemporary America.
This research began nearly twenty years ago, in the mid-1970s, a
time when many of us were full of the hope that we could change
the way Americans viewed and experienced birth. We were a mot­
ley crew—feminists, members of the religious right, “back-to-the-
earth” types, pro-family crusaders, peace activists, and libertarians—
truly strange bedfellows. Collectively, we were referred to as “the
alternative birth movement,” giving us a home among the many
movements that populated the American social landscape in the six­
ties and seventies. The better-known movements of that era—the
civil rights movement, the women’s liberation movement, the anti­
war movement—were, in fact, our inspiration. Compared with the
task of overturning centuries-old discriminatory laws or taking on
the military-industrial complex, our mission seemed easy. We were
confident we could “de-medicalize” pregnancy and childbirth, mak­
ing a place for birth at home and for midwife-assisted birth. The
need for change seemed so obvious, so rational, who could resist?
One need not have been a commune-dwelling hippie to see that the
American way of birth made no sense: it was costly, inefficient, and
subjected women to needless, often painful, medical interventions.

Our strategy for the childbirth revolution was twofold. On the
local level, we pressured hospitals to revise their policies, making
room for more natural, less technological birth practices. (Down
with routine shaving, mandatory IVs, electronic fetal monitoring,
routine episiotomies, drugs to speed—or slow—labor, separation of mothers and babies, infant formula! Up with alternative birthing rooms, fathers and siblings at birth, "bonding," breast-feeding!) On the state level, we organized and lobbied for the rewriting of medical practice acts in order to create an independent profession of midwifery. (Bring back the midwives!)

We were working against the grain, and we knew it. In American society it was decidedly abnormal to define birth as a normal, healthy process. The American view of birth was shaped by an obstetric science convinced that birth is fraught with risk; according to obstetricians, birth can be seen as "normal" only in retrospect, after technology has guided a woman around the dangers of deformed fetuses, prolonged labor, decelerating heart tones, excessive bleeding, difficult presentations, torn perineum, retained placentas, and the like.

What seemed so obvious to us, alas, seemed exotic and dangerous to nearly everyone else, including, unfortunately, the vast majority of childbearing women. We expected opposition from physicians and hospitals, but we were not prepared for either the resistance or the apathy we found among the very women we wished to help. As the decade wore on, our campaign to re-form American birth practices found few successes. We saw only cosmetic changes in hospital policies. And in spite of our grassroots organizing, we saw our innovative proposals for the licensing of midwives fail again and again. We began to see that the alternative birth movement was hopelessly overmatched. Given the economic, political, and cultural power of the medical profession, there was little we could do to establish a "new" profession of midwifery or a "new" view of birth.

The failure of the alternative birth movement fell hardest on midwives. It was their hope to establish themselves as independent professionals, emulating the model of midwifery care found in some European nations. Instead, they were forced either to become a part of the world of obstetrics or to be content with a peripheral role,
living in the shadow of questionable legitimacy. Nurse-midwives chose the former strategy, working under the supervision of physicians. This decision gave them a legitimate place in American medicine, but it led to accusations of selling out and co-optation. "Lay" midwives did not sell out. They refused formal education based in obstetric science and avoided entanglement in medical hierarchies. They retained their purity but were dismissed as countercultural throwbacks in a world moving away from the libertarian excesses of the sixties toward the staid conformism of the Reagan-Bush eighties. Midwifery, with its promise of a more natural view of birth, seemed destined to remain nothing more than an anomaly in America.

By the mid-1980s the alternative birth movement was largely dissipated, content with the relatively small victories of birthing rooms, freestanding birth centers, rooming-in, and staff midwives. American obstetrics had made some minor concessions, but it remained firmly in control of the birth experience.

In the second half of the 1980s, new hope for changing the American approach to birth arose from an unexpected quarter. Physician control of American medicine was challenged not by the alternative birth movement (or any other consumer movement) but by private enterprise. The business of medicine was gaining control over the practice of medicine. More and more medical decisions were being made not by M.D.s but by M.B.A.s. We sociologists began to analyze the "coming of the corporation" and the "proletarianization of the medical profession." We wondered aloud if physicians, working as salaried employees of health care corporations, could retain control of their turf.

