Chapter 2

The Emergence of Midwifery Regulation

The art of midwifery is undergoing a revival in the United States. At an earlier point in history, midwives were considered the only appropriate assistants for childbirth, which was "woman's business." The very thought of allowing a male physician into the lying-in chamber was appalling to the modest sensibilities of most women and their husbands. However, modesty and tradition eventually gave way to medical science, and by the middle of this century the overwhelming majority of births were attended in hospitals by male physicians. Midwifery was regarded as little more than the medically ignorant traditions carried on by a handful of midwives who served isolated pockets of our population—those who were cut off from the benefits of modern medicine by their remote geographic location, their immersion in cultures that had never abandoned the traditional approach to birth, or lack of resources. But in recent years this view has changed. At present, midwifery is emerging from the mists of folklore and disrepute into a modern and acceptable approach to childbirth. Somewhat ironically, midwife care, a form of health care with a centuries-long tradition, is now being offered as a nontraditional, an alternative approach to childbirth for all classes of women, not only the poor, the uneducated, or the immigrant.
Midwives and Other Birth Attendants

Although the midwife currently plays an insignificant role in the United States, she was and still is the primary attendant in the majority of the world’s births. In her report, "Maternity Care in the World," Bayes (1968) estimates that two-thirds of all babies are born with the sole assistance of nonmedical personnel, many of whom are the cultural counterparts of the midwife. A number of Western European nations employ trained midwives to attend the majority of uncomplicated births (Josiah Macy, Jr. Foundation, 1968: 105–46). Sousa (1976: 117) estimates that midwives of one type or another are responsible for managing 80 percent of all human births.

Throughout her history in the Western world, the midwife has existed in a somewhat anomalous position. Although she has always been a desired companion to women in labor, she has at various times been accused of everything from ignorance to being in league with the devil. In parts of medieval Europe her social status was lower than that of the executioner, and in these same areas the son of a midwife faced exclusion from trade guilds because of his mother’s profession (Forbes, 1966: 113). In later centuries she became the target of ambitious male practitioners who were armed with a variety of implements to assist and “ease” the process of childbirth.

References to midwives as a distinct occupational group extend at least as far back as the Jewish captivity in Egypt. The character of midwifery at that time is revealed by an account of the refusal of a group of midwives to obey an order by the Pharaoh to kill all male children born to the Hebrews. When the Pharaoh demanded an explanation for this disobedience, a spokeswoman for the group replied, "The Hebrew women are not as the Egyptian women; for they are lively and are delivered ere the midwives come in unto them" (Exodus 1:19). The Pharaoh’s acceptance of this rather lame excuse is enlightening, for as Samuel Gregory noted in 1848, "Even
this tyrant dared not invade their sacred office to make special inquisition" (Gregory, 1974 [1848]: 7). Commenting on this episode, Litoff (1978: 3) makes a similar observation: "This passage indicated that the presence of a midwife was considered sufficient when an attendant at birth was necessary and that parturition was believed to be such a normal process that many births went unattended." The responsibility for the control and management of birth was beyond even kingly jurisdiction, belonging solely to the mother and her attendant.

The Western midwife's position began to erode in the sixteenth century with the advent of male forays into midwifery and the appearance of regulatory measures. The church was the primary agent of midwife regulation in medieval Europe. On the Continent this ecclesiastical licensure gave way to municipal systems of registration as early as 1452 (Donnison, 1977: 5), but in England church regulation persisted until the eighteenth century, when its power diminished, leaving midwifery essentially unregulated until early in the twentieth century. These first efforts to regulate midwifery were more concerned with its social and religious aspects than with the mastery of any specified body of knowledge; regulation consisted of little more than formal licensing itself and the "suppression" of those who practiced without the proper certification. The church's major interest was the prevention of witchcraft. Because midwives used herbs, potions, and spells to assist in delivery, they were often confused with, or assumed to be, witches. While the accusations of witchcraft were seldom well-founded, the consequences could be severe. Forbes (1966: 127) documents several cases and concludes: "It is difficult, even impossible to separate actual from imagined offenses but there can be no doubt of the utter vindictiveness toward any midwife who was suspect" (see also Oakley, 1976: 23-30).

During the sixteenth and seventeenth centuries the midwife's control over birth began to be undermined by male intrusions in the lying-in chambers. At this point in history, male involvement in
birth was largely reactive. Typically, barber-surgeons—who by virtue of guild membership had exclusive rights to the wielding of surgical instruments—were called to assist in the most complicated cases. These ministrations were often disastrous for the mother and child as well as for the reputation of the male attendant. This gradual encroachment by doctors and other males into a previously all-female domain met resistance, but technology favored the emerging masculine claim to the role of birth attendant. The invention of the forceps, with their promise of shortened labors and their monopoly by men, is generally acknowledged as the crucial factor in the male’s rise to dominance in this field. Rousch (1979: 34) characterizes the forceps as “the fatal blow to the female midwives.” Litoff (1978: 7) regards the development of the forceps as “the single most important event” in the displacement of midwives. Donnison (1977: 21–22), while she is careful to enumerate other factors that contributed to the decline of female midwifery, contends that “the introduction of the midwifery forceps . . . precipitated . . . rapid acceleration in . . . an existing trend.” It is difficult to understand why midwives did not adopt the use of forceps in their practice. Wertz and Wertz (1977: 39) suggest:

Legal restrictions stemming from the power of surgeon’s guilds may have prevented it, and the simple force of custom, which associated men with instrumental interference, may have limited women’s use of forceps. Men may have also refused to sell forceps to women, or women may have found that using early versions required a degree of physical strength they did not have.

