The avowed purpose of midwife licensure is protection of public health and safety. Hence midwife licensure is most often evaluated in terms of medical outcomes; that is, the extent to which licensing reduces maternal and infant mortality and morbidity. While such evaluations are undeniably useful, they overlook important consequences of licensure not directly measurable in the survival and health of the clientele. These include changes in the composition of the profession and the nature of care offered. This chapter examines the latter consequences, particularly the ways licensing laws influence the practitioner and her encounter with clients.

Most studies of paramedical licensure focus on the negative effects of physician dominance. These effects cannot be ignored, but there are other, perhaps more important, ways in which licensure effects paramedical practice. For example, once licensure is instituted, characteristics of practitioners will change because of changes in educational requirements, recruitment patterns, relationships between practitioners, and the nature of the clientele.

The changes wrought by licensure can be demonstrated by comparison: the midwives in the three states studied present a rough continuum of state and medical control over the occupation. In California, where lay midwifery is prohibited, the state has only re-
active control, and medical control is all but nonexistent. In Texas, the registration requirement results in minimal state and medical control. In Arizona, the licensing law provides state control over practitioners and requires limited medical supervision and consultation.

I shall expand this continuum by adding a fourth category to our comparison: the licensed, certified nurse-midwife (CNM). There are three reasons for including the CNM. First, licensing laws, which usually require physician supervision and extended periods of education, reflect a desire to push lay midwifery in the direction of nurse-midwifery. Second, although the Arizona law requires licenses of midwives, it is too new for changes in recruitment and training to be apparent. Because the state still offers no established educational program, there has been no formalized production of licensed midwives. Most of the currently licensed midwives were practicing before the law was revised; hence they entered the profession with motivations and training similar to midwives in California and Texas. The recruitment and formal training of CNMs, on the other hand, are approximately what we would expect to find under an established licensing law. Finally, the introduction of CNMs into our comparison allows us to observe how midwifery is influenced by location in medical institutions. Most CNMs work in hospital settings under physician supervision. In their survey of nurse-midwifery in the United States, Rooks et al. (1978) collected data on 1,299 CNMs: only five (0.4%) of these were employed in private practice, and only forty-three indicated that they worked in non-hospital settings (3.3%). This provides an interesting contrast to lay midwives in Arizona, Texas, and California, who almost never assist in hospital deliveries. The importance of understanding how a hospital setting influences midwifery is underscored by the desire of many lay midwives to work in hospitals; indeed, proposed licensing laws often include provisions that would give midwives hospital access. For instance, the most recent California bill included a section that prohibited hospitals from discriminating against midwives as a
class of practitioners when granting the privilege to admit patients. Further, widespread physician opposition to home birth implies that, if midwives accept supervision by physicians as a condition of licensure, they will be working in hospitals.

Because the hospital-based CNM is employed in a variety of roles, it is necessary to outline these before proceeding in the comparison. While the practice of midwifery is generally associated with birth, CNMs are also capable of providing routine gynecological services and birth-control counseling. In fact, recent studies (Record and Cohen, 1972; Record and Greenlick, 1976; Rooks et al., 1978) show that a CNM brought into a hospital setting is pressed into extraneous clinical and educational duties, leaving her little time for obstetrical care. Those CNMs who do work in maternity wards are often assigned duties similar to those of an obstetrical nurse, acting as little more than an assistant to the physician and a companion to the mother, even though the American College of Nurse-Midwives maintains the CNM is capable of assuming "responsibility for the complete care and management of uncomplicated maternity patients" (Journal of Nurse-Midwifery, 1975).

The alternative birth center (ABC)—a recent development in maternity care—provides the hospital-based midwife with her greatest degree of autonomy, and there her style of practice can be suitably compared with the practice of lay midwifery.

As indicated in Chapter 3, the ABC attempts to approximate home birth within the hospital. Labor, delivery, and postpartum care are all (ideally) carried out in one "home-like" room in the presence of family and friends, with a minimum of medical interference. Should anything "go wrong," the complete facilities of the hospital are available at a moment's notice. ABC programs are open only to those whose pregnancies are medically defined as "low-risk." If this definition changes at any time during pregnancy or birth, the client is removed from the ABC and given standard hospital care. Although not all ABCs employ midwives, this setting provides the CNM a convenient niche within the hospital bureaucracy.
Because ABC programs segregate a population of low-risk pregnancies, the CNM is provided with "uncomplicated maternity cases" and is able to provide continuous care (that is, prenatal, intrapartum, postpartum) to her clients with a minimum of visible physician supervision. Except for occasional references to CNMs working in other environments, the following discussion will use the CNM employed in the alternative birth center as the main point of comparison with lay midwives in Arizona, Texas, and California.

In order to isolate the differences between licensed and unlicensed midwives that are attributable to licensure, comparisons will be made in four general areas: the nature of the practitioner; the nature of the client; the characteristics of the midwife-client relationship; and the structuring of the birth experience. Although these areas are presented as distinct categories, it should be remembered that they are arbitrary and overlapping distinctions.

The Practitioner

The educational requirements of licensing laws differentiate midwives significantly. Unlicensed midwives, who are not subject to such requirements, usually acquire their training through a combination of self-education and apprenticeship. This training enables them to sustain a naturalistic, noninterventionist view of birth assistance that conflicts with the medically dominant view of birth as an abnormality that usually requires intervention. Most lay practitioners are recruited through experience with the home birth of their children or by their presence at another home birth. In the course of my research I met only one lay midwife who had not had a baby at home. Many home birthers, in fact, have had bad experiences with hospital deliveries. And although health professionals are sometimes relied upon for training in seminars and workshops, the unlicensed midwife's skeptical attitude toward "organized medi-
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cine" insulates her from the subtle propagandizing found in formal educational programs.

