Introduction

For the last decade American midwives have struggled to reclaim a place in birth, to recapture the heritage of woman "with woman" during childbearing. But the heritage they seek can not be resurrected in the same form as it was interred earlier in this century. As midwifery regains popularity it may become more common to find women with women in the birthing process, but it is no longer possible for midwives and their clients to be truly alone in the lying-in chamber. In the modern world medicine and law are constant—perhaps unwelcome—companions at birth. Advances in medical science change the practices of all but the most isolated of midwives and laws in most states limit the clientele and technology available to these practitioners. The midwife's "bag" now contains the instruments of modern medicine and her vocation is now defined by statute. The worlds of medicine and law were of little concern to turn-of-the-century midwives; today's midwives can not practice without attending to these worlds.

What does it mean to attend to the worlds of medicine and law? Surely it implies being informed of the laws which regulate midwifery and having knowledge of medical developments relevant to birth. But that is not enough. Today's practicing midwife—as well as consumers of maternity care and the advocates and detractors of midwifery—must have a sociological understanding of the way law and medicine interact with and affect her profession. The future of midwifery, the very nature of the profession, is shaped by these worlds. And in turn, medicine and law are influenced by midwifery and the changes in society responsible for its renewed popularity.
In the following pages, I explore the laws which regulate midwives, considering how such laws came to be and the way these laws affect midwifery. My interest in, and concern for, midwifery grew out of a personal investigation of maternity care. When my wife and I learned that we were expecting our first child we explored various alternatives for birthing. Northern California offered us a number of options. The choices ranged from a home birth (with or without the assistance of a birth attendant of some sort) to the more conventional hospital birth (incorporating everything from "natural childbirth" to Caesarean section).

The exploration of available options began to arouse my sociological curiosity, and the decision to engage a certified nurse-midwife marked the beginning of my professional research. I had assumed midwifery to be an anachronistic profession, and was anxious to explore both its history and its recent resurgence. My early work involved a comparison of the medically educated, certified nurse-midwife and the self-taught lay midwife (DeVries, 1982). From there I branched into a study of institutional innovation in the treatment of birth (DeVries, 1979a; 1979b; 1980; 1984) and an investigation of birth as an example of "existence transition" (DeVries, 1981). As is evident, I was quickly drawn into aspects of the subject only vaguely connected with my role as expectant father. Although my personal experience offered useful data, I was also forced to get into the field to gather comparative and background information.

Our second and third children were born during the course of the research. By the time of the second pregnancy we were convinced that the best attendant at this birth would be a lay midwife. Our second child was born in California and our third in Massachusetts. Both were attended by lay midwives. Comparison of my children's births—one attended by a certified nurse-midwife, the other two by lay midwives—has provided my wife and me with new insights into American medicine.

My fascination with law and its relationship to society naturally
drew my attention to the interaction between law and midwifery. Preliminary study of the laws that govern midwives revealed great diversity in state regulations. This diversity—although disconcerting to midwives and their supporters—offered an ideal research setting in which to compare the origin and impact of different regulatory measures. After review of the laws in several states I decided that Arizona, Texas, and California provided an ideal comparison because of their varied regulations—ranging from licensure in Arizona, through loose control in Texas, to outright prohibition in California.

The variety of regulation in these three states allowed me to set up a loose, quasi-experimental research design (see Cook and Campbell, 1979). I wanted to gather information both on the creation of laws that regulate midwifery and on the effect of such laws on the way midwives practice. The first objective led me to explore how the need for advice from "medical authorities" on the part of legal institutions influenced the nature of midwife regulations. The second led me to the field itself; I was looking for variations in the quality and style of care, the cost of midwifery services, the availability and accessibility of midwives, and the willingness of established medical professions to work with lay midwives. In devising my quasi-experimental design, California—because of its lack of formal regulation—became the control, with Texas and Arizona representing degrees of regulation.