It is also likely that female midwives were hesitant to identify themselves with techniques and instruments characteristic of male midwifery. Elizabeth Nihell, a famous eighteenth century English midwife, offered the following evaluation of William Smellie, one of the “fathers of modern obstetrics”:
[He has] the delicate fist of a great horse god-mother of a he midwife. . . . His disciples [are] made out of broken barbers, tailors, or even pork butchers, for I knew myself one of this last trade, who after passing half his life in stuffing sausages, is turned an intrepid physician and man-midwife. See the whole pack open in full cry: to arms! to arms! is the word; and what are those arms by which they maintain themselves, but those instruments, those weapons of death! Would not one imagine that the art of midwifery was an art militare? (quoted in Aveling, 1977a [1872]: 122-23, emphasis added).

Except for her relative freedom from regulation, the situation of the midwife in America was similar to her counterpart in Europe. For instance, like their sisters in Europe, midwives in Colonial America were often suspected of practicing witchcraft. Anne Hutchinson, one of the more famous early American midwives, was accused of witchcraft and banished by the General Court of Massachusetts after assisting in the delivery of an anencephalic child (a child born without the frontal lobes of the brain—essentially brainless and headless).

The American midwife continued to play an important role at birth until the early twentieth century. At that point the medical profession turned its attention to her activities and found them lacking. The result was a "flood of articles and addresses on 'the midwife problem in _____'" which in turn spawned a rash of legislation restricting and regulating midwifery (see Kobrin, 1966). The effect of the medical establishment's attacks was dramatic. For example, the number of midwives practicing in New York City dropped from 1,700 in 1919 to 170 in 1939, and finally to just 2 in 1957 (Kobrin, 1966; Speert, 1968).

Professional rivalry was clearly a motive in the negative evaluation of midwives by medical professionals. Indeed, as Devitt (1979a: 366) points out, the choice of titles for the many critical ar-
articles published earlier in this century were variations of "the Midwife Problem" rather than the "Infant and Maternal Mortality Problem," thus reflecting the desire of physicians for the "expansion of [their] profession and the elimination of midwifery" (see also Devitt, 1979b; 1979c). Ostensibly, American physicians rejected the European idea of upgrading midwifery through education because it promulgated a "double standard of obstetrics," but actually they were concerned about the loss of income and access to cases used for teaching (Kobrin: 1966: 358). Consider this comment made by two American physicians regarding the passage of the 1902 midwifery licensing law in England:

The Midwife Bill ... has given England a fairly well-trained cleanly midwife, in place of the dirty midwife and the careless practitioner, but it has not instituted a new system, and in the light of modern medicine, it is of questionable advantage to the community, for it provides a double system in obstetrics, the midwife but scantily trained, depending upon the physician who is not certain to respond to her call. Some 30,000 women have taken enough practice away from physicians to obtain a livelihood. Unquestionably the field of physicians has been invaded and the community is the loser (Emmons and Huntington, 1911: 260, emphasis added).

As recently as 1968 a doctor reported to a conference on midwifery: "Let us be above board about it. We have a financial interest in delivering babies. If you don't include us in deliveries, we have no choice but to be obstructive to whatever thing you start" (Johnson, 1968: 95).

Two types of evidence confirm that the flurry of concern over midwives early in this century was more a consequence of physicians' fear of competition than a desire to protect the health of women and children. Devitt (1979c) has collected statistics on rates of maternal and infant mortality from several cities and states indicating that during the period from 1910 to the 1930s midwives
performed as well as, or better than, physicians. For example, data from Newark, New Jersey, for the years 1915 and 1916 show that physician-attended births had strikingly higher rates of neonatal mortality (death under 30 days of age) and infant mortality (death within the first year of life) than births attended by midwives (Devitt, 1979c: 171). Data from other locales are more equivocal, but in no case are midwives shown to be the direct cause of poor outcomes at birth. It is likely that the high mortality rates that prompted concern were due to the incompetence of general practitioners who had no training and little experience in birth (Yankauer, 1983). Writing about “Immigration and the Midwife Problem,” Ira Wile (1912) noted that foreign-trained midwives working in the United States were better trained, offered better service, and charged less than the typical physician.