Training by apprenticeship supports a wholistic approach to birth because the subject is not segmented into areas of study such as physiology, pharmacology, or anatomy. The unlicensed midwife does not reject the knowledge made available by obstetrical science, but she does resist a view of birth which reduces it to nothing more than a scientific process amenable to routinized care. In her book, "Spiritual Midwifery," Gaskin (1978: 11) points out:

The knowledge that each and every childbirth is a spiritual experience has been forgotten by too many people in the world today, especially in countries with high levels of technology. This book is revolutionary because it is our basic belief that the sacrament of birth belongs to the people and that it should not be usurped by a profit-oriented hospital system.

This view of birth is reflected in attitudes toward training (Merz, 1977: 548): "No matter how it is that a person acquired midwiving techniques, there is an element to being a midwife that cannot be taught. It is a gift, and one that must be shared to truly come to life."

The patterns of recruitment and training currently used by unlicensed midwives are supportive of a "spiritual" view of birth, a view which maintains that the body is capable of giving birth with little or no outside intervention. In cases where intervention is required, it is most often a "natural" intervention—for example, to help ease the baby's head out of the birth canal, midwives will use hot oil massages instead of episiotomies; to stimulate labor, midwives give their clients raspberry or cohosh tea rather than pitocin (see Peterson, 1983).

The educational programs mandated by licensing laws affect the type of person who chooses to become a midwife as well as her perception of the birth process. Currently, only CNM educational programs have the formal approval of physician associations, so it is
likely that other midwife training programs will seek to emulate them. To become a CNM, an individual must first be a registered nurse and then complete a nationally approved educational program in midwifery. By the time a CNM is ready to practice she has had "a minimum of 6 years of specialized training: 4 years in an accredited school of nursing, 1 year or more job experience, and at least 1 year or more of midwifery education" (Brennan and Heilman, 1977: 16—17, emphasis in original). Such educational requirements restrict entry into the profession and begin a process of medical socialization. Only those with the resources necessary to survive a lengthy period of training can hope to achieve the status of CNM.

A recent study of applicants to nurse-midwifery educational programs made the interesting observation that nearly 70 percent had no children (Warpinski and Adams, 1979: 6). This suggests that the majority of CNMs acquire their knowledge of birth only in medical settings under the direction of physicians. Arms (1977: 198—99) comments on the consequences:

Nursing school, like medical school, teaches that pathology, not the normal is expected. In her education as a nurse, the nurse-midwife is taught to expect anything and everything to go awry in birth, and she has a lusty respect for modern forms of interference which will protect a woman from her own working body. It is a rare nurse who leaves her training unscarred by that emphasis and expectation of disease and disorder. Thus, examined closely in light of her history as a nurse and the harsh reality of her hospital surroundings, the nurse takes her place on the growing obstetric team, but the midwife has changed and lost her essence in the process. The reason is a simple one. She is no longer the guardian of normal birth and watchful servant of mothers. She is a registered nurse with a post-graduate degree in a specialty called midwifery. And she looks and acts much like the physician authority whom she is licensed to assist. . . . Further,
[she] is trained . . . to defer to the authority of rank. She believes that the physician, not the birthing mother, knows best and holds the power to heal. By training, she sees life as a physician does, full of problems, abnormalities and complications.

In describing her experience with similarly trained British midwives, Comaroff (1977: 126) confirms the observations of Arms. She notes that midwives view pregnancy as a "condition akin to physical illness, suitably treated in terms of medical intervention." A nurse-midwife who works in the nurse-midwifery practice of a New York hospital concludes: "There's too much intervention here. They don't leave people alone. They don't have the patience to wait for nature. There are too many vaginal exams. They use routine IV's with glucose and give routine Pitocin after delivery" (quoted in Arms, 1977: 322). Rothman (1982: 245–48; 1983) also hints at the medical nature of the certified nurse-midwife when she observes that home births "radicalize" CNMs. She points out that nurse-midwives who enter home delivery practice must relearn what constitutes a "normal birth."

In examining the "changing role of the midwife" in Great Britain, Walker (1972) identifies other important changes that have accompanied licensure. She regards the British midwife's loss of independence as a threat to "the continuation of midwifery as such, as distinct from obstetrics" (p. 86). In particular, she sees midwives as "limited practitioners" (Wardwell, 1972) who have been strongly affected by two factors: the concentration on the hospital for maternity care and the trend toward teamwork in health care. While her perspective comes from British data, many of her observations have direct application to American midwifery.

Walker notes that as the use of domiciliary care has declined, midwives have gotten involved with several people other than their clients. In earlier days the midwife dealt primarily with her client; there was little interaction with doctors, supervisors, or other midwives. The modern midwife must interact with all these people as
well as social workers, hospital staff, and specialists. This holds true both for hospital-based and the few remaining domiciliary midwives. However, Walker observed a shift in emphasis in the hospital setting, in that the midwife's dealings with a variety of hospital personnel diminished the relationship with her client.

Walker's analysis applies equally well to licensed midwives in America. Even the relatively autonomous CNM who works in a birth center is limited by hospital and medical staff policies, and it is evident that the midwife's intrastaff relationships often impinge upon the client-practitioner relationship. The CNM is not free to provide her services to all who desire them. Written protocols prevent clients with "high-risk" pregnancies from admission to the program. Other policies also influence midwife-client contact. One CNM, for example, expressed displeasure that her "boss" (the head of maternal and fetal medicine in her hospital) would not allow her to accept patients enrolled in a prepaid health service at another hospital. The CNM was anxious to offer an alternative to these individuals, but had no choice but to obey her superior.

