Chapter 3

Midwifery in the Legislature: Licensing Laws in Arizona, Texas, and California

The interaction of medicine and law becomes most visible when different kinds of practitioners come before legislative bodies seeking passage of laws favorable to their profession. These cases commonly generate debate between representatives of established medical professions and a group of unorthodox practitioners and their clients. The latter group enters the debate at a disadvantage, however, because cultural faith in the allopathic ideology of "medical experts" weighs heavily in the decisions of legal officials. The struggle of lay midwives to win passage of favorable legislation affords a good example of this process; this chapter considers successful and unsuccessful attempts to establish licensing laws for lay midwives in the states of Arizona, Texas, and California.

The last several years have seen a flurry of legislative activity centered on the licensure of lay midwives. The issue began to appear on the agendas of state legislatures in the late 1970s. Since that time debates over the wisdom of licensure have echoed through statehouse halls and hearing rooms from New Hampshire to California. The nature of these debates varied according to existing state
statutes. In some places the argument concerns revisions of laws created earlier in this century; in others the battle is over laws which would legitimize midwifery after a period of legislative prohibition. But the issues here are essentially the same as in earlier laws licensing midwives. These new laws, like those proposed decades ago, are justified by appealing to public health, are concerned with socially accepted definitions of birth, are generally opposed by physicians and supported by midwives, and give control over licensure to nonmidwives. Study of these laws demonstrates that the licensing of paramedics suits the strategy of the more established medical professions.

When I began my research, the laws governing lay midwives in California, Texas, and Arizona could be described as follows. In California no system of licensure existed, and lay midwives were subject to prosecution for violation of the state’s Medical Practice Act. In Texas lay midwives had to register with the county, but were not required to complete educational programs or to demonstrate competency. As a result of an administrative updating of an old law, Arizona maintained a licensing program that required the successful completion of a course of instruction and the passing of a comprehensive examination.

In order to understand what happened in these states it is important to describe the general reawakening of interest in lay midwifery.

The recent concern with the licensing of lay midwives probably seems odd to the casual observer. After all, aren’t lay midwives a thing of the past? Why bother to license an archaic practitioner? In fact, legislative concern with lay midwives testifies to the renewed popularity of this practitioner.

As noted earlier, midwives were an important part of perinatal care in the United States until early in this century. Not being “true” medical practitioners, and therefore lacking access to hospitals, midwives officiated primarily at home births. The increasing popularity of hospital birth in this century nearly accomplished their de-
mise, as the proportion of hospital births in the United States grew from 36.9 percent in 1935 to 96 percent in 1960 (see Devitt, 1977; Jacobson, 1956). Laws governing midwives followed developments in medical science, and midwives gradually found themselves legally enjoined from practice in several states. In others they faced restrictions in the kind of women they could engage as clients and in the range of procedures they could employ.

There seemed little dissatisfaction with this state of affairs until the last decade or so. During the 1970s a collective murmuring about medically dominated hospital birth arose, and was accompanied by a small but significant turn toward home birth. The demand for lay midwives increased, in part because home birth became more popular and physicians have been hesitant to participate in home births. Many doctors feel that birth outside the hospital is inherently unsafe (for example, see Pearse, 1979); others feel constrained by threats to their malpractice insurance; there is also pressure from disapproving peers. In truth, most malpractice insurers will not cover a physician who assists at home births, and some physicians have lost their hospital admission privileges through participation in home births. According to the stated policy of one hospital, “Hereafter [December 1, 1976] any physician with OB [obstetrical] privileges at [this hospital] who intentionally participates in a non-emergency ‘home delivery’ will be viewed as no longer fulfilling the professional expectations of the OB staff of the hospital, and will immediately have OB admitting privileges revoked” (quoted in Annas, 1977: 11).

Table 1 provides evidence of the trend away from hospital births. This table indicates a gradual increase in both the absolute number and the percentage of out-of-hospital births between 1973 and 1977. Between 1973 and 1977 the total number of births increased 6 percent, while nonhospital births showed an increase of 122 percent. In 1978 nonhospital births declined sharply, probably due to a decline in the counterculture movement and a rise in popularity of in-hospital alternative birth centers (see DeVries, 1980;
Table 1. Number and Percentage Distribution of Live Births by Place of Delivery, United States, 1950, 1955, 1960, 1965, 1970–81

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Live Births</th>
<th>No. Attended</th>
<th>% Attended</th>
</tr>
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<tr>
<td></td>
<td>Live Births</td>
<td>In Hospital</td>
<td>Out of Hospital</td>
</tr>
<tr>
<td>1950</td>
<td>3,554,149</td>
<td>3,125,975</td>
<td>428,174</td>
</tr>
<tr>
<td>1955</td>
<td>4,047,295</td>
<td>3,818,810</td>
<td>228,485</td>
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<tr>
<td>1960</td>
<td>4,257,850</td>
<td>4,114,368</td>
<td>143,482</td>
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<tr>
<td>1965</td>
<td>3,760,358</td>
<td>3,660,712</td>
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<td>1970</td>
<td>3,731,386</td>
<td>3,708,142</td>
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<td>1971</td>
<td>3,555,970</td>
<td>3,523,860</td>
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<td>1972</td>
<td>3,258,411</td>
<td>3,233,703</td>
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<td>1973</td>
<td>3,136,965</td>
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<td>1974</td>
<td>3,159,958</td>
<td>3,133,797</td>
<td>26,161</td>
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<td>1975</td>
<td>3,144,198</td>
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<td>1976</td>
<td>3,167,788</td>
<td>3,123,439</td>
<td>44,349</td>
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<td>1977</td>
<td>3,326,632</td>
<td>3,276,732</td>
<td>49,900</td>
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<td>1978</td>
<td>3,333,279</td>
<td>3,300,659</td>
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<td>1979</td>
<td>3,494,398</td>
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<td>1980</td>
<td>3,612,258</td>
<td>3,576,370</td>
<td>35,888</td>
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<tr>
<td>1981</td>
<td>3,629,238</td>
<td>3,591,582</td>
<td>37,656</td>
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Since 1978, nonhospital births have once again climbed steadily. Further evidence of the discontent with hospitals may be found in the number of recent publications concerning birthing alternatives. These include periodicals such as Birth (formerly Birth and the Family Journal), Mothering, Newsletter of the Association of Radical Midwives, and The Practicing Midwife, as well as a variety
of monographs and anthologies (for example, see Lang, 1972; Mili­naire, 1974; Hazell, 1976; Sousa, 1976; Stewart and Stewart, 1976; 1977; Arms, 1977; Ward and Ward, 1977; Baldwin, 1979a). A num­ber of associations promoting alternative methods of childbirth have also been formed in the last few years. These include National Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC), Association for Childbirth at Home International (ACHI), the American College of Home Obstetrics (ACHO), the Association of Radical Midwives (ARM) in Britain, the Midwives Alliance of North America (MANA), and several state midwifery associations.

Although decisions to give birth outside the hospital are moti­vated by a variety of concerns, there are some common themes. Various social movements have encouraged critical review of the standard physician-attended hospital birth. Also, a growing body of literature calls attention to the negative, potentially damaging as­pects of birth in a hospital.

Both the feminist movement and a general emphasis on the ben­efits of "naturalness" have encouraged the turn away from hospital birth. The feminist movement led women to question the treat­ment they were receiving from society and its institutions; out of this grew the women's health movement and, specifically, discon­tent with the medical domination of females by males in obstetrics and gynecology (see Ruzek, 1978). Our cultural fascination with "natural foods" and "natural" life-styles, which grew out of the counterculture of the sixties and seventies and is now widely ex­ploited by advertisers, also prompted a reconsideration of hospital birth and its heavy dependence on drugs and machines.