The transfer of control over medical decision-making from physicians to administrators was a promising development for America's midwives and childbearing women. Independent midwifery offered cost-conscious health care managers an alternative to high-tech, high-cost obstetrics: an alternative as safe (or safer) than obstetric care, with the extra benefit of high levels of client satisfaction. Watching from the sidelines, the remnants of the alternative birth
movement were convinced that the clinically irrational resistance of physicians to midwives (i.e., an opposition to midwives stemming not from questions of safety but from fear of competition) could not survive the cool rationality of business managers. It was only a matter of time before obstetricians would be hoisted on their own petard of excessive, costly intervention.

In 1996, ten years into the managed care revolution, physicians continue to lose control to administrators. The medical citadel is crumbling, and yet, almost inexplicably, childbirth remains in the hands of obstetricians. American obstetrics survived the alternative childbirth movement and managed care essentially unchanged: today, more than 20 percent of all births in the United States are accomplished surgically; in spite of research suggesting negative effects, epidural anesthesia is increasingly popular and is used routinely by healthy women, a trend that has led to a new specialty in “obstetric anesthesiology”; electronic fetal monitoring remains the norm. Midwives have found a niche working in inner cities and in rural locations—medically underserved areas—but they attend less than 5 percent of the nation’s births. The view of birth represented by midwifery remains marginal.

The staying power of the status quo in American obstetrics is best illustrated by the plight of a group of midwives in New York City. In that city’s public hospitals, nurse-midwives provide a majority of the care for birthing women. Not surprisingly, midwives were brought into the system (in the late 1970s) because they were less expensive than physicians. An early assessment of their work showed them to be providing high quality care. The perinatal mortality rates for the midwifery service were lower than the average in New York City and in the nation, in spite of the fact that their clients had little or no prenatal care and inadequate nutrition (Haire, 1981). We proponents of alternative birth saw their success as further proof of the wisdom of changing our system of childbirth. If nothing else, here was compelling evidence for administrators seeking cost-efficient care.
This evidence notwithstanding, in 1995, a team of investigative reporters for the *New York Times*, looking to explain poor perinatal outcomes in New York City, turned their gaze to that which seemed out of place in American medicine: midwives. In a three-part exposé, the authors maligned midwives and the insufficient use of obstetric technology as the culprits for poor obstetric results. When the maternity care system is not functioning well, it is not the system that is to blame, rather it is the insufficient application of the system. Too many perinatal deaths? The solution must be more technology, more intervention. Following this logic, the authors faulted the midwives for their low rate of Caesarean sections, 12.9 percent, and asked why it was not closer to the city average of 23.1 percent.

In a letter of response to the exposé, an epidemiologist offers another way to think about the problem: "Among other causes for [the high number of perinatal] deaths, you blame insufficient use of birth technologies such as electronic fetal monitoring and Caesarean section, and midwives who do not function properly. These are . . . complaints of American obstetricians who wish to divert blame from themselves. . . . Underlying New York's maternity care crisis is an unfounded faith in birth technology. In your . . . article is the statement that 'a fetal monitor malfunctioned, making it impossible to determine the baby's condition.' Before there was a monitor there was a stethoscope. The monitor should only complement the stethoscope. The monitor should only complement the stethoscope" (Wagner, 1995, emphasis added; see also Marsico, 1995). Using evidence from European countries—where both Caesarean section and perinatal mortality rates are low—the letter writer characterizes the problems in New York City as the result of an overdependence on technology rather than of too little use of that technology. He argues that the proper use of technology requires the careful separation of healthy and high-risk mothers, reserving technological solutions for difficult cases. In New York City, misplaced faith in technology results in too little care in the selection of cases (if all births are high risk it makes no sense to separate them) and the improper use of obstetrical support.
(private patients get more attention from specialists than do public patients).

This story demonstrates that increased use of midwives and a shift to home birth will require more than a simple policy decision from an M.B.A. What is needed is a new way of thinking about birth. Our American conception of birth is deeply rooted in our culture. We might be willing to move birth from the delivery room to an LDR (one room that combines labor, delivery, and recovery) and to shorten the hospital stay after birth, but it is more difficult to re-envision birth as normal, to jettison the medical interpretation of this critical life event. In retrospect, it is clear that the kind of change we were seeking two decades ago was at least as radical as the changes demanded by the civil rights and antiwar movements. We were asking for a new view of our bodies, of our relation to technology, of our sense of “home,” of gender, of family. We were asking not just for social change but for cultural change.