A second kind of evidence that sheds light on the opponents of midwifery is the continued presence of midwives among poor and minority populations and those in remote locations. Despite the poor health of these people, physicians regarded them as undesirable clientele and left their care to midwives. Although physicians generally opposed midwife training programs, they supported such programs for midwives who worked in the urban ghettos and among the rural Southern poor (see Ferguson, 1950; Mongeau et al., 1961; Campbell, 1946). If the primary concern of physicians was the health of women and their babies, they would have pressed their services into these areas first and allowed midwives to practice among healthier populations. Holmes (n.d.) interviewed some “granny midwives” still working in isolated areas of the South and documented the important contributions they make to the community, not only in the area of health care, but in the preservation of tradition and in the provision of a sense of autonomy of poor blacks.

Despite all its setbacks, midwifery is currently making a comeback. The certified nurse-midwife is slowly gaining medical recognition and acceptance, and the lay midwife—who is often beyond
legal or medical control—is gaining in popular appeal. The status of the American midwife is somewhat confounded by the fact that each state and jurisdiction establishes its own regulations. This creates the wide range of controls alluded to earlier, sometimes prohibiting all midwives, sometimes allowing only certified nurse-midwifery, and sometimes allowing the ambiguous "legality by default" (Forman, 1973; see also Forman and Cooper, 1976; HOME, 1976b; Rooks et al., 1978; National Center for Health Statistics, 1979; Sallomi et al., 1981; Cohn et al., 1984).

Midwifery in the contemporary world exists in two basic forms: traditional practices continue in less industrialized countries, and in more advanced Western nations midwives have been gradually absorbed by the medical profession. Even in the Netherlands, a country often cited as an example of the feasibility of midwife-attended home birth (because its low infant and maternal mortality rates exist in conjunction with a large proportion of such births), midwives have recently experienced a significant decline in autonomy because of the decrease in the number of home births. The independent practices of Dutch midwives are disappearing as physicians in that country encourage more women to have their babies in the hospital (Laurillard-Lampe, 1981; van Arkel et al., 1980).

Technology continues to play an important part in the midwife's loss of independence. Her noninterventionist stance—the belief that birth should progress naturally without artificial assistance—has suffered at the hands of medicine's new devices, from the invention of the forceps to the development of the fetal heart monitor. Necessary accommodations of midwifery to the advances of obstetric science have undermined opposition to organized medicine, bringing midwives under the supervision and control of the medical profession. However, the lay midwives who have emerged in America and elsewhere (for instance, Canada; see Thomas, 1979) are an important exception to this trend. They favor home birth and have serious reservations about the efficacy of technological intervention in the birth process. These lay practitioners
perpetuate a significant bifurcation within the occupation. When pressed on the issue, it is not unusual for a member of one group to question whether the other group qualifies for the label of "midwives." For both groups, however, the regulation of midwifery has significantly influenced styles of practice. The following section looks more closely at the regulatory process, its effects on the role and status of the midwife, and the manner in which midwifery is regarded by the courts.

Midwife Licensure: Recognition or Restriction?

In his analysis of laws licensing occupations during the period 1890–1910, Friedman (1965: 494–97) draws a distinction between "friendly" and "hostile" licensure. In the former, the licensing process is controlled by individuals drawn from the occupation being regulated; in hostile licensure, an occupation group is placed under outside control. Friedman offers the licensing of dentists in the state of Wisconsin as an example of friendly licensing: in that instance the authority was granted to a "state board of dental examiners" consisting of "five practicing dentists, at least three of whom shall be members of the Wisconsin state dental society." Hostile licensure is exemplified in the regulations placed on peddlers in the same state; "transient merchants" had to pay fifty dollars for a state license and were also responsible for local fees that could be as high as fifty dollars a day. These exorbitant fees were prompted by the complaints of local merchants who disliked the competition from migratory peddlers. The history of midwife licensure provides another example of hostile licensing. As Friedman (1965: 516) recognized, the weakness of midwifery as an occupation derives from vesting licensing in medical or nursing boards rather than in a board of midwife examiners.
There has been little focus on the effect of hostile licensing laws, either on the regulated occupation or on society at large. As noted above, most studies pertaining to medical licensure deal with physicians. It is exclusive emphasis on friendly licensure that leads to the conclusion that licensing always benefits an occupation.

Many historians of midwifery regard legal recognition as necessary for the survival of the occupation, and they also believe it will improve the quality of care. In her analysis of the British Midwives Act of 1902, Donnison (1977: 174–75) acknowledges that, thanks to its various restrictive clauses, the act, "which was to lay the basis for the present law relating to midwives, was like no other registration Act, before or since, and was to put the midwives in a uniquely disadvantaged position among the professions." However, she still concludes that without the act the midwife

would most probably have vanished from the scene within the next fifty years, squeezed out by her medical competitors. Midwifery would then have become the sole prerogative of what is still . . . a predominantly male profession. Women would have suffered a double loss—the disappearance of a traditional female occupation, and the denial of female attendance in childbirth. Finally, from the standpoint of society in general, a medical monopoly of midwifery would have had important implications for the cost of obstetric care.¹


Subscribing to similar reasoning—reasoning steeped in common-sense understandings of licensure—lay midwives who are currently practicing have welcomed recent attempts to license their occupation, regarding such legislation as a means of improving quality and insuring their professional future. When one looks at the history and effects of midwife legislation in most Western nations, however, their optimism seems unfounded. The future se-
cured by licensure may not be welcomed by those who struggle to secure it. To demonstrate the relationship between midwifery and the law, we shall look at the historical development of midwife licensing laws, with special attention to the factors behind the creation of the law, the sanctions available for enforcement, and the influence of the law on the occupation.