Some recent studies of hospital birth criticize its procedures as dehumanizing, costly, and fraught with the potential for iatrogenic disease and death. Suzanne Arms' work, *Immaculate Deception* (1977), perhaps the most influential book for the home birth move­ment, describes in detail how the hospitals deprive the laboring and birthing woman of her humanity. She notes that the expectant
mother "is shifted from room to room and rolled from bed to bed; she is examined internally by several attendants she does not know, and poked, stabbed, strapped down and checked out by several more" (p. 109, see also Shaw, 1974). Arms also argues that routine hospital procedures result in assembly-line treatment of mothers and serve to separate parents and children during the crucial period following birth.

Several books that advocate home birth note its economic advantages. The cost of an obstetrician-attended hospital birth free from complications ranges from $2000 to $3000, whereas a lay midwife-attended home birth usually costs $400 to $750. But perhaps most devastating are studies suggesting that birth in hospitals is more dangerous than giving birth at home. Haire (1972) has outlined the potential for disease and injury inherent in modern childbirth techniques (see also Caldeyro-Barcia, 1975). After a study which matched 1046 home births with an equal number of hospital births on the basis of social and medical characteristics, Mehl and his associates (1976) reported no appreciable differences in mortality, but a significantly higher rate of birth injuries to the neonate for the hospital group.

Those who choose to give birth outside the hospital usually cite one or more of the criticisms outlined above as the motivating factor in their decision. And although not all who give birth at home seek the assistance of a lay midwife, it is this group that provides her clientele. Indeed, the midwife's clientele has changed. Those who used midwives earlier in this century were limited by their economic condition or geographic location, while those who currently employ lay midwives often consciously seek them out. Research by myself and others (Hazell, 1974; Ellis et al., 1980; Rubin, 1976; Anderson et al., 1978; Yankauer, 1983: 637) confirms that those who choose to give birth at home do so freely. Generally they are not poor, and many do not live in rural areas. Most are concerned with the spiritual and experiential dimensions of birth, and for them the midwife is the logical choice as attendant. The tradi-...
tion of midwifery entails a sensitivity to these aspects of the birth process (for example, see Holmes, n.d.; Gaskin, 1978), aspects that are ignored by most physicians, who feel they are superfluous to a healthy birth.

The competition engendered by moderate birth rates and growing numbers of physicians has alarmed medical professionals and organizations. They have reacted with warnings about the dangers of bypassing established medical care, and attacked the character of those who do. A former director of the American College of Obstetricians and Gynecologists (ACOG) has referred to home birth as "in utero child abuse." The past president of the Massachusetts section of ACOG states that home birthers are "kooks, the lunatic fringe, people who have emotional problems they are acting out" (quoted in Annas, 1977). An editorial published in the Journal of the American Medical Association provides the following tongue-in-cheek assessment of nonhospital birth (Pearse, 1979):

Of course, of the mothers who are screened carefully, some of their infants can be delivered at home, and not too many additional babies will die. Only some mothers will have to be rushed through an emergency room to the care of newly telephoned physicians who have never seen the patient. Since only one mother in 8,000 now dies in childbirth in the United States, these mothers and most of their babies will be rescued. What baffles me is why this is considered by some to be a great leap forward in birth care.

A different response by medical professionals has been the attempt to coopt the home birth movement (see DeVries, 1979a; 1980; 1983; 1984). In spite of their harsh condemnation of those who choose home deliveries, physicians and other medical personnel have altered hospital care to make it more attractive to its critics. This more positive reaction—supported by several medical professional organizations—calls for the creation of "family centered maternity and newborn care" in hospitals (ACOG, 1978;
AMA, 1977). In response many hospitals have set up “alternative birth centers” (ABCs). Although these programs vary, most permit a woman who is expected to have a “normal, uncomplicated birth” to labor and deliver in the same bed. They also allow friends and relatives to be present, and permit the infants and their parents to stay together from birth until time of discharge, usually twelve to twenty-four hours after the birth. Many ABCs attempt to recreate the atmosphere of the home with carpeting, hanging plants, pictures, a stereo, overstuffed chairs, and a dining table. Individuals responsible for setting up ABCs readily admit that the programs exist because of consumer pressure. One ABC coordinator told me, “The idea for an alternative birth center came from outside pressure. We felt that an alternative birth center would be a good idea, especially if we could get the people who were delivering at home.” The clinical supervisor of an obstetric ward in another hospital in the process of setting up an ABC told me, “I’m sure competition is a major factor in the desire of physicians to open an alternative birth center . . . because they have lost patients. I don’t think they have lost many patients yet, but even if you lose one it makes you stand up and think.”

In addition to the cooptative arrangements, some medical professionals continue to use peer pressure and legal tactics to prevent home births. A recent case in Nashville, Tennessee, testified to the effectiveness of this pressure. A physician who supported a group of certified nurse-midwives was forced to leave town after the cancellation of his malpractice insurance and the lack of referrals from his colleagues; this in spite of congressional hearings in Washington, D.C., to examine if he and the nurse-midwives were victims of illegal restraint of trade (see Committee on Interstate and Foreign Commerce, 1980).1 Similarly, a Texas midwife reports (Stanwick, 1977): “The one physician who was assisting us was visited by the County Medical Society and informed that if he did not sever all connection with us they would deprive him of hospital privileges and wreck his practice. He was forced to stop offering his services.”
Although they have no profession-based control over lay midwives who participate in home births, physicians have used state medical practice acts to prosecute practitioners. In states where the precedent in case law exists, midwives can be charged with practicing medicine without a license; physicians will often initiate prosecution when they feel enough evidence exists. If a midwife happens to be a registered nurse, she can be charged with exceeding her scope as defined in the nurse-practice act.

It is in this climate of criticism, charges, and countercharges that midwife licensing bills have been introduced in several state legislatures (see MAACC, 1980; Sallomi et al., 1981; Cohn et al., 1984). In some cases midwives who feared prosecution have sought a licensing law to enable them to practice. In other cases established medical communities have initiated licensing laws in order to gain more control over these practitioners. In the following sections we will look more closely at specific lay midwife licensing bills in Arizona, Texas, and California, analyzing both the motivations behind their introduction and reasons for their failure or success in gaining passage.

Arizona: Revision of a Permissive Law

Arizona is unique among the states being studied because its midwife licensing law was revised by administrative procedure rather than by direct activity of the legislature. However, this administrative change occurred in the context of threatened legal action and possible legislative revision of the midwifery statute. The administrative process circumvented the more publicly visible legislative route, and allowed the law to be altered by health department bureaucrats with the advice and direction of the medical community.

The first law regulating the practice of midwifery in Arizona was passed in 1957. It is estimated that about one hundred midwives were practicing in the state at that time, chiefly serving poor and
minority populations who lived in rural areas or community barrios. In particular, midwives worked among Hispanics and in rural Mormon communities. The law (Arizona Revised Statutes, 36-751–36-757) defined a midwife as "any person attending women in childbirth, habitually or for hire," and required all such persons to obtain a license before practicing. A license could be obtained upon payment of the one dollar application fee and demonstration of the ability to meet what were then very loose qualifications for office. These qualifications included:

(a) The ability to read and write [English].
(b) Knowledge of the fundamentals of hygiene.
(c) The ability to recognize abnormal conditions during labor.
(d) Knowledge of the laws of the state concerning the reporting of births, prenatal blood tests, and of the regulations pertaining to midwifery.

Applications had to indicate either the completion of a very minimal course of instruction or a passing grade on a qualifying examination. The law also established regulations defining the "duties and limitations of the practice of midwifery" and mandated penalties for violation of the regulations or for unlicensed practice.

After passage of the 1957 law, approximately 25–30 midwives were licensed; the supervision of this group was assumed by the Bureau of Maternal and Child Health of the Department of Health Services. Enforcement appears to have been minimal, as there is no record of disciplinary actions or convictions for unlicensed practice. Over the years most of these originally licensed midwives ceased practice; the one exception was a group of midwives who worked in a Mormon community located on the Utah border. Between 1959 and 1977 only four midwives were licensed.