Her boss was concerned with problems that might arise when patients required transfer to the regular labor and delivery suite. He was unwilling to have a woman in active labor transported to another hospital (where her medical costs were covered), whereas if she remained at his hospital he feared the difficulty of obtaining proper reimbursement from the prepaid plan.

Protocols also set parameters on the care a CNM may offer. In effect they require the midwife to surrender ultimate responsibility for a pregnancy or birth to a "more skilled" practitioner. Many of the policies contained in ABC protocols were inspired by CNM licensing laws. For instance, the law governing California's CNMs—the California Business and Professional Code (1977: 117–20)—states that the practice of midwifery

\[\text{does not include the use of any instrument at any childbirth, except such instrument as is necessary in severing the umbilical}\]
cord, nor does it include the assisting of childbirth by any artificial, forcible or mechanical means, nor the performance of any version, nor the removal of adherent placenta, nor the administering, prescribing, advising or employing, either before or after childbirth, of any drug, other than a disinfectant or cathartic.

The code states that the certificate to practice midwifery may be revoked for failure to refer to, or summon, a physician for specified conditions during pregnancy, labor, or the lying-in period.

The licensed lay midwife in Arizona faces similar restrictions. State regulations clearly define the boundaries of practice, and a midwife who steps over them is in danger of losing her license. In one case a midwife was sought out by a woman whose previous caesarean section made her ineligible for midwife care. Although the midwife told her she could not legally assist in her birth, the woman was intent on a vaginal delivery and presented herself on the midwife's doorstep when she was in active labor. Recognizing the danger of this situation (to herself and to the mother), the midwife immediately called the director of the midwife licensing program and explained her situation. The midwife was advised to leave the house and call the police. In another case a midwife had her license suspended for using a drug (pitocin) to control postpartum bleeding of a woman who had to be moved from her rural home to a distant hospital. Midwives in Arizona are frustrated by these and similar strictures that prevent them from satisfying the wishes of their clients. There are also some procedures Arizona midwives feel they can safely handle (for example, the use of herbs) that are prohibited by law.

The unlicensed lay midwife faces fewer complexities. They accept the need to limit their practice to "low-risk" pregnancies, but because of their independent position and extralegal status, definitions of risk are more negotiable for them than for licensed midwives. One lay midwife notes (Merz, 1977: 550):
We have no agreement about what constitutes a pregnancy at risk, and therefore not viable for home birth. Each situation is handled individually as a negotiation between parents and midwife. Parents are educated as to possible risks and the limitations of their midwife. Ultimately the decision is theirs. The midwife must then establish for herself whether or not she can take the responsibility for supporting them.

In their study of home birth, Mehl et al. (1977: 284) point out that, unlike definitions of risk found in hospital settings, "previous obstetric complications (with the exception of caesarean section) were not used as screening criteria because it was felt that they were iatrogenic to some extent." It is not uncommon for an unlicensed midwife to request her client to see a doctor for some prenatal care, and also to be on call should an emergency arise. The doctor and midwife thus enter into a relationship, but the lack of any bureaucratic framework equalizes their status with regard to the client. Only when it is necessary for the midwife and her client to enter the doctor's "turf" (the hospital) does the hierarchical ordering between the doctor and the midwife become evident.

The relationship of unlicensed midwives with each other serves some important functions. Because they feel a need to learn from each other, and because they share a distinctive and somewhat radical ideology with regard to birth, unlicensed midwives typically work in groups. In some areas these groups maintain contacts with other midwives in larger, informal networks to pass on referrals and to share knowledge. Sensitivity to their collective reputation also leads unlicensed midwife groups to discipline those whose work they regard as sloppy or dangerous. They use peer pressure on errant practitioners to reform or cease practice. The effectiveness of such informal control is difficult to assess. One case uncovered in this study concerned a midwife who was forced from practice because of an increasingly bad reputation among her peers. In this regard unlicensed midwives are similar to physicians, who also use
referral networks to rid themselves of incompetent practitioners. In both cases, however, this "local discipline" may drive a practitioner from one area, but does not bar him/her from practice elsewhere. In contrast, licensed midwives lack control networks. Because their authority for training and discipline belongs to state agencies, these midwives do not feel the need to learn from each other or patrol their ranks.

Another difference between the licensed and unlicensed midwife is the nature of their relationship with organized medicine. CNMs have well-established relationships with obstetricians and physicians. Licensed lay midwives in Arizona have established working relationships with medical institutions, despite difficulties in finding supportive physicians. While unlicensed midwives may have informal relationships with certain physicians, these relationships are fragmentary because of the threat of professional sanction (loss of hospital privileges, for example) facing doctors who collaborate. Studies also document that the formal ties between doctor and midwife necessitated by licensure result in the more frequent resort to physician assistance by midwives. Donnison (1977: 185) reports that in Britain, "Ever since the 1902 [licensing] Act had come into operation, the proportion of cases in which midwives had sent for the doctor had been rising steadily." In those American cities which employed licensing, "Midwives, more secure in their licensed status, were calling doctors earlier and oftener" (Kobrin 1966: 356).