My exploration of midwife regulation began with a close look at the current laws in the three states. I was concerned with what the laws allow, what they prohibit, and the relationship between the statutes and the reality of day-to-day practice. Other topics included the degree to which the law is an example of "friendly" or "hostile" licensing (that is, do lay midwives govern themselves or are they placed under the control of medical or nursing boards?), the origin of the law, and the justifications used to gain its passage. I also examined past and current legislation to determine how changes in the bill accommodated the demands of various interest
groups. Specific data that provided insight into all these matters included: 1) descriptive statistics on the number of births and the practitioner in attendance; 2) information relevant to midwife licensure drawn from the media, newsletters of various organizations, medical journals, and state archives; and 3) interviews with legislators, lobbyists from medical professional groups, and representatives from midwife and consumer groups.

Information about the effect of licensure came from detailed interviews and observation. I conducted interviews with midwives, their clients, and medical professionals who work with midwives. My earlier historical study of midwife regulation (DeVries, 1982) indicated that licensure significantly affected both styles of practice and the kind of client who would employ a midwife. With this in mind, my observations and interviews were structured to collect information on: 1) the routines and practices of the lay midwife (What are the limitations set up by the law? Do midwives adhere to them? Does licensure expand or restrict the midwife's prerogatives and behavior with regard to medical procedure? Is interaction with physicians facilitated or hindered by licensing law? Will physicians continue to work with unlicensed midwives once a licensing law is passed?); 2) the nature and attitude of the lay midwife (Does licensure alter the kind of individual drawn to the occupation? Does the medical training necessitated by licensure change the lay midwife's attitude toward the efficacy of medicine?); and 3) the nature and motivations of the clientele who seek the services of the lay midwife (What are their motivations? Does the nature of the clientele change when the practice is given state sanction? If so, does this change the nature of the practice of lay midwifery?). I also observed midwives on their daily rounds—which included watching their interactions with clients, other midwives, and physicians—in order to check and clarify data supplied in interviews.

My research began with an obvious handicap: I was a male investigating a female-dominated occupation. Not only are most midwives women, but all their clients are women. Feminist sensiti-
ties, in which the intentions of all males are suspect, compounded the difficulties. Interestingly, I faced greatest opposition from several women in the academic world who thought it inappropriate for a male to study what they perceived as a uniquely female issue.

As expected, the problem of gender limited my access on certain occasions. For instance, I delayed my arrival at a midwife educational workshop because part of the workshop included instruction on the insertion of catheters and the midwives were going to practice on each other. I am not the first researcher to face this problem. In his report of a meeting of Mississippi midwives in 1948, Ferguson (1950: 93) reports that the male physician accompanying him grew nervous when it appeared the midwives were about to demonstrate how to give an enema. In an informative article on this problem, Daniels (1967) discusses the difficulties she encountered as a female civilian researching the military. She suggests that while being a "low caste stranger" is hardly ideal for a researcher, it does provide some unique opportunities and insights. In my own case, for example, I discovered that midwives often went out of their way to explain matters they thought would be unclear to a male. Some midwives were also anxious to include me in their activities as their "token male"; an offer of apprenticeship I received was an example of this. The midwives felt it would be nice to have an apprentice who could relate to fathers.

When I sought financial support for this research I immediately confronted problems with the university's human subjects committee (more formally referred to as the Institutional Review Board or IRB). Research involving human subjects in almost any capacity—even as the subjects of interviews or observations—must gain the approval of the local IRB. The IRB was hesitant to approve my research plan because I was gathering information on an illegal activity (midwifery in California), information that potentially could be used to indict and convict some of the subjects of my study. I finally won approval by convincing the IRB that my results would not be published until well after the statute of limitations for the offenses I
observed had run out. The delay, however, damaged my chances of acquiring funding by forcing me to submit grant proposals "pending IRB approval."

The problem of "sentimentality" in social research is another difficulty I faced. Becker (1964: 4) uses the term "sentimentality" to refer to "a disposition on the part of the researcher to leave certain variables in a problem unexamined." He defines "conventional sentimentality" as that which takes for granted the dominant assumptions of a society, and "unconventional sentimentality" as that which leaves unchallenged assumptions of society's marginal groups. It is the task of the researcher to take a neutral, disinterested position on the phenomena under study, but as we well know, this task is difficult, if not impossible, to achieve completely.