In 1976, corresponding with the new popularity of lay midwifery, the Department of Health Services received what they regarded as an "influx" of requests for licensure. It is generally be-
lieved that this influx was inspired by publication of a chart that outlined existing state regulations of lay and nurse-midwives. The chart was prepared by an organization known as Home Oriented Maternity Experience (HOME, 1976) and gained wider circulation through publication in various periodicals associated with the alternative birth movement (including Birth and the Family Journal, Mothering). This chart identified Arizona as one of fourteen states that either licensed or allowed lay midwives to practice. The chair of the Maternal and Child Health Committee of the Arizona Medical Association told me: "Lay midwifery got its start elsewhere and then those groups started to look for places where they could practice legally. They discovered Arizona and started applying to the Department of Health Services for licenses." Several midwives confirmed that they were made aware of the Arizona law by the HOME chart, but I could find no evidence that anyone moved into the state simply to take advantage of the permissive law.

The Department of Health Services responded to this surge in requests for licensure by hiring a certified nurse-midwife to head a task force charged with updating the regulations governing lay midwives. The 1957 law granted the director of the department authority to "provide reasonable and necessary regulations to safeguard the health and safety of the mother and child," and this authority was cited as justification for revising "loose" or "minimal" regulations. The task force was comprised of medical professionals, including representatives of the Maternal and Child Health Committee of the Arizona Medical Association. Proposals for new regulations were solicited from groups such as the Arizona State Nurses Association, the American College of Nurse-Midwives, the Arizona Medical Association, and identifiable groups of consumers and midwives.

While the regulations were being reformulated, the Department of Health Services had to deal with the pending applications for licensure. In an attempt to postpone the issuance of new licenses, applicants were told that the department was out of applications or
that the qualifying examination was not prepared. At least one midwife responded by hiring an attorney who reminded the department of their obligation to provide applications and offer the exam on a timely basis. Given this legal nudge, the department agreed to offer applications and examinations to the seventeen women who had requested them under the old regulations. Ten of the seventeen were licensed after receiving a grade of 80 percent or better on the examination, which consisted of oral and written sections.

The new regulations were adopted on January 23, 1978. The adoption process requires submission of the revised regulations to the attorney general, who inspects them, signs them, and passes them to the secretary of state for filing. The department was able to expedite this process because a task force member's husband worked in the office of Attorney General (now Governor) Bruce Babbit. The new regulations are considerably more stringent than those they replaced. Each applicant is now required to show evidence of completing a course of instruction with specified content, observe a minimum of ten births, deliver a minimum of fifteen women under the supervision of a licensed practitioner, and pass a qualifying examination that includes written, oral, and practical sections. The regulations also detail the responsibilities of the midwife and the limitations on her practice. Department surveillance of midwives is established by requiring submission of quarterly reports that contain information on each pregnancy.

Since the adoption of the new regulations only a few women have been licensed. By the end of 1978 there were seventeen licensed midwives in Arizona; this included two Mormon midwives licensed before the new regulations, ten midwives who passed the exam while the regulations were being revised, and five midwives licensed under the new regulations. As of July 1981, only seven other midwives had been licensed, bringing the total of licensed midwives to twenty-four, half of whom received their licenses under the old regulations. A major hindrance to potential midwives is the lack of accredited educational programs. While approved in-
struction is required by the licensing law, the state recognized no educational program at the time of my research. Since then a pilot program was set up at a community college, but it later closed down.

The 1980–81 legislative session saw an attempt to allow unlicensed midwives to practice if they received no compensation for their services. This bill would also have temporarily allowed the issuance of provisional licenses to practicing midwives who had not completed an approved educational course, if they could pass the qualifying examination. The holder of a provisional license would be granted a regular license upon documentation of successful assistance in at least fifteen births. Senate Bill 1336 was authored by a senator whose constituency included a number of Mormon midwives who were dissatisfied with the existing regulations. They objected to the difficulty in obtaining the mandated education and also to the regulation requiring licenses even for those who assisted (only at births of fellow Mormons) without compensation. Given their religious convictions, these midwives were particularly uneasy about continuing their practice in violation of the law. The bill's sponsor admitted being partial to the midwives' cause because of his experience with midwives. His grandmother, a midwife in Texas, had assisted at his own birth.

Senate Bill 1336 passed the senate and made it out of committee in the house, but it died when the session ended without the bill being called for a vote before the house. Although the bill failed to pass, the political maneuvering that surrounded it is instructive. The Arizona Medical Association lobbied strongly against the bill. The author of the bill informed me that the bill had enough votes to pass the house; he suggested that it was never called for a vote because the speaker of the house, who was aware it could well pass, "belonged" to the Arizona Medical Association. The author of the bill also observed that "licensed midwives gave me more opposition [on this bill] than doctors did." He interpreted this opposition as their fear of competition. Finally, it is interesting to note the re-
action of the Department of Health Services to the near success of S.B. 1336. As the bill's author told me: "They know legislation is coming if they don't change [the regulations]. They know they will have to work with us." And indeed the department official who supervises the licensed midwives informed me that the regulations will be revised to deal with the predicament of Mormon midwives. I was told by this official: "We will change the rules and regs. We have to do it. If we don't do it, it will be legislated and they would like to change other things. The climate is now antiregulatory and the department regulates everything." She also indicated her fear of legislation that might allow provisional licenses; she felt that people "would come out of the walls" to take advantage of such a clause. As expected, the law granting a one-year grace period for the issuance of provisional licenses did pass in the next legislative season. Fourteen midwives were granted provisional licenses during that year.

The Arizona situation demonstrates the ways in which existing statutes can be tinkered with without the knowledge, input, or consent of consumers or midwives. It is clear that this licensing scheme did not promote the growth of the profession, and that the Department of Health Services succeeded in preventing an "influx" of lay midwives seeking to use the licensing law to become legitimate practitioners. Table 2 indicates that the rate of home births in Arizona is not remarkably different from the national pattern. The presence of licensed midwives has not inflated the number of non-hospital births; in 1978 licensed lay midwives were responsible for only 261 (0.6%) of the 531 births attributed to midwives in Arizona (the rest were delivered by nurse-midwives). Finally, we should also note that legitimation through the revised regulations has not impressed the medical profession. Nearly three years after the adoption of the revised regulations, a spokesperson for the Arizona Medical Association stated (Scott, 1980: 47): "[The association] has not dropped or changed its opposition to lay midwives. Its members hope that new programs of patient education about the availability of birthing rooms will defuse the movement."
### Table 2. Hospital and Nonhospital Births in Arizona, 1970–82

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Births</th>
<th>Number Attended</th>
<th>Type of Attendant at Out-of-Hospital Birth</th>
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<td></td>
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<td>Out of Hospital</td>
</tr>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>1970</td>
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<td>1982</td>
<td>52,368</td>
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<td>98.1</td>
</tr>
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</table>

Source: Arizona Department of Health Services, Department of Family Health Services. Taken from birth certificate data, Phoenix.

* It is likely that the majority of these are midwife-attended births; "other" includes unattended births, and deliveries by fathers, nurses, firemen, paramedics, etc.

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**Texas: Legislative Attempts to Tighten a Permissive Law**

Like Arizona, Texas shares a border with Mexico. But unlike Arizona, there is a great deal of interaction between the Mexican and American cultures along the Texas border. The continued use of the traditional Mexican birth attendant—the *partenera*—is just one
Parteras and other non-Mexican lay midwives have always figured significantly in the care available to pregnant women in Texas (see Philpott, 1979; Lee and Glaser, 1974; McCallum, 1979; Ortman-Glick, 1978; Streck, n.d.), and, at the time of my research, the state legislature had not yet found it necessary to regulate their practice beyond requiring that they register with the "local registrar" (Texas Department of Health, 1976: Article 4477, Rule 49a; see also Texas Department of Health, n.d.). Table 3 indicates the recent level of activity by midwives in Texas.