The establishment of well-defined relationships with physicians alters the midwife's style of practice. Oakley (1977: 24) comments: "In a home confinement, where [a midwife] must summon a doctor for the repair of an episiotomy, she may be motivated to deliver the baby's head more slowly in order to stretch the perineum gradually and thus avoid the need for an incision." In the case of lay midwives, where physician back-up is not always well-established, and where there is a disinclination to use hospitals, the motivations cited by Oakley result in a style of practice geared to avoiding med-
ical assistance. Interestingly, some techniques employed by lay midwives to avoid medical procedures have influenced physician care. Mehl (1976: 96), in his study of home and hospital birth, reports that "the perineal massage technique used by the midwives to aid in preventing vaginal lacerations during delivery was effective, and, as the physicians adopted this technique, their laceration rate decreased."

Licensed midwifery recruits individuals with motivations different from those of unlicensed midwives. This is probably the most significant indirect effect of licensure. Those who practice midwifery in states where it is prohibited have a strong commitment to their occupation. Yet if midwifery were to be licensed in those states, it would become merely another legitimate career opportunity, a job chosen by an individual because it appears an interesting way to make a living. In his discussion of chiropractors, Roth (1977: 118) states:

As more and more people enter the field, a greater proportion do so to make a living. They are concerned with holding their own against the competition and with expanding the scope of their practice, if possible. If this means looking more like a doctor and doing things a doctor does, so be it.

These findings apply to midwifery. There may be other intentions, but most CNMs engage in their occupation to "make a living." Being salaried, they are concerned with the efficient use of time, and the client-practitioner interaction becomes part of business. Most of the midwives now licensed in Arizona once practiced illegally, and were drawn to the occupation for reasons similar to unlicensed midwives. How much their orientation can change is illustrated by the Arizona midwife who capitalized on her new status by expanding her practice, staffing it in the fashion of the typical physician practice, and offering regular office appointments. In contrast, [unlicensed] lay midwives wish to be paid, but they have no desire to make midwifery especially lucrative. Many believe that it should
not just be offered as a commercial service, for midwifery is a calling for dedicated, spiritual women working in concert with like-minded patients" (Ruzek, 1978: 138; see also Arms, 1977: 195, 251–52). In her “instructions to midwives” Gaskin (1978: 285) says:

The spiritual midwife tries to find a way that she can practice without charging money, as this makes it easier to keep birthings spiritual. Her husband and/or community may assume her support. If she is helping ladies for free, she has a better moral position if she needs to talk to a lady about her attitude.

Because they are not interested in “making a living,” lay midwives typically have fewer cases and are freer to spend more time with their patients during both pregnancy and childbirth (see also Mills, 1977: 52).

Licensure serves to define a jurisdiction for practitioners. Once defined, those who meet the requirements guard their territory jealously. Certain CNMs told me that lay midwives should be regarded as no more than “birth attendants” because they cannot offer their clients the complete store of knowledge and techniques that are a part of midwifery. In Arizona, some licensed midwives have been diligent in their responsibility to report and thereby prevent the practice of midwifery by unlicensed persons. In that same state licensed midwives fought a bill that would have loosened the requirements for entry into the profession.

The restrictions of licensure limit the practice of midwives and the kinds of clients they are allowed to see. These limitations can reduce the clientele of midwives, particularly when regulations are newly introduced. Evidence from the city of Brownsville, Texas, where a training program for midwives was begun in 1976 and certification ordinance introduced in 1977, confirms this observation. Strict limits on the definition of normal childbirth, coupled with mandated education and increased surveillance, reduced the number of births with midwife assistance:
In 1974, 66% of all babies in Brownsville were delivered by lay midwives. In 1975, 84% or 2784 were delivered by midwives and 536 were delivered by doctors. In July 12, 1976, the program began and 75% were delivered by lay midwives. . . In 1977, 66% were delivered by lay midwives and the ordinance #913 was passed on May 2, 1977, and we could then enforce the need for regulation, education, and observation of lay midwives. In 1978, 50% of the deliveries were done by lay midwives (Brownsville Department of Public Health, 1979).

Not unexpectedly, the differences in licensed and unlicensed midwives as practitioners result in characteristic differences in their clientele.

The Client

One characteristic common to clients of both licensed and unlicensed midwives is self-selection. The present structure of maternity care in the United States more or less channels expectant parents toward a standard hospital delivery. It takes an active effort by parents to obtain a midwife-assisted delivery.

This search for an alternative is often rooted in strong feelings of where the responsibility for birth should lie. Parental desire to assume this responsibility varies widely. My own interviews with parents as well as data collected by others (Millinaire, 1974; Nash and Nash, 1979) reveal a range of feelings extending from total reliance upon medical personnel (as in hospital births where the mother is only semiconscious) to a desire for complete responsibility (as in home births where the father “catches” the baby). Hazell (1974: 24) concluded that the home birth couple usually feels that the “primary responsibility for birth” lies with the parents, “not with the doctor or the hospital.” Those with such convictions often seek out the lay midwife because “her function is to assist, not to take over
responsibility" (p. 37). Lay midwives respect this feeling. One midwife notes that her clients are "people who are taking control of their lives... and they're willing to take responsibility for the risks involved." She continues: "I won't let them put those responsibilities off on me. That is what the doctors have done traditionally. They pat the lady on the hand and say, 'Don't worry, dear, I'll take care of everything.' But that is not the traditional role of the midwife" (Anderson, 1978: 1). Those who employ lay midwives to assist in home births are often inclined to accept the consequences of their decision as part of some larger plan. In case of mishap these individuals tend to fall back on fateful explanations rather than faulting themselves for not choosing a hospital birth. The father whose child died five days after a home birth concludes: "We believe that it was the hand of the Lord and we have accepted that. Nobody wanted that baby more than we did. We feel grieved about it, but we are at peace in this" (quoted in King and Saltus, 1978).

