Chapter 6

Conclusion: Birth, Medicine, and the Law

The fields of law and medicine have much in common. Their practitioners are regarded as professionals and receive the benefits of that status. Both occupations have attained a measure of freedom from outside sources of control; they regulate themselves through their own professional organizations. Perhaps most important, medicine and law are characterized by extensive technical bodies of knowledge, the mastery of which provides authority to the professional. However, the right of lawyers and physicians to the claim of "neutral" and "scientific" authority has long been questioned, though not by the public. Sociologists and others have demystified medical and legal institutions by exposing the social forces that influence them. Justice Oliver Wendell Holmes debunked the pretensions of law in 1881:

"The life of the law has not been logic: It has been experience. The felt necessities of the time, the prevalent moral and political theories, intuitions of public policy, avowed or unconscious, even the prejudices judges share with their fellow men, have a good deal more to do than the syllogism in determining the rules by which men should be governed (quoted in Lerner, 1943: 51–52)."

Here and elsewhere (Holmes, 1897) Justice Holmes was concerned with demonstrating that the law is not a body of logically
consistent principles, but rather that the law is subject to a variety of social influences which reshape and recast legal principles. The science of medicine can be evaluated in a similar fashion. In fact, it is not unreasonable to apply a slightly altered version of Holmes' statement to medical science: "The felt necessities of the time, the prevalent moral and political theories, . . . even the prejudices doctors share with their fellow men, have a good deal more to do than science in determining the nature of medical practice." As Springer (1973: 294) notes, medicine has expended its efforts according to the concern of society at large: "Great exertions of time and energy have been made and large infusions of dollars have been required to alleviate particular illnesses. Medicine has responded to articulated felt needs." Springer's observations are confirmed by studies that demonstrate the political nature of medical research (Chubin and Studer, 1978; Krause, 1977). Far from being objective, medical decisions are influenced by "felt necessities," "intuitions," and "prejudices."

If we are to explore the relationship between medicine and law, we must examine the social forces behind the facade of scientific objectivity. That is my intent in this concluding chapter. With midwife licensure as the case in point, I will examine the ways licensure affects the regulated profession, the field of medicine, and the larger society.

Licensure and Dominance

My study has shown that state sanction to practice does not bring autonomy to midwives, but rather formalizes the dominance of physicians over them. This conclusion confirms the cultural power of scientific medicine and its primary agents, physicians. William White (1979) has provided a study of the licensure of clinical laboratory personnel that, rather interestingly, fails to take account of this cultural power. White (1979: 119–20) offers three models of support for licensure:
(1) the public interest model, in which consumers or their agents seek licensure in order to improve the quality of services,

(2) the acquired model, in which occupational elites or rank-and-file members of an occupation seek to use licensure to increase their incomes, and

(3) the bureaucratic model, in which bureaucrats support licensure in order to increase their agency budgets and improve their own career opportunities.

White concludes that the bureaucratic model most accurately applies to the subjects of his study, although he grants that most laboratory workers (the "acquired model") supported licensure also. White's conclusions are insightful, but limited. For example, White (1979: 122) notes that physicians, reluctant to share their power, have "consistently opposed licensure [of clinical laboratory personnel]," but he does not consider the ways in which licensure is won at the expense of independence.

In his studies of allied health occupations in Great Britain, Larkin (1983) suggests that the dominance of scientific medicine is not affected by paramedical licensure. Larkin (1981: 16, 25—26) observes:

Many para-medical groups have achieved state registration in the post-war period, and prominent members of those professions have considered such developments to be a kind of "professional emergence." It [is here] argued that, in the longer historical perspective, such changes were conclusive steps in a logic of subordination. . . . Para-medical innovation may add to the division of labor, but rarely alters it . . . . Limited recognition is no more the end of dominance than imperial withdrawal is the remoulding of international economic relationships.