Texas possesses a case law that affects the practice of midwifery. After Diana Banti assisted in the birth of a child who subsequently died, a complaint was filed against Ms. Banti alleging that she did "unlawfully treat and offer to treat Julia Valdez, a human being, for a disease and physical disorder, mental and physical, and a physical deformity and injury and to effect a cure thereof." It was further alleged that "she charged therefore and that she did so without having registered a certificate evidencing her right to practice medicine." She was convicted on these charges, but the Court of Criminal Appeals reversed the conviction and established a precedent that separated midwifery from the practice of medicine (Banti v. State, 289 S. W. 2d 244):

It would appear . . . that the legislature of Texas has not defined the practice of medicine so as to include the act of assisting women in parturition or childbirth insofar as the practice of medicine without registering a certificate evidencing the right to so practice is made punishable as an offense. . . . We agree that childbirth is a normal function of womanhood, and that proof that the appellant for a consideration agreed to and did attend Julia Valdez at childbirth does not support the allegation of the complaint that she treated or offered to treat Julia Valdez for a disease, disorder, deformity or injury or effect a cure thereof. Not only has the Legislature failed to include within the definition of "practicing medicine" the branch of medical science.
which has to do with the care of women during pregnancy and parturition called "obstetrics" but has in a number of statutes recognized practical obstetrics or midwifery as outside the realm of the medical practice act.

The court concluded that as long as midwives did not hold themselves out to be "practitioners of medicine" they could assist in childbirth and charge for their services with no fear of legal action against them.

In 1977 Representative Chris Miller introduced House Bill 1314, "relating to the regulation of the practice of midwifery." The bill was an attempt to provide certification of all midwives who wished to practice, giving responsibility for their education and regulation to the Texas Department of Health. The bill enjoyed little if any support, and it suffered an early death. In 1978, the Texas Board of Medical Examiners asked the attorney general to issue an opinion on the services that midwives may legally provide in Texas. The attorney general responded by reaffirming the legality of midwife as-

Table 3. Texas Live Births by Type of Attendant, 1977–82

<table>
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<tr>
<th>Year</th>
<th>Total Births</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
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Source: Texas Department of Health, Austin.
* This category probably includes a number of midwife-assisted deliveries.
sistance in the "normal function" of childbirth and went on to note that "if the performance of an episiotomy or a repair of a laceration of the birth canal by suturing the wound following the delivery of the child is incident to normal childbirth, the midwife may perform the same" (Texas Attorney General Opinion No. H-1293, 1978). The opinion also stated that midwives may not possess or dispense dangerous drugs without the supervision of a physician, nor diagnose disease or obstetrical complications (see Pickens, 1979). Thus, although limits are placed on their practice, Texas midwives have a great degree of autonomy.

This autonomy has troubled the medical community and some legislators, particularly when reports of the mismanagement of births by midwives surface in the press (for example, "Midwife Charged in Baby's Death," San Antonio Light, 1979; "Attending Doctors, Lay Midwife Agree: Woman's Death 'Totally Preventable,'" Watson, 1979; "(State Senator) Truan Presses Investigation of Pregnant Woman's Death," Lyon, 1979). Prompted by a concern over poorly trained midwives, Representative Hector Uribe introduced House Bill 635—"a bill to be entitled an act relating to the regulation of lay midwifery, providing penalties"—to the 1979 Texas Legislature. Prior to his election to the legislature, Mr. Uribe was an attorney in Brownsville, a town located near the border in a county with a large percentage of midwife-attended births. In Mr. Uribe's home county (Cameron) nearly 31 percent of all births in 1978 were attended by midwives; in Brownsville during that same year midwives delivered at least half of all children born. Mr. Uribe had also dealt with lay midwifery during his career as an attorney, defending a lay midwife charged with murder and practicing medicine without a license.

In drafting the bill, Representative Uribe sought input from a variety of medical professionals. Particular medical agencies and associations had specific provisions they wanted in the bill. The Department of Health wanted to be able to gather information on the practice of midwifery. The Texas Medical Association (TMA)—
firm in its opinion that midwives offer inferior care—was anxious to ensure that the legislation would in no way sanction or certify midwives. Midwives in Texas had not yet unified, so their input on drafting of the bill was limited. A few midwives did testify when the bill was introduced, but they had little if any impact.

The legal counsel of the TMA drafted a bill for Representative Uribe that made no allowance for certification, registration, or even education. Although Uribe objected to the lack of educational requirements in the bill, he was willing to forego required certification, primarily because a local "licensing" law for Brownsville midwives resulted in a decrease in the number of midwives in the city from seventy-four to ten. He felt that many midwives were driven "underground" by the ordinance, and he did not want this to happen on a statewide level.

The version of the bill introduced into the legislature showed signs of compromise. It created a lay midwifery board, to be appointed by the Texas Board of Health, that would administer a voluntary educational program for midwives. It was hoped that midwives would be cajoled into education by another section of the bill that required them to inform their clients "in oral and written form" of the limitation on their practice and whether or not they had successfully completed the training course. In keeping with the requests of the Department of Health and the TMA, the bill required the "identification" of midwives. In its original form the bill had used the words "registration" and "registry," but in order to placate the TMA these potentially sanction-conferring words were replaced with the more neutral terms "identification" and "roster." The bill also created, for the first time in Texas history, a statutory definition of "normal childbirth" ("the delivery, at or close to term, of a pregnant woman whose physical examination reveals no abnormality or expected complications and who does not exhibit signs or symptoms of hemorrhage, toxemia, infection, abnormal fetus position, or abnormal presentation") and placed statutory limits on the practice of midwifery.
The final version of the bill had wide support and no vocal opposition. The Department of Health was pleased with its authority to gather information on midwifery. The TMA was happy with statutory limits on the practices of midwives. And midwives were satisfied with its voluntary nature. The bill passed both houses of the legislature, but the governor vetoed it. His veto message was short (Clements, 1979):

This bill would require the Board of Health to appoint a midwifery board which would establish a voluntary training course and examination in order to supposedly improve the quality of midwife services. All this would do would allow some midwives to pass themselves off as professionals and this state recognition of midwifery would give credibility to a group that may or may not have credibility. The public would have no way of knowing whether midwives were state sanctioned or not because the whole procedure is "voluntary." No midwife practicing in public would be required to take any course or exam. Although the purposes of the bill are noble, it is questionable if the public would be protected one bit, and I therefore veto House Bill 635.

To some, the veto indicated that the public support given H.B. 635 by the TMA had been undermined by private opposition from this same organization. Representative Uribe was surprised at the governor's action and expressed the feeling that the TMA was responsible for the veto. Although TMA denies this (a TMA lobbyist told me, "We had to convince Hector we were not behind the veto"), comments by TMA spokesmen are strangely echoed in the governor's veto message. Ace Pickens, TMA legal counsel, noted that he was "not entirely in opposition to the bill," but felt it was important to clarify that the educational program could not and would not be construed as certification of lay midwives. He said that the TMA was "fearful that the letter of completion [offered by the educational program] will be used to some extent to indicate certification" (Odessa American, 1979). Another TMA official,
pointing to his organization's stance against midwifery, claimed that the TMA supports the registration of midwives for the purpose of identification, but remains opposed to licensure. As recently as 1981 the TMA reaffirmed its policy, first formulated in 1977 (Wilcox, 1981): "TMA . . . opposes any action by the State Legislature to expand or endorse lay midwifery by nonmedical personnel."