Although limited data make definitive statements difficult, it appears that early, church-sponsored systems of midwife registration had little impact on the occupation. The creation of an ecclesiastical licensing system reflected the church's desire to prevent midwives from coercing fees, giving abortifacients, practicing magic, or concealing information about birth events or parentages from civil or religious authorities. Further, the church was interested in insuring a proper baptism for infants who died in childbirth. The following excerpt from a midwife license issued by the bishop of London in 1588 illustrates the concerns of the church (Hitchcock, 1967: 75–76):

First that ye shalbe dilligente faithfull and redye to helpe everye woman travelinge of Childe as well the poore as the ritche and that in tyme of necessitie you shall not forsake and leave the poore woman and goe to the ritche. Item you shall neyther cause nor suffer anye woman to name or put other father to the Childe but onlye him that is the verye father indeede thereof. Item you shall not suffer anye woman to ... clayme anye other womans childe for her owne. Item ye shall not suffer any childe to be murdered maymed or otherwise hurte.... Item that ye shall not in anye wise use or exercise anye manner witchcraft charme Sorcerye invocations or other prayers then may seeme withe godes Lawes and the Queenes. Item ye shall not give anye Counsaile or minister anye herbe medcyne pocon or anye other thine to anye woman beinge withe childe wherby she sholde destroye or caste out that she goethe withall before her tyme. Item ye shall not enforce anye woman by
paynes or by other ungodlye wayes or means to give you more for your paynes and labor in bringinge her abed then they wolde otherwise doe. . . . Item if anye childe be ded borne ye your selfe shall see yt buryed in suche secrett place as neyther hogge dogg nor anye other beste maye come to yt. . . . Item ye shall use your selfe in honeste behaviore unto other women beinge lawfully admitted to the room and office of a midwife in all thinges accordinglye. Item that ye shall trulye pute to my selfe or my deputye all suche women as ye shall knowe from tyme to occupie and exercise the room of a midwife within the foresaid dioces and Jury of London without my licens and admis­sion.

Receipt of an ecclesiastical license was not based on a demonstration of competency or dependent upon the completion of an educational program; it relied solely upon a woman's ability to prove her good character and willingness to take an oath of office (see Donnison, 1977: 6-7; Forbes, 1966: 143-49). The sanctions available to the church, which included the prohibition from practice, excommunication, and forced penance, were unevenly applied and largely ineffectual. In spite of the requirement that licensed midwives must report all women practicing without a license, several sources indicate that many midwives remained both unlicensed and unpunished (Hitchcock, 1967; Petrelli, 1971; Roberts, 1962; Donnison, 1977: 7, 22). There was at least one widely employed way of circumventing the law: "Since possession of a license was not required for practice as a 'deputy' to a licensed midwife, women might continue in this capacity for many years without enquiry into their mode of life" (Donnison, 1977: 7). In sum, possession of a church license did little to distinguish a licensed from an unlicensed midwife. Because the latter were still available and because prospective clients saw no advantage in retaining a licensed midwife, traditional modes of practice remained largely unchanged.6
Although the first known government-sponsored law regulating midwives was adopted in 1452, municipal regulation of midwives did not begin in earnest until the 1500s. Government-sponsored regulation was the result of a different set of motivations and had more important consequences for the occupation. The laws sponsored by secular authorities grew from a concern for public health coupled with the new and "scientific" view of childbirth that was emerging in the sixteenth century. France's newly created hospital schools provided surgeons and midwives with the opportunity to observe many births and encouraged a rational approach to labor and parturition. The new science of midwifery seemed an improvement over the practices of the traditional midwife, which were regarded as potentially dangerous and governed by ancient superstition (see Wertz and Wertz, 1977: 31–33). For example, among the many books on childbirth published in the sixteenth and seventeenth centuries was that of Gervais de la Rousche (1567), entitled *The most important and sovereign science of the art and natural activity of the infant. In opposition to the most accursed and wicked incompetence of women who call themselves midwives or stepmothers, who by their ignorance are responsible for the deaths of many women and infants*. Faith in the scientific approach to birth gradually expanded, and municipal officials interested in the health of their population began to feel it necessary to require competence on the part of midwives. To accomplish this, earlier licensing procedures were revived and made more rigorous by the addition of a formal examination (given by either a physician or an experienced midwife) and/or the requirement of some form of education. An ordinance issued in the French municipality of Lille in 1568 is typical (cited in Petrelli, 1971: 282, emphasis added):

It came to our notice that several persons were daily assuming the cure of some difficult cases and practicing surgery and assisting in childbirth without having demonstrated their competence; from which follow deplorable accidents to the disadvan-
tage of families and the loss of His Majesty's subjects. For this reason, we forbid very emphatically all persons . . . henceforth to assist in childbirth without previously having been presented to the authorities and without having been examined by the experts, who for this purpose will be delegated and commissioned by us, and without record of their approval and admission for the practice of midwifery.