Although midwifery has different, more autonomous roots than the occupations Larkin studied, his conclusions are applicable. Where midwives have been licensed, they have suffered an increase
in surveillance and control by physicians. Licensing laws proposed for lay midwives would have similar consequences. In her study of health licensing in seven countries, Roemer (1973: 258–59) confirms the loss of independence:

Midwifery, like nursing, shows the same pattern of close supervision of education by the licensing agency or a closely related agency. . . . Continual upgrading of educational requirements for midwives is tending toward a fusion of the professions of nursing and midwifery. . . . All statutes are meticulous in specifying the duties and functions of midwives and their responsibility to summon a physician in abnormal or difficult cases.

Given the fact that licensure works against the autonomy of these paramedical professions, it is important to explore how physicians deflect challenges to their dominance. Their cultural prestige is probably the most important factor, but they derive their formidable political power from well-established professional organizations that defend their interests anywhere that policy decisions are made. By way of contrast, paramedical groups are weakly financed, less thoroughly organized, and often suffer from internal division. In their study of attempts by optometrists to gain favorable legal recognition, Begun and Lippincott (1980: 91) observe that "internal segmentation in optometry [has reduced] its political effectiveness." On the other hand, the cultural power of physicians is continually reinforced. Almost daily the electronic and printed media carry stories about the advances of scientific medicine in the "war" against disease and illness. And although scientific medicine has its critics (for example, Illich, 1976; Mendelsohn, 1979), the marketing of medicine through the media serves to sanctify physicians as the priests of scientific medicine (see Montgomery, 1982). In his ethnography of power relations on a Health Systems Council, Hanson (1980) describes how the cultural power granted to physicians results in provider (that is, physician) control of what is supposed to be a consumer-oriented agency. Hanson (1980: 172) concludes:
In significant ways "provider mystique"—characterized by consumer dependency on providers and a provider attitude which conveys the idea that physicians and other medical professionals know what is best for consumers—is carried into council meetings for consumers and providers. Since consumers are generally socialized to respect the prestige, knowledge and power of the medical profession, the stage is already set for providers to dominate discussion and control the meetings. The mystique supplies the predominant definition of the situation at council meetings.

The cultural authority of physicians also gives their testimony before legislative bodies the status of "expert advice," thereby enhancing their influence over legislation.

As paramedicals—including midwives, optometrists, radiographers, and nurse-practitioners—have sought scientific respectability through licensure, physicians have invoked their power to ensure that these new occupations remain subordinate. Licensing laws are typically written in a way that requires paramedicals to gain the cooperation of physicians. And often physicians fail to cooperate, claiming medical or legal problems prohibit consort with the lesser trained. For instance, physicians have expressed a reluctance to work with a midwife because they cannot be certain of the midwife's competence and are fearful of malpractice suits if they assume responsibility for her actions (see Wilcox, 1981; Scott, 1980).

A more subtle way that physicians assert and maintain dominance over paramedicals is through their exclusive authority to diagnose patients. All midwife licensing laws, for instance, stipulate that midwives can attend only women expected to have a "normal" or trouble-free pregnancy and delivery. Unfortunately for midwives, the definition of "normal" is left to physicians, who can restrict it to a highly select group of women. Oakley (1980: 22) suggests that it is in the interest of physicians to classify all pregnancies as "abnormal":
The doctor views reproduction as a potentially problematic condition, reserving the label "normal" as a purely retrospective term. Every pregnancy and labour is treated as though it is, or could be abnormal, and the weight of the obstetrician's medical education acts against his/her achievement of work satisfaction in the treatment of unproblematic reproduction. The consequence of this attitude is of course that "normal" reproduction becomes an anachronistic category:

[Physician]: Interesting, very interesting, most unusual.
[Registrant]: You mean it was a normal delivery?
[Physician]: Yes—pushed the baby out herself!

The equation of "normal" with "unusual" illustrates the medical rationale, for if this equation did not hold, obstetricians would presumably have no valid role in managing reproduction.