When licensure is introduced, part of the parents' responsibility for birthing is transferred to the state. The client often assumes that a licensed midwife is competent because she is certified. On the other hand, when midwives are not licensed, the client must assess the qualifications of the practitioner herself. Licensure actually encourages the client to forego any personal evaluation of the practitioners, even though most clients are not familiar with certification requirements. In Texas, before passage of the most recent law, many midwives took advantage of the registration requirement by advertising themselves as "registered midwives." In turn, many of their clients confused registration with certification. I interviewed several clients who noted that their midwife was registered, and though admitting that they did not know exactly what this implied, most assumed (incorrectly) that it involved some type of training and monitoring. Inclusion of the state as a third party in the relationship between the midwife and her client undoubtedly alters feelings of where responsibility for birth lies.

If licensure moves midwife-assisted birth into the hospital—as it
has for the CNM—responsibility for the birth will be shared not only with the state but with physicians. The CNM’s client may be more involved in the birth experience than the patient in a standard hospital delivery, but this is still very different from the total responsibility assumed by the mother delivering at home with an unlicensed midwife. Upon entering the ABC, the CNM’s client places the ultimate liability for her birth on medical professionals; "responsibility" for the birth is hers only as long as these medical experts define the situation as safe. Should a “regular” hospital delivery be necessary, medical personnel take charge and the parents more or less become bystanders. A proponent of “natural childbirth” comments:

The mother who goes to the hospital to have her baby is in an impossible situation, really. If a doctor says he’s doing something for the safety of her baby, there is nothing she can say. Once she is told a procedure is for her baby, she can offer no argument. If you were in a hospital and your obstetrician said, “Look, we are a little worried about your baby. We want to put you on a fetal heart monitor,” what would you say? I don’t think a mother really has a choice (quoted in Arms, 1977: 123).

The most responsible parents prepare carefully for birth. According to one doctor: “In our experience, it is usually the parents who are most informed . . . who choose a home or home-like birth. Those parents who are least informed relinquish themselves to doctors and hospitals without question” (Hosford, 1976: 38, emphasis added). Yet there are subtle distinctions between home-birthers and those using the ABC. Clients of the CNM receive only minimal training in the physiology of birth; instead there is a heavy emphasis on “psychoprophylaxis.” Psychoprophylaxis refers to breathing techniques employed during delivery as a substitute for anesthetics. This training is geared for hospital deliveries and emphasizes the division of practitioner and client responsibility. The
client is supposed to remain physically and emotionally relaxed so that the practitioner can focus on, and be responsible for, the birth. Those having births at home must learn more about the birth process. Most frequently this knowledge is gained through reading, but occasionally lay midwives organize a class for expectant parents. The classes stress "getting in touch with your body," and encourage self-examinations which allow the mother to determine the progress of labor. Training for CNM-assisted birth tends to downplay this kind of involvement by the mother, recognizing instead the superior knowledge of the practitioner and her colleagues.

When not constrained by poverty or geography, women will choose a birth attendant whose view of birth is consistent with their own. Those choosing a lay midwife view birthing as a "family event" rather than a medical abnormality. The fact that medical backup is arranged in most of these births does not negate this observation. On the contrary, it demonstrates a belief that medical aid will be needed only in case of an emergency. Those who make an informed choice of an unlicensed midwife assume the greatest responsibility, because they deny the state the right to judge the competence of the practitioner. Those who opt for a CNM-assisted birth share their responsibility with the state, which evaluates and certifies the practitioner, and with physicians, who supervise the CNM. The CNM and her patient confirm the idea that birth is abnormal by placing it within the hospital, although the ABC does allow more family participation and diminishes the "medicalization" of birth.

The Practitioner-Client Relationship

Compared to the obstetrician, the midwife establishes closer and more personal relationships with her clients. In their study of CNMs in a hospital setting, Record and Cohen (1972: 358) cite evidence of the client's personal satisfaction with the midwife:
"She thinks of all the little things the doctors don't have time to talk about. There are hundreds of things you don't want to bother your doctor with."

"I admit that I asked questions of [the CNM] that I was shy to ask my doctor, or questions that I thought were too silly to take his time for since he is so busy."

The investigators conclude that "such remarks suggest that either because of individual characteristics, or perhaps because she is a female, or perhaps because as a paramedic she is less removed from [her clients] by professional mystique, the CNM may not only be substituting for the doctor . . . but providing a service that the doctor cannot provide." For many of the same reasons, the lay midwife also creates a personal relationship with her clients, but beyond the general fact that midwives are more approachable than doctors, there are variations in client interactions with licensed and unlicensed practitioners.

The unlicensed midwife cannot offer prenatal care to clients in medical settings such as an office, clinic, or hospital. Usually their care is provided in their own or the client's home. These settings, coupled with the less demanding caseload of unlicensed midwives, create relationships that go beyond concern with the ongoing pregnancy. Furthermore, lay midwives, in keeping with their wholistic view of birth, feel that it is important to know the total person. They believe that emotional problems are a serious obstacle to the smooth progression of birth, and that if the attendant is aware of these potential emotional blocks she will be better able to deal with them. An unlicensed midwife commented in an interview: "Prolonged labor could be because a lady is uptight—outside pressure . . . a fight with her man, fear of becoming a parent, so much more than just physical."

Midwives with legal status can meet clients in what are regarded as more traditional medical environments. Many midwives in Texas and Arizona maintain offices where they see clients for pre- and
postnatal care. Those with larger practices maintain offices like those of a physician, with receptionists, appointment schedules, and waiting rooms. The office environment focuses attention on the pregnancy and limits discussion of topics not related to the impending or recent birth.