Unlike ecclesiastical licensing, municipal regulation worked to limit the scope of the midwife's practice. Because these regulations recognized a body of knowledge related to birth that had been developed by physicians ("the experts" mentioned in the Lille ordinance), the midwife was placed in a subordinate position. In most instances she was required to send for the assistance of a doctor or surgeon in difficult births, and in certain locales she was prohibited from using hooks or other sharp instruments. Like earlier church-sponsored laws, many of these municipal licensing laws required the certified midwife to inform the authorities of any woman practicing midwifery without a license (Donnison, 1977; Petrelli, 1971). These various penalties associated with the violation of these laws included fines, prohibition from practice, imprisonment, and in certain cases, death. But as with earlier regulatory schemes, enforcement was difficult. Undoubtedly, municipal licensing laws reduced the number of uncertified midwives, but the gradual acceptance of the scientific approach to childbirth was far more important. The spreading public belief in the benefits of the new obstetric art suppressed the traditional midwife more effectively than the strongest legal penalties.7

With the rise of nation states in Europe, municipal systems of midwife regulation gradually gave way to state-sponsored licensing laws. Although the relative autonomy granted to midwives varied by country, the creation of state regulations in Europe established the midwife as a legitimate and permanent part of childbirth care, albeit in a subordinate role. In England and America, where there
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were only scattered instances of municipal regulation, the issue of state-mandated licensing did not arise until the turn of this century, and it often became the subject of bitter debate (see Donnison, 1977: 116–202; Litoff, 1978: 48–134; Kobrin, 1966). The desire of some doctors to use regulatory measures to subordinate and eventually eliminate midwifery provoked strong enmity in opponents in the controversy.

In England, proposals for the secular regulation of midwives had been made intermittently since 1616 (see Aveling, 1977a [1872]), but it was nearly three hundred years before a state-sponsored system of midwife licensing was enacted. The proposals for midwife registration made over that three-hundred-year span reflected the concerns of other European countries for improving competency and reducing maternal and infant death. In justifying one of his several regulatory schemes, Peter Chamberlen (1647, quoted in Donnison, 1977: 15) noted that the current licensing system required the testimony of “two or three Gossips . . . But of Instruction or Order amongst the Midwives, not one word.” Another proponent of midwife licensure, J. H. Aveling, observed that the history of this issue in England was marked by “a conviction often reiterated, and now and again vehemently urged—namely, that it is necessary to give instruction to midwives, and a guarantee of their skill to the public” (Aveling, 1977a [1872]: 14, emphasis in original).

A lack of consensus on the desirability of midwife registration among English doctors, midwives, and the public prevented the first serious proposal for midwife licensing (introduced in 1890) from becoming law. Modified versions of the bill introduced over the next twelve years met a similar fate. Many doctors opposed midwife registration bills on the grounds that midwifery would die a natural death if left alone. When it became evident that some form of midwife licensing law would eventually be enacted, these same doctors began to favor registration; but they sought to insure tight medical control over midwives. There was some opposition to registration among the midwives. The Manchester Midwives’ Society, a
group of sixty certified midwives from Manchester and surrounding areas, strongly objected to registration under medical control, seeing it as a “sacrifice” of the occupation (Donnison, 1977: 151). On the other hand, the London-based Midwives' Institute, which had a larger constituency and more political influence than the Manchester group, took the position that the “need for regulation in the interests of poor mothers was so great that, provided certain clauses safeguarding midwives’ rights were retained, any Bill was better than nothing” (Donnison, 1977: 153). The wishes of the Midwives' Institute were realized in 1902 when the Midwives Act was finally passed into law. Although the 1902 version of the bill was more favorable to the midwife than some of the earlier drafts, it did subject her to substantial medical control by (among other things) creating a medically dominated regulatory board, prohibiting unlicensed practice, and requiring the midwife to send for a doctor if abnormalities in labor were detected. Failure to adhere to the often minutely detailed provisions of the act could result in the loss of certified status.

While enforcement was difficult and uneven, this act, coupled with other developments in perinatal services, set in motion a process which has nearly eliminated independent midwifery in England. The British midwife is now part of an “obstetric team” headed by a physician. Domiciliary confinements have all but disappeared, and there is periodic consideration of a requirement that would make nurses' training mandatory—a move that many feel would make midwives indistinguishable from obstetric nurses. The effect of the licensing law was not immediate. But this law became part of the social environment and had important indirect effects on the occupation. Donnison (1977: 186–87) suggests that the independent practice of midwifery in England began to disappear because of the lack of cooperation by physicians, falling birth rates, the growth of subsidized midwifery services, and the increased popularity of hospital birth. The 1902 Midwives Act was in part a product of these developments, and it contributed to the loss of inde-
dependence for midwives. For instance, lack of cooperation from physicians would not have had a severe impact on midwives without regulation. With it, midwives were drawn into the hospital and subjected to direct supervision by physicians.