Evidence from alternative birth centers verifies the reluctance of physicians to judge pregnancies "normal." By definition, women in these programs have been classified as "low-risk" pregnancies, but from 30 to nearly 50 percent are removed before birth because of the diagnosis of some "abnormality" (see DeVries, 1980). The power to diagnose, given exclusively to physicians, allows wide control over potential competitors.

Some organizations interested in promoting the independent practice of midwifery recognize the dangers in licensure. Commenting on a recent midwife licensing law in the state of Washington—a law passed with the help of midwifery advocates (see Evenson, 1982)—the executive director of the National Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC) stated (Stewart, 1981: 21):

The new bill just passed firmly reinstates [control of midwives in the Medical Licensure Board], which is why the doctors and nurses endorsed it . . . Considering the openly stated opposition of doctors and nurses in Washington State to the idea of "the free
practice of midwifery," one can only hope that the new bill, which has also been lauded by some midwives there, will increase and not decrease the availability of midwifery services. From NAPSAC's official standpoint, we cannot support this bill, nor any bill that would place physicians in any authority over midwives. Medical doctors can rightfully regulate themselves, but there is no way they can regulate other competing professions without an unavoidable conflict of interest. In the end, it is the public who suffers the degradation of health care services that inevitably results from such a conflict.

Several studies of licensed health occupations reveal that licensing does little to control quality of care, restricts the supply of practitioners, reduces their productivity and competition, and interferes with their geographic mobility (see Begun and Lippincott, 1980: 59). After their review of health-care regulations, the editors of the Iowa Law Review (1972: 1162) conclude:

While the consumer naturally assumes that the public regulatory system is working to protect his interest, the reality of the situation is that the public regulatory system is so closely entwined with the private regulatory system that the public interest has been distorted for the benefit of private interests. The result is both an inadequate assurance of the quality of health-care personnel who perform needed services as well as an inadequate supply of such personnel.¹

Dominance over medical care also creates some problems for physicians. Ultimate authority by implication gives physicians full responsibility for health. This increases the likelihood of malpractice actions by disgruntled patients who for one reason or another were not successfully treated. By way of contrast, paramedical personnel, who are given only limited authority in medical care, are very rarely the subjects of malpractice actions. Physicians are also more likely to be sued because their imposing authority leads to
formal relationships with their patients. Paramedics, on the other hand, tend to establish closer relationships with their clients. An individual is less likely to sue a friend than an institution.

Law and Medicine in Society

Although the influence of physicians on the licensing of paramedics has been immense, physicians have not freely wielded the law as a tool of dominance. Laws do alter the practice of medicine. Similarly, developments in society have forced physicians and other medical practitioners to change their ways.

It is difficult to generalize about the relationship between law and the practice of midwifery. Earlier discussion pointed to the differences between licensed and unlicensed practitioners. We can conclude that as her practice is legalized—that is, subjected to regulation and licensure—the lay midwife will begin to approximate her certified counterpart. Licensing bills introduced in the California and Texas legislatures (which evolved from less to more medical control and supervision), restrictive revisions in the Arizona law, and current attitudes toward home birth among medical professionals (see Pearse, 1979) suggest that licensure will push the lay midwife toward more medical training and direct medical supervision. These changes will bring individuals with a different set of motivations into lay midwifery, alter client-practitioner relationships, and significantly influence the nature of the lay midwife-attended birth. These facts and the examples of past midwife licensure indicate that the law will continue to change the nature of this occupation.

It appears that law, however, is incapable of immediately altering traditional relationships. Aubert (1966), in his study of the Norwegian Housemaid Law, has shown the difficulty of legislating long-standing arrangements between individuals. In this case a law attempting to define the working conditions of housemaids was unable to penetrate the privacy of individual homes or change the
relationships between housewives and their maids. Similarly, midwife licensure has not wholly disrupted established patterns of care related to childbirth. In many areas, prevailing traditions make a license inconsequential. This is particularly true for midwives working in rural areas among poor and minority populations, where enforcement of licensing laws is notably lax.