As expected, relationships between midwives and clients are most specialized in a hospital setting or a doctor's office. Because the majority of CNMs work in one or the other of these locations, their opportunities for interaction with clients are limited. When prenatal care of the CNM's patient takes place in a clinical setting, there is little or no segregation between patients who see a doctor and those who see the midwife. Both groups are routinely processed through a central nursing station for such preliminaries as blood pressure, weight and urine tests, and then must wait to see their respective practitioners. In this context the mother becomes little more than a "maternity patient." Although the CNM's para-professional status might make her more approachable, the effects of the clinical setting are unmistakable. The contingencies of appointment schedules and staff responsibilities leave little time for discussion not directly related to the pregnancy. Furthermore, the CNM's large caseload often results in segmented care because she is unable to attend to the needs of all her clients.

Client control of the practitioner also differs between licensed and unlicensed midwives. The CNM is in a bind because she is responsible both to her patient and to her supervisors. A patient entering an ABC finds herself at the lower end of a chain of command since the licensing law stipulates that the CNM's treatment of her is regulated by physician supervisors. If a patient request is not in accord with hospital and/or physician policy, it is often denied. Arizona's licensing law also limits midwives' ability to respond to client requests. Although most of Arizona's licensed midwives are familiar with herbal remedies for conditions of pregnancy and birth, they cannot legally give advice on their use. In contrast, the unlicensed midwife's sole responsibility and ultimate accountability lie with
the client, leaving much more room for negotiation between practitioner and client on matters of treatment. 

Location also helps determine who controls the pregnancy. The client who enters a hospital is more or less a guest of the practitioner and is less able to direct her care. In general terms, Roth (1972: 430) has noted that in a hospital "control of the patient's treatment is taken out of his hands and information about his treatment hidden from him." "A crucial means of control in the hospital is the strangeness of the setting to the client and the dependence of the client on hospital personnel for orientation to the setting, techniques and routines of the hospital" (Shaw, 1974: 125). On the other hand, if care is given in the client's home, the practitioner becomes the guest of her client and must respect her wishes. Most of those who choose to give birth at home are aware of this. One couple reports (Longbrake and Longbrake, 1976: 158):

Foremost, and underlying our whole enthusiasm for home-birth, was our desire to be in control of the situation. The setting was familiar and comfortable. We could arrange it to suit our needs. Instead of being "intruders" into the medical personnel's world, the midwife and the doctor were our visitors. During the process of labor we were freed from having to respond to new and unfamiliar hospital routines and to adjust ourselves to conform to the behavioral expectations of others. Rules for institutional convenience and safety were unnecessary.

Ruzek (1978: 132) states: "Thus, unless a woman remains on her own territory, she will not retain the power to control her birthing. The structure of health-care institutions insures that medical definitions of the situation prevail. Lay definitions are legitimate only in lay territory." These varying centers of control are reflected in the roles assumed during birth. Many studies of obstetricians emphasize their role as the "star" of childbirth. CNMs try to avoid this, but they struggle against the environment in which they work. Lay midwives insist that they are just assistants in the birth process.
True to this belief, they do not "deliver" babies, but "catch" them (see Sousa, 1976: 120).

The midwife-client relationship is further affected by the differential recruitment patterns discussed earlier. CNMs are recruited from the ranks of RNs, and their commitment to a long period of training makes it likely that their only experience with birth occurs as an assistant in a medical setting (Warpinski and Adams, 1979). Lay midwives typically enter their careers after a home birth of their own. Established lay midwives are hesitant to take as an apprentice a woman who has not had a baby, because they feel such a midwife cannot be truly empathetic. By making midwifery a legitimate occupational choice for career-minded women (who are less likely to have children) and by requiring lengthy periods of training, midwife licensing laws discourage midwives from having children. Of course, it can be argued that midwives should not have children. One CNM, agreeing with sociologists who see value in neutrality, claimed that a practitioner who had borne a child would lack the objectivity and even harshness needed to snap a laboring woman out of self-pity (see also Holt, 1969).

Licensure affects the economic arrangements between the midwife and her client. Although I found no evidence that licensure drove up the cost of midwifery services, it did serve to formalize fee collection. In California and other states where lay midwifery is prohibited, midwives must be careful about the collection of fees. Payment renders them in technical violation of the Medical Practice Act, which allows a "friend" to help at birth, but not a fee-charging, unlicensed practitioner. For this reason unlicensed midwives are willing to barter and, when paid, often request cash. An unhappy consequence of the unlicensed midwife's strong commitment to her work is that she often receives less than full payment. Because she is not in midwifery to make money, and because her activities are covert, she finds it difficult to press for payment. Her clients are more apt to thank her for the wonderful experience, offer her a gift, and forget the cash. The licensed midwife is more for-
tunate. In several states she can collect third party (that is, insurance) payments, and the authority and right to practice publicly makes it easier to insist on payment by clients. But although licensure offers an immediate practical benefit to midwives, the formal economic arrangements and the desire to “make midwifery pay” gradually alter the nature of practice.

Finally, the relationship between the unlicensed midwife and her client reflects its illegal nature. In her study of an illegal feminist abortion collective, Bart (1977) notes some positive functions of illegality. She observed that it fostered not only group cohesiveness, but also efficiency, since less time was spent “hassling with licensing agencies and filling out forms.” Bart’s primary interest lay in intrastaff relationships, but much of what she documents holds true for unlicensed midwifery. The cohesiveness in the collective is similar to the closeness of the unlicensed midwife and her client. The midwife is providing a necessary service that she and the expectant parents believe in and yet that is defined as illegal, allowing for a sense of unification behind a “cause.”