The history of state-mandated midwife regulation in America is complicated by the federal/state political structure. Litoff (1978: 56–57) observes: "No two states provided for their midwives in exactly the same way. The laws regulating midwives varied from state to state and the forty-eight separate bureaus of child hygiene worked at cross purposes on a number of occasions." Nevertheless, it is possible to make a few general statements about the changes in the legal status of midwifery in the United States. As in England, the issue of midwife regulation began to emerge around the turn of the century. At least one state (Connecticut) had a midwife licensing law on its books as early as 1893, but more commonly, midwives practiced without state interference or control until the 1920s. The midwife debate reached its height between 1910 and 1920 and took place largely in medical journals and at medical conferences—two arenas of discussion which transcended the political boundaries of the states. In her analysis of the controversy, Kobrin (1966: 353–54) has distinguished four characteristic approaches to midwifery legislation.

1. At one extreme were those who advocated outright abolition of the midwives, with legal prosecution for those who continued to practice.

2. A second group . . . favored eventual abolition, with the existing midwives closely regulated until substitutes could be furnished.

3. A third group was pessimistic about ever abolishing the midwife and thus felt that regulation plus education would elevate the midwife to the relatively safe status she had achieved in England and on the continent.

4. Finally, there were those, especially in the South, who felt
that if, somehow, midwives could be made to wash their hands and use silver nitrate for the babies’ eyes, that would, because of a host of economic and cultural reasons, be the most that could be expected.

All parties in this debate professed an interest in public health. The 1921 Sheppard-Towner Maternity and Infancy Protection Act provided funds that allowed several states to institute programs of midwife education and registration. By 1930—one year after the Sheppard-Towner Act expired (chiefly because of strong opposition from the American Medical Association)—all but ten states required their midwives to be registered. Because (unlike England) there were few, if any, midwife associations, much of the legislation generated at this time reflected the views of physicians’ organizations anxious to suppress or eliminate the midwife. But even where medical societies were able to secure “favorable” (that is, repressive) legislation, enforcement presented a problem. In Massachusetts, where midwifery was prohibited in 1918, midwives were still attending a sizable number of births as late as 1935. If anything, the Massachusetts experience served to indicate the futility of abolishing midwives, “for illegality did not remove them but only made it impossible to supervise them” (Wertz and Wertz, 1977: 213). The problem of enforcement also suggests that the upsurge in regulatory acts was not solely responsible for the gradual disappearance of the American midwife. In fact, three separate histories of the American midwife locate the reasons for her demise in larger social and cultural changes (see Kobrin, 1966: 362–63; Litoff, 1978: 139–42; Wertz and Wertz, 1977: 215–17). These changes include declining birth rates, restricted immigration (which both prevented new midwives from arriving and reduced the need for them), an increase in the number of hospital beds available for maternity cases, and a growing anxiety about the dangers of birth. However, as in England, it is important to note that regulatory law existed in interaction with these other social developments.
As noted earlier, midwifery was kept from extinction in the United States by the needs of the urban and rural poor. The Maternity Center Association in New York and the Frontier Nursing Service in Kentucky were created to serve the needs of the indigent; their training programs were chiefly responsible for the re-emergence of nurse-midwifery in America (see Rothman, 1982: 63—75). The certified nurse-midwife was given formal recognition by the obstetricians' professional association (American College of Obstetricians and Gynecologists, ACOG) in 1971, and she is now able to practice legally in fifty-one states and jurisdictions. However, this acceptance was bought at the price of independence. Because nurse-midwifery re-emerged in the context of nursing—an occupation created to assist physicians—nurse-midwives inherited a history of control by the medical profession. While some nurse-midwives acknowledge this control, others are struggling for professional autonomy. According to the American College of Nurse-Midwives, "The American nurse-midwife always functions within the framework of a medically directed health service....She is never an independent practitioner (ACNM, n.d., emphasis in original; see also Runnerstrom, 1968). In contrast, the more independent lay midwife is perceived as an anachronism with limited legality and no effective national organization.

Midwifery and the Law: Some General Comments

The history of midwife regulation reveals some persistent patterns. Similarities are found in the justification offered for legislation, the process by which proposed legislation became law, and the effects of such legislation.

A concern for public health was always behind the drive for secular systems of midwife regulation. Suggested solutions to the "mid-
wife problem" ranged from virtual elimination of the practitioner to continued unrestricted practice. Of course, implicit in the concern for improving public health is the notion that better methods for optimizing the well-being of the population are available. In this case, the growing science of obstetrics was gaining both public and official acceptance as the safest method of managing birth. Gradually the practice of midwifery was restricted to midwives with demonstrated competence in and allegiance to knowledge developed by physicians.