By the next legislative session (1981) Representative Uribe had become State Senator Uribe, and he introduced a revised version of House Bill 635 to the Senate. Because they bear the mark of political compromise, the revisions made in the new bill, Senate Bill 1093, merit further examination. After the near passage of H.B. 635, midwives began to sense the need for organization, and in May of 1980 a group of them founded the Association of Texas Midwives. Their concern over restrictive legislation is evidenced in the letter they sent to prospective members: they hoped "to secure a continued place for the practice of professional midwifery in the State of Texas" (see also Association of Texas Midwives, 1981). Uribe was anxious to gain their endorsement for his bill, which enabled them to gain a few significant revisions. They were able to restrict the definition of normal childbirth to cases that exhibit "no abnormality or expected complications," excluding the more specific references to "hemorrhage, toxemia, infection, abnormal fetus position or abnormal presentation." They were also able to slightly alter the composition of the lay midwifery board; however, the balance between lay midwives and licensed medical professionals remained even.

Control over the practice of midwifery was tightened by a few revisions intended to satisfy the TMA and the governor. Following the advice of the chairman of TMA's Maternal and Child Health Committee, a section was added requiring that the written disclosure—which lists the limitations on the practice of midwifery and notifies the client whether the midwife has passed the training course—be signed by the client and forwarded to the Department of Health. The chairman had also proposed that a section be added
directing midwives to "insist" that their clients seek prenatal care and, if complications arise, "medical care." Such a section was added, but it directed midwives only to "encourage" clients in these directions. Another section was added in an attempt to avoid any appearance of state sanction for midwifery practice: "A lay midwife may not . . . use in connection with his or her name a title, abbreviation, or any designation tending to imply that he or she is a 'registered' lay midwife as opposed to one who has identified himself or herself in compliance with this act." Violation of any section of the law is regarded as a "class C" misdemeanor, punishable by a fine of $200 and thirty days in jail.

Like its predecessor, S.B. 1093 received wide support and little opposition. Uribe's office received letters of support from the Department of Health, the TMA, the Texas Nurses Association, and the Nurse-Midwifery Committee of the Texas Perinatal Association. The Association of Texas Midwives was a little more wary in its support. Their letter reported that "it is the consensus of the Board [of Directors] that we do not object to Senate Bill 1093 in its current form." In spite of this support, S.B. 1093 died an unnatural death. The bill passed the Senate and cleared the House Health Services Committee, but it died in the House Calendars Committee. Once again Uribe was surprised at the outcome. The house sponsor was on the calendars committee and the senator fully expected that the bill would have no problem reaching the floor. Again the actions of the TMA were suspect. Explaining the failure of the bill, Uribe told a TMA lobbyist: "We see a lot of ghosts, including you guys." The senator's aide told me: "We suspect the docs got to [house sponsor] Wilson and had him kill it quietly." A TMA lobbyist assured me that they were not responsible for the bill's failure: "We are not happy with midwifery as an alternative, but we thought it was a good bill."

The legislative activity in Texas demonstrates an attempt to tighten a permissive law. If either H.B. 635 or S.B. 1093 had passed, Texas midwives would have found themselves faced with clearly defined limits on their practice, limits which did not previously ex-
The impetus for this legislation came almost exclusively from its author, and his skill in drafting and willingness to accede to the requests of various organizations produced a bill that was difficult for anyone to oppose. The voluntary nature of the training program outlined in the legislation was the result of a strange coincidence of interests. Senator Uribe and his staff were afraid that mandatory education and certification would drive midwives underground and separate them further from the established medical community. The TMA was afraid that mandatory certification would give a new credibility to midwives. Midwives felt that any mandatory program would be too restrictive.

The failure of the legislation suggests that Uribe's perception of medical opposition may be correct. The TMA is very candid about its opposition to midwifery. The medical lobby is powerful, and while it would damage their image to publicly oppose legislation aimed at improving health services, they are capable of working behind the scenes to defeat bills they regard as threatening. On the other hand, some representatives of the medical establishment indicated that this kind of legislation was desirable; they felt it would gradually destroy midwifery by increasing access to physicians for the traditional clientele of midwives. These clients would note the superiority of physician care and would abandon the untrained midwife. This conclusion seems based on the questionable assumption that midwife care is sought only because access to physicians is blocked by financial or cultural barriers. In fact, many women with ready access to physicians choose midwives in order to avoid "standard medical treatment."

The absence of state legislation has led certain communities to pass local ordinances regulating the practice of midwifery. The city of Brownsville passed a law requiring all midwives to be certified through a city-run program. The cities of El Paso and Laredo considered similar ordinances. The debate over these laws was similar to that described above; their effects will be discussed in the following chapter.
In June 1983, after the data-gathering phase of my research was complete, the Texas legislature passed Senate Bill 238, a lay-midwifery practice act. Once again Senator Uribe was the sponsor, and in most important respects S.B. 238 was identical to S.B. 1093. A lay midwifery board—comprised of three lay midwives, three consumers, an obstetrician, a pediatrician, and a certified nurse midwife—was charged with creating an educational program, a manual, and a test for lay midwives; but most significantly, the training program and examination created by the bill remained voluntary. The bill permitted lay midwives to attend only normal childbirth, which is legally defined for the first time, and prohibited a midwife from using any title that would imply “that he [sic] is a ‘registered’ or ‘certified’ lay midwife as opposed to one who has identified himself in compliance with this act.”

California: Legislative Attempts
to Loosen a Restrictive Law

The legal history of midwifery in California is uneven, marked by overlapping regulations and tempered by various pieces of case law. Midwives were required to register with the state as early as 1917, but it was not until 1937 that a certification program began. Only twelve years later, the licensing program was halted. Midwives holding a license were still allowed to practice, but no new licenses were issued. This situation remained unchanged until 1974, when a perceived shortage of obstetrical care in rural areas prompted legislation enabling certified nurse-midwives to practice. The responsibility for licensing under this new program was placed with the Board of Registered Nursing. The board decided to use the certification standards of the American College of Nurse-Midwives as the licensing criteria, which meant that midwives could practice only under physician supervision. A limited number of training pro-
grams and the restrictions inherent in the bill have prevented nurse-midwives from making a significant contribution to maternity care in the state. In 1981 there were only 170 certified nurse-midwives working in California, and (reflecting the distribution of physicians) most of those were located in the bigger metropolitan hospitals.

The legal status of lay midwifery remained hazy until the mid-seventies. Because they intervened only minimally in the birth process, lay midwives felt they were in little danger of arrest for violation of the Medical Practice Act. Some were concerned that compensation for services made them liable for practicing medicine without a license, so attempts were often made to conceal remuneration through systems of barter or by the acceptance of cash only. In March 1974 the worst fears of midwives were realized when, following a year-long undercover operation, three midwives from the Santa Cruz Birth Center were arrested for practicing medicine without a license (see Ruzek, 1978: 57-60). The case made its way to the California Court of Appeals, which ruled, in agreement with the Banti decision in Texas, that "pregnancy and childbirth are not diseases but rather normal, physiological functions of women" (Bowland et al. v. Municipal Court, 1 Civil 35739). The court continued:

Therefore, to state that a person practiced or held himself or herself out as practicing a mode of treating a woman in pregnancy or childbirth or the practice of undertaking to assist and treat such a woman does not allege an offense proscribed by section 2141 [of the Business and Professions code, which defines the practice of medicine as treating or diagnosing "the sick or afflicted . . . for any ailment, blemish, deformity, disease, disfigurement, disorder, injury or other mental or physical condition"].

Having clarified that assistance at childbirth was not the practice of medicine, the Court of Appeals ordered the lower court to either amend the complaint against the midwives or dismiss the case.
The midwives' celebration of this victory was shortlived. The attorney general, fearing that the ruling sanctioned midwifery and home birth (see Her-Self, 1976), requested a rehearing of the case by the California Supreme Court, which issued its decision on December 6, 1976. Referring to that portion of the statutory definition of the practice of medicine that prohibits the unlicensed from treating any "mental or physical condition," the court stated (Bowland et al. v. Municipal Court, 18 Cal. 3d 479, 1976): "We have concluded that normal childbirth, while not a sickness or affliction, is a 'physical condition' within the meaning of . . . section 2141, [and therefore] it is clear that the practice of midwifery without a certificate is prohibited." The case was remanded to the court of origin. The charges against the midwives were eventually dropped, but an important precedent in case law had been established.