As licensure makes midwifery more medical, it is likely that the relationship between clients and their midwives will change in the direction noted by Walker (1972: 91):

In moving from a home to a hospital environment, the midwife has moved from a culture characterized by personel relations, familiar procedures, active family participation, continuity of care, and a large degree of control over the situation by the mother and her family, to a scientific culture which involves impersonal relations, specialized procedures, a passive role for family members and control by experts.

The Birth Experience

Prospective parents who seek the services of a midwife desire to control the birth experience. However, the presence of any knowledgeable attendant has a great effect on the experience. The very
act of requesting assistance from any practitioner is often a tacit acknowledgment of the parents' uncertainty and a recognition of the superior abilities of the attendant. Thus the parental desire for control is effectively modified by the practitioner's definition of the situation, which varies with the practitioner in attendance.

The experience of birth is influenced by the degree to which it has become a standardized routine. The experience, the training, and the hospital location of the CNM lead her to streamline her procedures. The ABC supplies written protocols to define "normal" progression through pregnancy and birth. Although these are negotiable to a certain extent, the definitions present an idealized frame of reference. Because any variation is regarded as abnormal, this routine view of birth anticipates intervention (see Nash and Nash, 1979). Approximately 25–30 percent of those who begin labor in an ABC are in fact removed because of some complication (De-Vries, 1980). Theoretically, if the patients do not agree with the proposed treatment, they are free to refuse care and leave the hospital, but they seldom do. As Linck (1973) observed in reference to extent of dilation, "Eight centimeters is not the time to fight."

On the other hand, the lay midwife consciously avoids treating birth in a routine fashion. After describing some elements of a "typical" birth, a lay midwife noted (Merz, 1977: 551): "Here I must stop with my description of repeated rituals, because there is no repetition from birth to birth. Each birth is a unique process that cannot be duplicated." One result of this approach is a lower rate of transfer to the hospital than found in ABCs. Mehl et al. (1977: 284) report that the lay midwives involved in their study hospitalized only 17 percent of their cases, compared to the 25–30 percent in an ABC as mentioned above.

It is not surprising that licensure pressures lay midwives toward standardization. A licensed midwife in Arizona, for instance, is prohibited from attending a woman over thirty-five years of age, with no allowance made for factors such as the health of the mother, number of previous pregnancies, or obstetric history. Furthermore,
the training requirements and medical supervision that accompany licensing laws push midwives toward routinized birth. Altered recruitment patterns also provide midwife trainees who are more likely to accept medical definitions of birth. In addition, the expanded practice that often accompanies legitimation fosters standardization as an expeditious method of dealing with a large number of clients.

The dependence upon breathing techniques in labor and delivery ("psychoprophylaxis") also threatens parental control over birth. These techniques are often considered a suitable substitute for anesthesia or analgesics, but as Margaret Mead has commented:

> It should be pointed out that natural childbirth, the very inappropriate name for forms of delivery in which women undergo extensive training so that they can cooperate consciously with the delivery of the child, is a male invention meant to counteract practices of complete anesthesia, which are also male inventions (quoted in Arms, 1977: 178–79).

ABCs typically encourage the mother to employ these techniques to "get outside of the situation." In effect, then, there is little difference between this and the use of drugs; both function to remove the mother from the experience and allow the practitioner to dominate (see Oakley, 1979: 628–31). Lay midwives also employ breathing techniques, but in a less structured way and with a different emphasis. It is their contention that the breathing helps the laboring woman focus on her situation and allow her to "go with the flow":

> We don't practice breathing techniques during pregnancy because we feel that if you practice in a certain way, you might tend to be a little rigid when it comes to the actual experience of childbirth. We work out breathing techniques in the here-and-now at the birthing (Gaskin, 1978: 84).
If licensure results in midwifery becoming a hospital-based practice, midwife and client will unquestionably surrender a degree of their autonomy to the institution. This will likely include use of the more rigid breathing techniques—convenient for the institution because they make for an efficient and quiet operation—as well as other routines necessary to deal with a number of birthing women in a central location. Indeed, the organizational demands often require the "pacing" of deliveries. A fixed amount of available space coupled with an unpredictable number of patients often necessitates speeding up or slowing down the normal progress of birth. Rosengren and Devault (1963: 282) suggest that the pacing of births is also related to professional status:

As one resident put it, "our average length of delivery is about 50 minutes, and the Pros is about 40 minutes." Thus, the "correct" tempo becomes a matter of status competition and a measure of professional adeptness. The use of forceps is also a means by which the tempo is maintained in the delivery room, and they are so often used that the procedure is regarded as normal.

Such constraints are not found in the home. Ruzek (1978: 138) points out that lay midwives operate on a different time frame than the professional:

Rather than viewing midwifery as a full-time occupation, a job, or a task to be completed as quickly as possible, lay midwives look forward to births as meaningful, spiritual life-events to experience and enjoy. The long hours spent with laboring women are rewarding and satisfying because of the "birth energy": They are not draining, as are long hours worked in a frenetic hospital delivery service.

Note that Ruzek is discussing individuals who choose midwifery for reasons other than simply "making a living." As midwifery is legitimated through licensure, we can expect more practitioners who
regard it as nothing more than a "full-time occupation, a job, or a task to be completed as quickly as possible." Thus midwife-assisted birth will come to look more like medically directed hospital birth.