A crucial element in midwife regulation was the scientific redefinition of the birth experience. Several sources note the changes in birthing care as prime examples of the "medicalization" of life in the twentieth century (see Zola, 1972), but no one has described how this "medicalization" came about. Historical studies show that in the case of birth, medicalization was preceded by "abnormalization." Obstetricians in both England and America made a concerted effort to convince the public that birth was a pathologic condition, not a routine, normal event. Donnison (1977: 38–39) notes that English "men-midwives . . . anxious to establish their own importance in the eyes of the public . . . exaggerated the dangers of childbirth and frightened women into believing that extraordinary measures, and therefore male attendance, were more generally necessary than they actually were." Similarly, Kobrin (1966: 353) observes that American obstetricians early in this century "argued again and again that normal pregnancy and parturition are exceptions and that to consider them normal physiologic conditions was a fallacy." An instructional book for expectant mothers published in 1935 warns:

To consider childbirth as normal and natural is in a sense misleading, as every woman in childbirth is potentially a major surgical case. The risk of an emergency is always present whether with the first baby or the fifth. Therefore, in every maternity case
selection of the doctor is as vital as it would be in a case of pneumonia or appendicitis (Heaton, 1935: 209).

Perhaps the most illustrative of the abnormalization process are the comments of Dr. Joseph DeLee (1920: 39–41) in a passage from his trend-setting article, "The Prophylactic Forceps Operation":

It always strikes physicians as well as laymen as bizarre, to call labor an abnormal function, a disease, and yet it is decidedly a pathologic process. Everything, of course, depends on what we define as normal. If a woman falls on a pitch-fork, and drives the handle through her perineum, we call that pathologic—abnormal, but if a large baby is driven through her pelvic floor, we say that it is natural, and therefore normal. If a baby was to have its head caught in a door very lightly, but enough to cause a cerebral hemorrhage, we would say that is decidedly pathologic, but when a baby's head is crushed against a tight pelvic floor, and a hemorrhage in the brain kills it, we call this normal, at least we say that the function is natural, not pathogenic. [If] the fall on the pitchfork, and the crushing of the door [are] pathogenic [then] in the same sense labor is pathogenic . . . and anything pathogenic is pathologic and abnormal. . . . So frequent are these bad effects, that I have often wondered whether Nature did not deliberately intend women to be used up in the process of reproduction, in a manner analogous to that of the salmon, which dies after spawning.

The "Friedman curve," which defines normal durations for the various stages of labor, is another example of abnormalization. Developed in the late 1950s by Dr. E. A. Friedman, the curve suggests that women whose lengths of labor fall outside a statistical average are abnormal and in need of medical intervention (see Rothman, 1982: 259–60). Parenthetically, I should note that the process of
abnormalization and medicalization has occurred in areas other than birth. Before a problem or condition can be placed in the medical bailiwick, the public must be convinced that there is something abnormal about that condition that makes medical attention necessary. The popularity of genetic counseling, for instance, has increased as more couples become convinced that getting pregnant, rather than a normal process, is fraught with the potential for abnormal offspring.

Public acceptance of birth as abnormal can be attributed to two factors. First, the newly enfranchised woman was receptive to modern obstetric technology because it offered further liberation from traditional roles. Second, the self-imposed limitation on the number of births made the expense of a medical birth seem a worthwhile investment. The impressive array of obstetric technology was seen as insurance of a healthy birth.

The consequences of acceptance of this view of birth for midwifery and its regulation were enormous. If birth is accepted as abnormal, then only medical solutions are appropriate. It becomes the duty of the state to replace antiquated methods with more modern approaches.

Another feature of the institutionalization of midwife regulation involves the attitudes of the members of occupations most directly involved. With few exceptions, physicians opposed the registration of midwives on the grounds that legal recognition would enhance the midwife's position, take births away from doctors, and hinder the development of obstetrics. While many doctors regarded assisting in birth as a time-consuming, often messy, and manual task, it was an important way of developing and maintaining a clientele. On the other hand, and for many of the same reasons, midwives favored some type of licensing law, viewing such legislation as a necessary condition for survival. These positions seem consistent with the best interests of the occupations involved, but the effects of regulation turned out differently than either side expected. Instead of es-
tablishing midwifery as an independent profession, they placed the midwife in a position of decreased autonomy.

The enforcement of midwife legislation posed certain problems. It required collaboration by those least likely to provide it—namely, those who employ the unlicensed midwife. However, when action is taken against a midwife, she receives harsher treatment from a regulatory agency or board than from a court of law. Donnison (1977: 182–83) states that the supervisory and disciplinary powers granted by the 1902 Midwives Act to local authorities and the Central Midwives Board in England were often used vindictively to suspend or expel women from practice for minor infractions. The irony is that regulatory measures are only effective in controlling the certified midwife. It is the court’s responsibility to sanction unlicensed practitioners, but courts have proved unwilling to prosecute, partly because of lack of evidence and partly through an unwillingness to deprive anyone of care (see Donnison, 1977: 184).