In June of 1977, with the support and encouragement of the California Department of Consumer Affairs, Assemblyman Gary Hart introduced Assembly Bill 1896, the Midwifery Practice Act of 1978. This bill, originally drafted by the Department of Consumer Affairs, provided for the training and licensing of non-nurse midwives. It is not surprising that the Department of Consumer Affairs (DCA) was interested in this legislation. Under the administration of Governor Jerry Brown, the DCA, formerly just the institutional home of various licensing boards, adopted a strong consumer advocacy position. One of their priorities was the reassessment of the medical establishment and the monopoly held by medical professionals. To that end several projects were initiated, including the "Health Career Ladder Project," which sought ways to encourage the use of midlevel practitioners (see DCA, 1979), and an extensive study of the ways health is influenced by the current construction of the Medical Practice Act (see Public Affairs Research Group, n.d.; California Board of Medical Quality Assurance, 1982).

In background information papers (DCA, n.d.; DCA, 1977) prepared by the DCA to support A.B. 1896, the agency revealed why it was interested in the bill. First, there was a concern over a lack of
obstetrical care. The DCA noted that seventeen of the state's fifty-eight counties had no practicing obstetricians, 27 percent of the state's pregnant women received little or no prenatal care, and only 37 percent of the state's obstetricians were accepting patients with Medi-Cal, California's version of Medicare. Second, the DCA observed that because midwives could provide care more cheaply than physicians, costs for obstetrical services could be reduced by $20 million annually. It was calculated that the state treasury would save $10 million annually. Third, the DCA admitted that the bill was a response to the "growing problem of 'black market' midwives." It was estimated that four hundred lay midwives were practicing illegally in California. In a letter intended to gather support for the bill (Krisman, n.d.), a DCA official suggested that the agency had two choices:

1. Legalize the practice with safeguards to protect the public health and safety, or
2. Vigorously enforce the current law [i.e., arrest midwives].

This official went on to note that the DCA had chosen the first option.

The original version of the bill, with elaborately detailed training programs and licensing requirements for midwives, was opposed by nearly all associations of medical professionals. Its most formidable opponent was the California Medical Association (CMA). Speaking for the CMA, Dr. Thomas Elmendorf (Anderson, 1978: 5) said the association

is opposing the current legislation on midwifery . . . because we don't think it is in the public interest. We believe that we have made very significant inroads into perinatal mortality and infant mortality . . . and are impacting the statistics that were formerly thought to be so bad for this country . . . However, we believe . . . that if midwifery is passed and more birthing occurs under less competent supervision . . . our statistics will begin to be reversed.
The California Nursing Association (CNA) was also opposed to the bill, particularly in the revised form that merged nurse-midwives and lay midwives into a single category, "the certified midwife." This proposal troubled the CNA because it would remove jurisdiction over midwives from the Board of Registered Nursing and locate it in a medical licensing board (see Moorhead, 1978). Although lay midwives in California had just formed a state organization, the California Association of Midwives (CAM), no statement on the bill emerged from this group. There seemed a lack of consensus on the merits of licensure among midwives. Some felt it was desirable because it would allow them to abandon the cloak of secrecy and expand their practices; others expressed concern over the possibility of medical dominance (for example, see Ehrlich, 1976).

The bill was effectively killed when it appeared before the Assembly Subcommittee on Health Personnel in January of 1978. The CMA and the CNA had expressed their strong opposition to A.B. 1896, and after some debate it was reduced to a simple directive encouraging the DCA to conduct experimental pilot projects "in order to comprehensively and definitively evaluate the methods by which midwifery training and care may be delivered in California." No money was given to the agency for such experiments. The CMA continued to oppose the bill, although the intensity of its opposition decreased when the bill was neutered in committee. A.B. 1896 eventually passed both houses and was signed into law, but it has not yet led to experimental programs related to midwives.

A second attempt to license lay midwives occurred in April of 1980, with State Senator Barry Keene's introduction of Senate Bill 1829, the Professional Midwifery Practice Act of 1980. Like its predecessor, this bill was drafted by the legal staff of the DCA. Having learned from its earlier defeat, the DCA altered its strategy. In order to curry the favor of the CNA, no mention was made of nurse-midwives, whose supervision was left to the Board of Registered Nursing. The background material prepared in support of S.B. 1829
made no reference to the potential monetary savings afforded by the lower cost of midwifery care. The bill instead focused on the need for midwifery services and the high quality of care offered by midwives. DCA's emphasis on the low cost of midwifery services in A.B. 1896 had backfired; representatives of minorities had assumed that cheaper care meant inferior care and that the state was trying to save money at the expense of the poor.

Like A.B. 1896, the new bill prohibited uncertified practice and limited the practice of professional midwifery to "normal childbirth" under the supervision of a physician. Midwives were to prepare for certification with two years of schooling and a one-year residency, or by a three-year apprenticeship followed by a one-year residency. Upon completion of their training, applicants would be required to pass an examination consisting of written and clinical sections. Responsibility for the certification program would be located in a "Professional Midwifery Examining Committee," which in turn would be under the jurisdiction of the Board of Medical Quality Assurance.

S.B. 1829 gathered more support than its predecessor. The CNA, no longer concerned about losing control over nurse-midwives, threw its support behind the bill. In addition, the CNA felt that the bill would clarify the scope of midwifery practice, an issue that had been muddled by a recent opinion of the California attorney general, which stated that certified nurse-midwives could not perform episiotomies or suture except under direct physician supervision. What "direct supervision" meant was unclear. The California Association of Midwives also supported the bill. While there was no official association statement in favor of the bill, the CAM sponsored a "Rally for the Midwifery Practice Act of 1980" outside the capitol building on the day the bill was heard in committee. A flyer announcing the rally proclaimed: "Control over women's health care must be returned to women. Legalizing the practice of professional midwives is one way we can do it. We demand an immediate end to harassment of all women health practitioners, including lay mid-
wives." Governor Brown was another source of support for the bill. The governor publicly endorsed the legislation and personally lobbied individual senators.

Opposition to the bill came from physician organizations. In 1979 the CMA's House of Delegates approved a resolution reaffirming its call for births in "obstetrical units of properly accredited and staffed facilities" and "vigorously" opposing all programs encouraging home birth. Joining the CMA in opposition to midwife licensure were the California chapter of the American College of Obstetricians and Gynecologists (ACOG) and the California Association of Obstetricians and Gynecologists (CAOG).

There were isolated instances of opposition from feminist groups. Writing for the Oakland Feminist Women's Health Center, Barbara Raboy (1980) informed the DCA:

We cannot endorse or support legislation such as S.B. 1829. . . . This is so because S.B. 1829 is the type of legislation that would put many restrictions on midwives [sic] and put it in the hands of professional medicine, particularly male doctors. . . . I am a bit surprised that the California Medical Association and the local chapter of the American College of Obstetricians and Gynecologists opposed S.B. 1829. If they were thinking clearly, and supported S.B. 1829 they would have total control of women's birthing.

The bill was first heard before the Senate Business and Professions Committee. In his presentation of S.B. 1829 to that committee, Senator Keene stressed the maldistribution of obstetrical care in the state and noted the ability of midwives to remedy that situation. He also observed that midwives could meet the demand by consumers for more family-centered births. Representatives of the CMA, ACOG, and CAOG testified against the bill by noting that it is difficult to distinguish between normal and abnormal birth. Dr. Thomas O'Sullivan, representing CAOG, noted: "It takes a lot of ex-
pertise to know which of these babies are going to be hazard. It takes more than two years." Senator Keene offered to meet the objections of the physicians by amending his bill to require closer supervision by physicians, but the physicians stood firm in their opposition. Keene then asked the physicians: "The bottom line is, you've got to be a doctor?" Dr. O'Sullivan replied: "Unfortunately, yes."