The role played by culture in shaping the care given at birth was not as apparent to me when I wrote the first edition of this book in 1984. Since then, I spent a year researching maternity care in the Netherlands. The Dutch have a sophisticated and modern medical system, in which, interestingly, midwives and home births remain an important part of perinatal care. In 1992, midwives attended 45.8 percent of the births in the Netherlands, and 31.5 percent of all births occurred at home (Centraal Bureau voor de Statistiek, CBS, 1992). This is contrary to the logic of professions (those with more power—physicians—will move to control the turf of those with less power—midwives) and to the logic of technology (the technological imperative: if the technology exists, it will be used). According to the conventional wisdom of medical sociology, the advance of medical systems and the development of medical specialties lead, inevitably, to the hospitalization of birth. But this has not happened in the Netherlands. Why?

The most common explanation of this phenomenon focuses on the structure of Dutch medical care: historians and sociologists
point to early legislation that favored midwives, to an insurance system that gives midwives an advantage over their competitors, and to a well-developed program of postpartum care in the home (Hingstman, 1994). These (and other) factors have played a part in the current system, but still we are left asking, “Why did this structure emerge in the Netherlands and not elsewhere?” To answer that question we must look beyond structure to the unique culture of the Netherlands.

A complete analysis of the role of culture in generating and sustaining Dutch maternity care is the subject of a longer study. But a few examples can help illustrate the way culture shapes health care. Taken alone, none of the cultural features listed below—ideas about home, gender, and solidarity—can account for maternity care in the Netherlands; but taken together they create a context that allowed the current system to develop and persist.

The Dutch system of birth is nurtured by a view of home and family different from that found in the United States. As van Daalen points out, the family “nuclearized” earlier in the Netherlands than elsewhere, making birth a private event, not suitable for the public setting of clinic or hospital (van Daalen, 1988; 1993). The Dutch idea of the gezin (or nuclear family) coincided with, and overlapped, Dutch notions of domesticity and home. In his analysis of our modern conception of “home,” Rybczynski (1986) concludes that the idea of home as a place of comfort and refuge for the nuclear family was created by the Dutch. Schama (1988) confirms this analysis, noting that in the seventeenth and eighteenth centuries the Dutch were renowned for their domesticity. Homes were small, tidy, and the center of family life—a perfect setting for birth.

Not surprisingly, Dutch beliefs about home and family are tied to prevailing views of gender. The position of women in the Netherlands is somewhat paradoxical: women are regarded as strong and independent and yet remain tethered to the family. Trying to explain this paradox, historians have turned to the peculiar economy of the Netherlands. Dutch ideas about the family grew up in an
economy centered on trading, fishing, and farming, each of which demanded strong roles for women in the context of family. Consequently, the idea that home is the appropriate place for women survived longer in the Netherlands than elsewhere. Dutch women differ from their European sisters in the persistence of high fertility rates and the relative slowness with which they entered the paid workforce. The domestic sphere, including childbirth, belongs to women. Except in unusual circumstances, birth should be kept in this sphere.

In comparison with the United States, Dutch culture places far greater emphasis on solidarity. Long-running battles against nature, in the form of rising waters, and against a series of foreign occupiers required the Dutch to develop systems of cooperation. By way of contrast, we Americans, with our endless frontier, learned to cherish rugged individualism. The Dutch emphasis on solidarity is the foundation for cooperation between midwives and physicians and for an approach to health care where resources are managed cooperatively, for the good of all citizens. A maternity care system that reserves a place for home birth is not the ideal of all mothers in the Netherlands, some of whom are convinced that it is better (safely, cleaner) to give birth in the hospital; but it is tolerated because it is in the interest of the population at large.

Independent midwifery and home birth were able to survive in the Netherlands because the cultural soil there could sustain them. The cultural soil in the United States is not nearly as hospitable, and it is no small task to rework it.

The first edition of this book, *Regulating Birth*, was published in 1985. My analysis gave me little cause for optimism, but I stubbornly clung to my belief that careful study of earlier efforts to improve the position of midwives—looking at what worked and what did not work—would provide the information needed for the creation of an independent and successful profession of midwifery in the United States. It was my naïve hope that by 1996 *Regulating Birth* would be nothing more than a curiosity: evidence that there was
once a time when midwife-attended birth was the exception, when even healthy women in labor were "managed" with continuous electronic fetal monitoring and anesthesia, when those choosing to have their babies at home were accused of child abuse. Sadly, my book remains relevant. Sociological lessons learned in the seventies and eighties continue to be useful to childbirth reformers of the nineties who are looking for a better way of birth.