The creation of the ABC is partial evidence that the medical profession is aware of the benefits of a home environment. But even though the ABC allows greater freedom, it is still an enclave within the larger hospital. The coordinator of one ABC involved in my study told me, "It may not be hospital in here [the ABC] but as soon as you step out that door it is . . . and you cannot forget that." The laboring woman must leave her home, travel to the hospital, and be processed through admissions before she can take advantage of the "home-like" environs. Even inside the ABC, hospital influences are pervasive. For example, hospital staff, frequently unknown to the mother before her arrival, are responsible for monitoring the course of labor, nor is it uncommon for the ABC to be within hearing distance of other hospital patients. Family involvement in birth can also be restricted by age limits on observers. In her assessment of ABCs, Jordan (1978: 87) comments:

Hospital birthing rooms, in spite of a bit of interior decorating to make them more homelike, are no improvement over the labor and delivery room in regard to the territory issue. The woman still gives birth in an unfamiliar environment, attended by unfamiliar people, a guest on somebody else's turf with few rights and fewer resources. While more flexibility is allowed in such things as position during labor, real decision-making power remains with medical personnel. In important ways the woman still does not own the birth. One could characterize the introduction of birthing rooms as a token demedicalization and a fairly superficial response to public demands for change.

Some features of birth at home cannot be duplicated in a midwife-assisted ABC birth. Lay midwives and others advocating home birth cite cases where labor has slowed and even stopped because of unfamiliar surroundings or the intrusion of strangers. The home
environment permits alternatives for stimulating labor that would not be workable in an ABC. Sexual stimulation, for example, is sometimes helpful in speeding a slow labor, but use of this technique is unlikely in an ABC, where the couple cannot be certain they will not be interrupted.

Summary: Licensure and the Practice of Midwifery

Most studies of licensure focus on quantitative outcomes. They measure the way licensure alters the accuracy and efficacy of services offered clients (White, 1979; Sullivan and Beeman, 1983). I have looked instead at the qualitative effects, in particular how licensure works to change the nature of the practitioner, the client, and the relationship between the two. Several previous studies have discussed how professionalization and increased bureaucratic control change health care (Daniels, 1969; Engel, 1969; Freidson, 1970; Goode, 1960; Goss, 1963), but few have examined how these variables literally create a "medical" encounter.

A few general points remain. First, state certification does not ensure medical endorsement. Although licensure laws mandate medical supervision for midwives, the medical profession remains reluctant to accept practitioners from other than traditional medical fields. CNMs have gained a degree of medical acceptance (see Journal of Nurse-Midwifery, 1975) because they are drawn from the ranks of nurses, an ancillary medical occupation. Having no such tradition, lay midwives—both licensed and unlicensed—find it difficult to obtain physician support. In Arizona and Texas, where lay midwives practice legally, they often find support only among physicians who are marginal to the medical community (for example, osteopaths, or doctors near retirement), and therefore relatively immune from reprisals from their peers. This lack of medical sup-
port is harmful only to the degree that midwives need it to provide adequate care. The compromises required to win medical endorsement would undoubtedly refashion lay midwifery in the mold of nurse-midwifery.

Second, licensure laws are only partly successful in limiting unlicensed practice or unauthorized procedures. The imprecise nature of physiological processes allows the midwife to adjust some facts to fit the regulations. In Arizona, for example, because the birth of twins is often not predicted by physicians, their delivery by a licensed midwife does not bring disciplinary action, though it is prohibited and the midwife might have known about it in advance. Similarly, the length of labor or the time elapsed since rupture of membranes are easily altered to fall within mandated guidelines. However, Arizona midwives are disciplined for knowingly violating the regulations. The fear of suspension or revocation of their licenses prevents them from stepping too far beyond their legal mandate. One midwife told me that although she felt competent to perform some prohibited procedures, she felt a responsibility to uphold the Arizona law as an example to other states that might be leaning toward licensure.

It is difficult to judge the extent of unlicensed practice in Arizona. A licensure law on the books drives unlicensed practitioners further "underground" because their actions are now clearly defined as illegal and incur specific penalties. One unlicensed Arizona midwife was issued a "cease and desist" order at the request of a licensed midwife, but she apparently ceased practice for only a short period and is now back at work.

These observations highlight the essential irony of licensure. Midwives who work where midwifery is prohibited and no licensing law exists, have a type of autonomy that is denied midwives working with the "benefit" of licensure. When midwifery is illegal, midwife and client become coconspirators unwilling to report or provide evidence against each other. This fact, coupled with the private nature of home birth, gives the unlicensed midwife a great
deal of freedom in her practice. The more formal relationships that licensed midwives have with their clients force them to stick closely to the legal definition of practice. In this sense, midwives who are allowed to practice openly face more restrictions in their practice than midwives who are legally prohibited from practicing.

But there is a price paid for freedom. Working without a license puts a strain on midwives; they cannot openly advertise, and are often unable to accompany their clients to the hospital when complications arise. Many unlicensed midwives also admit to a nagging fear of facing legal action through some unavoidable mishap at a birth. A number of recent cases against midwives have fueled these fears. The California Association of Midwives compiled a list of fifteen midwives who were either formally charged or investigated between 1980 and 1983 (CAM Newsletter, 1983). In response, some midwives are quitting their practices, and others are returning to school for training in more legitimate health occupations as registered nurses, physician assistants, certified nurse-midwives, or nurse practitioners. We shall explore disciplinary proceedings and legal actions against midwives in the next chapter. As might be expected, licensing laws influence these proceedings, altering both their formal and informal characteristics.