The Senate Business and Professions Committee agreed with Dr. O'Sullivan, failing to give the bill the five votes necessary to get it out of committee. As evidence of his continued backing of midwife licensure, Governor Brown met with supporters of S.B. 1829 immediately following its defeat. He pledged his support to similar legislation for the following year and encouraged the group to build a politically active constituency for midwifery. DCA officials were given instructions to help the midwifery proponents.

The DCA, a state agency legally enjoined from lobbying the legislature, realized some steps were needed to counteract the powerful medical lobby if a midwife licensing bill were to arrive on the governor's desk. In 1975–76, the CMA spent more than any other group ($1,353,309) to influence the legislature. In 1977–78 they were the ninth highest spender (Keplinger, 1977; Cooper, 1979). Agency officials decided to create the Midwifery Advisory Council (MAC), whose stated purpose was to advise "California state government on midwifery and childbearing issues" (MAC, n.d.). Thirty thousand dollars was made available to hire two staff persons and to pay traveling expenses for members of Northern and Southern California steering committees. The hidden agenda of the MAC was to politicize the midwifery issue and initiate a grassroots movement capable of putting pressure on legislators. The MAC prepared a slide show on midwifery, arranged to send speakers to community organizations, and periodically issued press releases. It also organized a "Labor Day Picnic and Homebirth Reunion" to attract media attention to midwifery and set up a network of individuals on the basis of legislative district that would allow quick mobilization of "pressure" (by means of phone calls, letters, and telegrams) on
particular legislators. The MAC also helped to redraft the bill for submission in the next legislative session.

The stage was set for the third attempt to license lay midwives. The now familiar line was drawn between opponents and proponents. In an editorial, a local newspaper endorsed the licensing of midwives and chastised the medical community for its opposition (Sacramento Bee, 1980): "Despite all its talk about childbirth safety, the medical community is not meeting the public's safety needs by insisting that the number of licensed midwives be strictly limited and that those who do practice be kept under the control of doctors." The president of the Northern California Obstetrical and Gynecological Society responded (Berry, 1980):

Your July 8 editorial encouraging the licensing of lay midwives has left me saddened, dismayed and frustrated. Advocacy for the provision of health care by untrained individuals is untenable. . . . You do not leave the controls of an airliner in the hands of flight attendants, nor can we leave the management of childbirth, the most hazardous trip any of us may ever have to take, to inadequately trained individuals.

In March of 1981, Senator Keene introduced Senate Bill 670, the Midwifery Practice Act of 1981, to the state senate. The bill was scheduled to be heard by the Health and Welfare Committee in April. One significant change had been made from the earlier bills. In order to insure the continued support of the CNA, the Midwifery Examining Committee had been located under the jurisdiction of the Board of Registered Nursing. The California Association of Midwives, several of whose members served on the Midwifery Advisory Council, officially supported the bill, notifying its members of the bill's introduction and encouraging them to contact their legislators. Within the last year several midwives had been arrested for practicing medicine without a license, and many midwives had begun to feel that a licensure law was necessary, if only for protection.
One midwife said, "Every time I do anything, I am risking my neck, my home, my family."

At the hearing, proponents of the legislation focused on the need to protect the health of women and their babies by regulating the 500 to 600 illegal midwives practicing in the state. According to a spokeswoman for CAM, "Our primary concern is the health and safety of mothers and infants." Commenting on the ongoing trials of two midwives, she noted that regulation should not be accomplished through court action; she also emphasized that the current situation separated the clients of lay midwives from the medical system. Once again the opponents of the bill were drawn from professional associations of physicians. The physicians who testified against the bill centered their testimony in three areas: the use of "untrained" practitioners, the difficulty of separating normal from abnormal birth, and the worrisome composition of the Midwifery Examining Committee. One physician noted that lay midwives offered "second-class medical care," and compared their use at birth with using a high school graduate who had a "thirty-month crash course in criminal law to defend someone against a murder charge." Nearly all the physicians pointed to the need for expertise because of the impossibility of distinguishing between "high-risk" and "low-risk" during labor. Several doctors expressed concern that only one obstetrician would be included on the eleven-member Midwifery Examining Committee. The other members would include four midwives—two nurse midwives and two non-nurse midwives—three "public members," a hospital administrator, a pediatrician, and a family practitioner.

The hearing was held in an auditorium that could seat approximately five hundred people. The auditorium was nearly full, and at one point the chair of the committee asked those in favor of the legislation to stand. Almost everyone stood, the majority of them women and children. When the chair asked those opposing the bill to stand, about a dozen people stood, most of whom were middle-aged men. Five votes were needed to move the bill out of commit-
tee, and after both sides had given their testimony there was a call for a vote. Some members of the committee were now absent, and others withheld their votes, resulting in a 2–2 tie. The bill was put on call, allowing the absent members and the uncertain members to vote later in the day. Lobbying of those who had not voted continued, but by the end of the day it was clear that the bill was headed for defeat.

California provides an example of attempts to use legislation to loosen the laws that restrict the practice of midwifery. Originally the legislation was sponsored by a state agency interested in promoting consumer causes. Gradually midwives were drawn in to support the various bills presented to the legislature. At times the interests of the state agency and the midwives clashed. Midwives were interested in a licensing law that would allow them autonomy; the DCA was chiefly interested in getting a midwife licensing law on the books. Consequently, the DCA was willing to (and often did) make compromises that midwives felt were too restrictive. The DCA justified its action by reminding midwives that the Brown Administration regarded midwifery favorably, and if no law passed during his tenure it was likely that midwives would suffer in the future. The failure of all three bills introduced in the California legislature is indicative of the political and cultural power of medicine. Their political organization and the general cultural faith in their practice provides medical professionals with a power that marginal medical groups find difficult to overcome.

Licensure and Strategies of Dominance

These recent attempts to regulate midwifery confirm conclusions from earlier regulation and reveal that the strategies used by established medical professions to maintain dominance remain much the same. As with previous legislation, concern for public health is central to all certification plans. In Arizona the law was revised because
of a concern that the old regulations, instituted in 1957, were insufficient to guarantee the quality of midwifery services. In Texas, a voluntary training program was proposed to upgrade care and thereby avoid mishaps like those recently reported in the press. In California, the Department of Consumer Affairs drafted a licensing law to control "black market" midwives who practiced with no "safeguards to protect the public health and safety." Each state made an effort to insure that individuals who chose to avoid standard care had the benefit of a midwife who was trained in modern medical technique, and who was ready to call on a physician should any complication arise.

As in earlier midwife legislation, the definition of birth was part of the issue. Where the intent was to tighten permissive laws (as is historically the case with midwife licensure), birth was portrayed as a dangerous event, not a natural process that could be supervised by an informally trained attendant. California, however, provides an interesting contrast in that proponents of the licensing bill, who were interested in loosening a restrictive law, had to persuade officials that birth was in fact a normal event. Anisef and Basson (1979: 354–59) have noted that midwifery flourishes where birth is regarded as a "natural, normal physiological process." The near-total hospitalization of birth found in the Western world suggests that physicians have convinced the public that birth is abnormal. Aware of the need to counter this view, the Department of Consumer Affairs in California issued the following statement in support of its bill (DCA, 1977: 2):

Today's California hospitals and obstetricians are strongly oriented to caring for the abnormal, complicated birth with drugs, technology and other forms of medical intervention. Though these advances in medical science have produced dramatic reductions in infant and maternal mortality rates, drugs and medical intervention are not always necessary to births which are uncomplicated, normal deliveries. According to experts at the
medical schools of the University of California in San Francisco and Los Angeles, most mothers can be screened in the prenatal period into high-risk and low-risk groups, with 90 percent of all mothers generally falling into the low-risk population. . . . Since most births are uncomplicated and normal, alternative birthing practices are safe and reasonable.