Although the alternative birth movement and managed care have had little success in altering American obstetrics, all hope is not lost. Elsewhere in the world, midwifery is being (re)established as the best approach to birth. Most notable are changes taking place in Canada and the United Kingdom. In 1993 the British government released its report, Changing Childbirth, which recommended that the National Health Service move to a model of maternity care where midwives serve as "lead professionals" (Department of Health, U.K.). The province of Ontario recently introduced a model of midwifery care based on that found in the Netherlands, using Dutch midwives as consultants to set up education programs and practice guidelines. These programs, in other English-speaking countries, will doubtless generate new data (in English-language journals) showing the benefits of midwife care. As evidence of the efficacy of midwifery mounts and as costs increasingly impinge on interventionist obstetrics, perhaps even in American culture birth will regain its status as a normal and healthy life event. It is in the interest of continuing the struggle against a system of maternity care that is costly, inefficient, painful, and dangerous that this book is being republished.

A few notes on this second edition. First, a comment on the use of this book. My study of midwives is nothing more or less than a work of sociology in the tradition of C. W. Mills. I point to connections between biography and history, demonstrating that "private troubles" are, in fact, "public issues." The problems faced by one woman whose birth seems unnecessarily difficult are not hers alone. Her difficulty is part and parcel of a medical system and a culture
that together define appropriate and inappropriate birth. In its original edition, this book found an audience among medical sociologists and those working in health policy and public health. It is my hope that the appearance of this work in a paperback version will allow the audience to expand: to midwives, to consumers, to students in other fields. Students of medicine, nursing, women's studies, and the sociology of occupations, the sociology of organizations, and the sociology of law all have something to learn from the midwife's campaign for legitimacy. This book will also be useful to historians of women, health care, and nursing who wish to understand the complicated struggles of women and midwives to regain control of birth in the latter decades of the twentieth century.

Second, a word about words. When I was writing the first edition of the book, midwives who were not "certified nurse-midwives" proudly called themselves "lay midwives." The term was seen as an act of resistance against the overly technical and cold approach of medical "professionals." Not long after the book was published, however, many lay midwives decided that the term lay created an image of incompetence. Within a few years the term lay was abandoned, replaced by a collection of new names: practical midwife, empirical midwife, traditional midwife, community midwife, direct-entry midwife, or sometimes, simply, midwife. For reasons related to the needs of the (re)production of the text, the term lay midwife remains in this edition. My apologies to those who find it offensive.

Finally, a few acknowledgments are in order. This second edition would not have been possible without the persistent efforts of Karen Reeds, editor at Rutgers University Press. Her belief in the value of this work led her to push until it found the light of publication. Support for the new research reported in this edition came from the Fogarty Center of the National Institutes of Health (Grant number F06-TW01954), NIVEL (Netherlands Institute for Health Care Research), and from a collection of faculty development grants from St. Olaf College. As with the first edition (and with all aca-
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Acknowledgments

Spanning almost seven years, this study is intertwined with a part of my life that included the births of my three children, at least four different jobs, and four different residences. In the course of this nomadic, eventful existence I have accumulated several personal and intellectual debts. My greatest debt is to the subjects of the study—the midwives, parents, physicians, legislators, lobbyists, and employees in various state departments of health and state medical societies—who were willing to have a nosey sociologist poke around in their affairs. In most research of this type, certain subjects become more than subjects. The friendships I developed with Jan McNabb, Patricia Ternahan, and Anita Pandolphe Ruchman helped to enrich both this study and my life.

My friends in the academic world also contributed to this effort. Those familiar with the work of Ed Lemert and Julius Roth will see their ghosts wandering these pages. When I was a graduate student, Lemert and Roth infected me with the "dis-ease" of sociology, an incurable ailment that causes discomfort by forcing its victims to question everything they had previously taken for granted. The disease is contracted by watching others work and seeing the freshness in their views of the world. These men have a way of offering new insights into some of our oldest institutions: law and medicine.

My study benefits from these insights. In addition, Lyn Lofland, Gary Hamilton, George Annas, Allan Solares, and Robert Clark provided editorial advice, suggestions, and moral support. Sheryl Ruzek has followed my study from its earliest phases. Given her knowledge of the literature in women's health I could have found no better editor.
for this book. Her investment in this work is responsible for much of what is good here. Additional editorial assistance offered by Janet Francendese, Jennifer French, Dorothy Wertz, and Irv Zola made this a more readable, logical work.

The making of a book requires all sorts of mundane assistance provided by the unsung heroes in the production of knowledge. In my case these heroes include Betty Fleming, Jackie Meers, Wava Fleming, and Mary Lee Burdette.

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For His glory.

Raymond G. DeVries