Of course, the social control exerted by regulation is not limited to disciplinary proceedings. Mandated education for midwives serves as an important means of social control. Donnison (1977: 183) comments on the decrease in penal cases brought before the Central Midwives Board that followed the disappearance of the “bona-fide” midwife in England. Bona-fide midwives were women who had received licenses on the basis of experience rather than through an approved educational program. As this kind of midwife disappeared, the need for the reactive control of penal proceedings diminished and was replaced by the built-in proactive control of socialization that accompanied midwifery training. One form of social control replaced another.

The history of midwifery indicates that health-care occupations are not exclusively shaped by law and technology. Medicine is shaped by the larger culture. Changes in the style of attendance of birth can be traced to changes in the composition of the population
and changing attitudes toward technology. The law works in interaction with these other developments. While earlier discussion has shown that the decline of midwifery was tied to the rise of obstetric science, it is clear that the law accelerated this trend by providing the public with a visible means (a license or certificate) to distinguish those who were schooled in this new science from those who were not. Well aware of this, medical professionals have pushed certification by educating the public on the benefits of having a certified practitioner, trained in the new techniques, at childbirth. Outlining a nineteenth century plan to "improve the condition of midwives" put forth by the London Obstetrical Society, Aveling (1977a [1872]: 165) notes: "A diploma . . . is offered to those who can show themselves to possess the minimum amount of knowledge which an ordinary midwife should have, and it is hoped that the distinction thus offered will induce midwives to seek the instruction necessary to obtain it." In her narrative concerning Georgia's granny midwives, Campbell (1946: 40, emphasis added) comments:

How much of the Old Law is mingled with the New Law in the practice of midwifery by the grannies? Only direct supervision of each delivery would tell. And the public health nurse in Georgia carries too heavy a load for that. She does make home visits to expectant and new mothers. She does what teaching she can in the home and at clinics, hoping that the mother will come to expect and insist upon the best care the midwife can give.

The new laws often disrupted traditional relationships important to the midwife. Mongeau et al. (1961) state that the decline of the granny midwife in North Carolina can be attributed to disruptions in the traditional midwife-apprentice, midwife-doctor relationships engendered by regulation. In that state, licensing procedures supplanted long-established training by apprenticeship, and prohibited midwives from using a variety of remedies they once employed under the direction of a local physician. It was only a matter of time
before the granny midwife—who had no successor nor the sanction of a privileged relationship with the local physician—began to disappear. One old Southern woman recalls (quoted in Wiggin­ton, 1973: 286):

They didn't have t'have a license when they first began, as far back as I can remember. I didn't know of 'em havin' t'have'em until up t'later years. Then they got t'where if they delivered babies, they had t'have a license. And they were finally just completely cut out of th' job at all. Weren't allowed t'do th'job at all.

Legal recognition altered the style of practice by cooptation. Because legal status often brings privileges as well as increased visibility, those who benefit from it are often unwilling to disregard mandated standards. This is apparent in the unwillingness of the American certified nurse-midwife to violate the code of conduct established by her professional organization, and it also holds for licensed lay midwives. An example is provided in Fran Ventre's (1976) account of how an obsolete statute helped her gain legal status as a lay midwife in Maryland. She had been assisting with births illegally, but after receiving the first license issued in her county since 1924 she comments (Ventre, 1976: 114–15):

Ironically enough, since receiving my license I have been free to do very few deliveries. One limiting factor has been the refusal of many obstetricians to provide the medical backup stipulated by the law. To do deliveries without it would risk forfeiture of my license and possible imprisonment. I have not gone underground again because I feel a strong commitment to keeping this license.

It would be misleading to conclude this chapter without recognition of the real benefits licensure offered midwives. Actually, it might be more accurate to say the benefits that licensure offered midwifery, for the advantages of licensure lay in providing public legitimacy for the occupation and in enhancing its image. As tech-
nology of medicine extended its dominance over birth, public demand for scientifically trained practitioners increased. Licensure, which allowed midwifery to link itself with medical science, improved the marketability of the profession. But therein lies a dilemma. While licensure improved the image of midwifery, it reduced the independence of individual midwives by requiring midwives to submit to physician authority. Licensure therefore benefited the profession of midwifery while damaging individual professionals. Of course the fates of individual practitioners are inextricably linked with the fate of the profession. Without licensure, midwives faced the prospect of retaining autonomy while being ignored and rejected by the public. This dilemma persists in current struggles over the licensing of midwives.

Lay midwife licensing laws, which have begun to appear in several states, provide more recent examples of the relationship between law and midwifery. In Chapter 3 I look closely at legislation aimed at regulating lay midwives in the states of Arizona, Texas, and California. Examination of these bills and the debate they engendered—in their respective legislatures, among medical professionals, and among the public—reveals the continuation of themes visible in earlier midwife legislation.