The attempt to "demedicalize" birth required counteracting the view that birth is an abnormal event appropriately handled only by trained physicians. Of course, medical professionals defended their proprietary rights by insisting that birth, while it might appear normal to the untrained, is fraught with danger. In his testimony in opposition to the California bill, one physician adduced this specious logic: "If birth isn't a disease, why am I required to have twelve years of specialized education?"

Midwife licensure has been dominated by medical science throughout modern history. As the scientific view of birth gained wide acceptance, laws emerged requiring midwives to abandon their traditional ways and adopt medical techniques. It is significant that the issue of midwife licensure has re-emerged in a period when the medical domination of childbirth is being questioned. As noted in Table 1, home birth is increasing. More importantly, studies of those who choose home birth and employ lay midwives in Arizona (Anderson et al., 1978), Texas (Ortman-Glick, 1978; McCallum, 1979), and California (Hazell, 1974; Rubin, 1976; Ellis et al., 1980) reveal that it is no longer just the poor or minorities who are avoiding hospitals and doctors during pregnancy and childbirth. Yankauer (1983: 637) has noted an upward trend in the educational attainment of women who choose home birth. Nearly half of the women who have midwife-attended out-of-hospital deliveries have thirteen or more years of schooling.

Medical professionals were little concerned as long as they felt that midwives were serving only isolated populations that chose their services because of poverty or cultural preference; midwifery
seemed merely a problem of ignorance that would be overcome as the benefits of medicine were more widely known. However, midwifery became a threat to medical professionals when better educated individuals chose to avoid the "benefits" of medicine in favor of the services of midwives. The response to such a threat is enforcement of restrictive laws and the tightening of permissive laws.

In the past, physicians were generally opposed to midwife licensure, while most midwives favored it. These attitudes by and large remain unchanged. In none of the three states studied did midwives oppose the proposed statutes. There was some concern over supervision by the medical profession (see Daniels, 1981a) but most midwives were anxious to obtain the sanction offered by certification. On the other hand, most physicians in the three states wanted to abolish midwifery. Their position on licensure, however, varied according to the social conditions and laws already existing in their states. In California, where non-nurse midwifery ran contrary to case law, medical professionals vigorously opposed certification. In Texas, where traditional birth attendants have a long and continuous history, case law permits unlicensed midwifery. Medical professionals there were willing to endorse a bill that increased government surveillance and limited midwife practice, but did not provide the sanction of certification (or even registration). In Arizona, where midwives had the advantage of an old law in their favor, the state altered the regulations by administrative procedure both to make it more difficult to receive a license and to enhance government control.

All the laws proposed are examples of "hostile licensure." The Texas and Arizona laws place authority over midwives in a committee or agency comprised of a majority of nonmidwives. In California, the proposed Midwifery Examining Committee was dominated by midwives, but that committee was under the jurisdiction of the Board of Registered Nursing. These laws can be considered "hostile" in requiring midwives to obtain the cooperation of physicians in order to practice. For example, S.B. 670 in California stated: "All
applicants for certification shall be required to submit upon application for licensure a written plan describing a mechanism for providing to clients continuity of care. The plan shall include a working agreement with a licensed physician and surgeon with current training and practice in obstetrics. Other laws create a dependence on physicians for such things as education or certification of physical and mental health. These allow disapproving physicians to prevent midwife practice by withholding cooperation. The executive director of the Texas Medical Association commented on an ordinance to regulate midwifery proposed by the city of Laredo (Williston, 1980, emphasis added):

Any proposed ordinance or statute embracing medical and health care needs physician understanding and support in order to be effective. Physicians at the State level with whom we have conferred feel that there are some real medical shortcomings in the ordinance which is being considered by the City of Laredo. . . . The ordinance . . . implies that there will be a physician available to care for those who are referred by the lay midwives. That, of course, is unrealistic.

In Arizona, would-be midwives find it difficult to realize their career objective because the medical community that administers the midwife program has not established or accredited any schools to provide the mandated training.

The lack of effective organization has prevented midwives from significantly influencing legislation aimed at them. Referring to earlier legislation, Litoff (1978: 107) observes:

Because midwives were poorly organized, they were not able to help draft the laws and regulations governing their practices. For example, no statements by midwives were made before the 1927 United States subcommittee hearings on the practice of medicine and midwifery in the District of Columbia. In contrast, lengthy testimony was presented by members of the recognized medical profession.
The same was true in the three states studied here. Compared with the medical associations, midwife organizations were poorly organized, pitifully underfinanced, and incapable of achieving a consensus on political issues. When legislators and departments of health sought advice on proposed legislation, medical associations responded immediately, while the associations of midwives spent time and energy trying to organize and seek consensus. When the regulations were being altered in Arizona, there was no midwife association at all, leaving the Department of Health Services to seek the opinions of individual midwives and consumers.

As in most health legislation, consumers had little input. The consumers who did testify at legislative hearings were invariably supporters of midwifery. Midwives were able to mobilize their clients to attend rallies and appear at hearings. Physicians could not, or at least did not, call on their clients in this way. The exceptions here are a few minority spokespeople who expressed concern that the licensing of midwives was a thinly disguised attempt by the establishment to offer cheaper, second-class care to the poor. Midwives felt that these statements were based on a misguided desire to emulate the rich—the same misguided desire that caused the poor to give up breast for bottle feeding.

The examination of midwife legislation reveals the cultural power of medicine. Apart from the political power of their association, medical professionals sustain their dominance in health care through the possession of scientific solutions to illness. A generalized belief in science gives authority to its priests, who are unlikely to condone modes of treatment different from their own. Alternative practitioners are overcome not only by political power but also by public faith in physicians.

There is a certain irony in the drive for licensure by paraprofessional groups. They hope to secure and expand their practice, but receipt of a license often brings restrictions on practice and a consequent decrease in autonomy. Yet the idea of licensure remains seductive. Paramedical groups view the monopolistic benefits
granted to physicians by licensure, and assume that similar benefits will accrue to them. Unfortunately, these aspirations rest on a naive view of licensure. Physicians were the first medical practitioners to obtain licensed status, and they were free to define and thereby dominate health care. As their political and cultural power has grown, they have become less willing to surrender any authority to ancillary medical professions. In this climate, others who wish to be licensed must be ready to accept control by physicians.

A review of paramedical occupations that have acquired licensed status confirms that "state licensing fortifies medical control" (Larkin, 1981: 16; see also Larkin, 1978; 1983). Although midwives have an autonomous history compared to other paraprofessionals, licensing laws have similar effects on their independence.

Changed social and cultural conditions give modern midwife legislation distinctive features. While earlier regulatory acts in Europe and America sought to control and bring the "benefits" of medicine to a widespread folk practice, the current bills represent attempts to recognize an alternative practice used only by small numbers of people. The supporters of these bills view them as a method to expand the choices available to pregnant women. However, the effect of licensing is more likely only to medicalize the lay midwife. Commenting on the bill to license midwives in California, Roth (n.d.: 2) points out:

The changes from the original version to the amended version show a major shift toward training and requirements which fit the standard medical model and increased control by the medical profession. What little innovation the concept once had as a piece of legislation has been largely dissipated... [T]his bill contains the crucial features of exclusive licensure. It creates a restrictive monopoly and makes the equivalent activities of all others illegal. It lays on the standard threats of monopoly occupations—not only keeping out the uncertified, but threat-
ening the certified who do not conform to conventional expectations with charges of "unprofessional conduct," which in practice means whatever those currently in power want it to mean. It is the classic tactic to cut off criticism and innovation.

We may conclude that legal recognition for midwives implies restriction. And although the law is limited in its ability to change health-care practice, it helps to create and accelerate conditions that contribute to changing styles of care. Furthermore, legal status alters individual modes of practice, a factor which has a significant impact in aggregate. The following chapter explores the implications of midwife regulation by focusing on the qualitative aspects of births attended by both licensed and unlicensed midwives.