All field researchers experience a tension between the "research self" and the "social self." The researcher sets out to gather interesting, high-quality data, but soon the person grows involved in an array of relationships with his subjects that range from close and affectionate to openly hostile. Of course, a good researcher knows how to blend the research and social selves in order to maximize both the quality of the study and the quality of his life, but even the most facile of investigators is constantly forced to balance personal and professional interests in the field. A bittersweet reality of qualitative research is that the subjects of investigation often become friends. The friendships are rewarding, but the researcher is afraid of "going native" and suffers the guilt of using information given on the basis of friendship. As Davis (1961) points out, the subjects the researcher feels closest to are usually the subjects that are most thoroughly used (that is, exploited).

I established some rewarding friendships with the midwives who were my subjects. As a result, it is likely that I exhibit a trace of "unconventional sentimentality" which leaves unquestioned parts in favor of the midwives' point of view. But let me suggest that if I lean toward unconventional sentimentality it only serves to coun-
teract the conventional sympathies toward medicine that pervade our society.

The issue of sentimentality raises some interesting problems. To what extent, for example, does sentiment govern the recommendations of researchers? When pressed for specific policy recommendations, do analysts base their advice on how it will affect their subjects (that is, their new friends) or is such advice grounded solely on the outcomes of their scientific study? In many studies the research evidence supports policy changes beneficial to the subjects in question, but this is not always the case.

My own research offers an example where the policy suggested by the data differed from what many of the subjects perceived as their own best interests. As my research progressed, the conclusions I was drawing were not always welcome news among my midwife friends. Most of these friends did not question the essential validity of my findings—that licensure would alter, and perhaps destroy, the uniqueness of lay midwifery—but nevertheless disagreed with the full implications of my work. They agreed that licensure was potentially dangerous, but felt certain the bills they supported would prove less destructive.

Most of my midwife friends were unwilling to accept the implications of my evidence—that is, that lay midwifery should remain unlicensed, hence illegal. To accept that notion would require them to live under the continued threat of prosecution, even persecution. Several midwives in California had in fact run afoul of the law around the time of my research. The case that most frightened my friends was that of Rosalie Tarpening, a midwife who came to the attention of the authorities when she attended a birth where the infant died. Her arrest and subsequent jailing offered stark evidence of the danger of remaining unlicensed. Although convinced of the truth of my findings, this incident and similar cases made it difficult to ask my friends to live by this truth.

The dilemma came to a head when I was asked by a group of Cal-
ifornia midwives to help devise a strategy to gain passage of a licensing bill in that state. How could I, a supporter of midwifery, contribute to a campaign I was convinced would spell doom for that profession? On the other hand, how could I refuse to contribute to a cause that, if successful, would make the lives of my friends more tolerable? In this case, I let my heart rule my head and threw myself into working for the passage of the licensing bill. I planned, lobbied, marched, phoned, and did all those things associated with mobilizing a constituency behind legislation. I must admit that I took my researcher's notebook with me wherever I went, but I genuinely worked for passage of this bill.

The failure of the bill in its three versions left me with mixed feelings. All the people I worked with were disappointed, and I understood their frustration. On the other hand, I felt that the defeat, which allowed midwifery to continue in its unique but threatened status, was a paradoxical victory for the profession. It is the nature of this paradox, the true dilemma of licensure, that I explore in this book.

In the following chapters I examine several aspects of the relationship between midwives, medicine, and the law. I begin in Chapter 1 by exploring some common sense, but inaccurate, views of medical licensure. In that chapter I discuss the implications of licensure for the provision of health care. Specific consideration of midwifery begins in Chapter 2, where I lay the foundation for analysis of modern laws governing midwifery by reviewing the history of midwife regulation. There have been several excellent histories of midwifery in recent years (for example, Litoff, 1978; Donnison, 1977) but none have focused exclusively on regulation. In Chapter 3 I look at successful and unsuccessful attempts to get midwife licensing laws passed by legislatures in Arizona, Texas, and California. My focus lies on the social setting and the key players in the creation and evolution of these laws. Chapter 4 considers the impact of the various regulatory schemes on the practice of midwives. Here I examine the direct and indirect changes initiated by law.
Chapter 5 explores the ways regulatory law influences the social and legal nature of disciplinary actions. In the conclusion, Chapter 6, I comment on the relationship of law and medicine and outline some of the consequences of alternative policies for regulation.