But if its immediate impacts are limited, law has proven to be an important element in shaping midwifery. Licensing sanctions a particular group of practitioners. Established medical professionals are restricted to interacting with licensed midwives, and the public gradually accepts the "benefits" of retaining certified practitioners. Cut off from the mainstream, the uncertified midwife faces a decreasing clientele and eventually drops from sight. Midwives who are already licensed begin to alter their practices in order to comply with the law. One Arizona midwife informed me that she had changed some of her earlier practices, even though she believed the changes were detrimental to her clients: "Before [being subject to] the regs I used to use cayenne to control [post partum] bleeding and I never had to transport a woman [for that problem]. Now that I can't use herbs I have had to transport women for bleeding and occasionally they even need to be transfused." Although many would question the wisdom of using cayenne as an antihemorrhagic agent, this midwife's change in practice demonstrates the effect of law.

Licensure also affects the midwife's clientele. Several clients in Texas and Arizona told me that they would not employ a midwife if they lived in California, where lay midwives practice illegally. This demonstrates the effect of state sanction, and such changes in clientele undoubtedly influence the midwife-client relationship and (consequently) alter the nature of midwifery.

Neither medicine nor law is independent of the social conditions that surround them. Indeed, both respond to the "felt necessities of the time" (Roth, 1977: 122–24). It has been suggested that a complete understanding of change in medicine requires the exploration of how medical and nonmedical movements interact. Consider
midwifery. The methods of attending birth have been attacked or supported by a number of social movements with broader concerns (see DeVries, 1981: 1085–87). The movement of birth into the hospital and the subsequent decline of midwifery earlier in this century are in part traceable to the collective efforts of women suffragists who spread the gospel of hospital birth and "twilight sleep" (see Wertz and Wertz, 1977: 132–77). Similarly, the gradual shift of birth back to the home and the growing demand for midwives (licensed and unlicensed) are linked to diffuse social currents in contemporary society. The revolt by women against traditional sex roles—and in particular, the dominance of obstetrics by men—increased the demand for home birth and midwifery (see Ruzek, 1978; Scully, 1980). A general interest in "natural" life styles led to criticism of the technological interference in the natural process of birth, and it also renewed interest in the noninterventionist techniques of midwifery. Finally, the interest in self-fulfillment, which earned the seventies the title of the "Me decade," created a concern with the experiential dimension of birth (see Lasch, 1978; Yankelovich, 1981). Birth was no longer a necessary evil to be endured by those who wanted children. It was now relished as an important life experience, an experience marked by growth, achievement, and personal satisfaction. Midwives were sought out because they were sensitive to this dimension of birth.

These social movements have accompanied (and encouraged) movements for change within medicine, contributing toward a slow "humanization" of medical care (Howard et al., 1977). Renee Fox (1977) has suggested the possibility of a decline in medical dominance and a "demedicalization" of society. Reforms of this type within the medical establishment demonstrate the direct influence of larger social movements. Thus alternative birth centers in hospitals were created to appeal to new consumer interests and to deflect interest in home birth.

On the whole, the law follows more than it initiates change. However, as we have seen, the ability of law to sanction practition-
ers can gradually alter the structural conditions of medical practice. Laws generally prove most effective when their mandates conform to the cultural conceptions of the public. In this case, the desire of midwives and other paramedics to gain the benefits of scientific medicine makes them willing to adhere to the law, even though adherence can detract from the special, nonmedical aspects of their practices.

Medical Hegemony and the Law

W. F. Cottrell (1940: 36) called our attention to the "tremendous interrelationship between technological and social facts" in his study of railroading. The law is one of the more important social facts that interacts with technology. Hurst (1950: 10) has suggested that much of the influence in this relationship flows from technology to law: "The law has almost always been acted upon by, or has responded to technological change, rather than controlled it. The relation between law and technical change was full of color and tension. But in almost every case, the scientist or the inventor took the initiative." Hurst's observations remain accurate. The segmentation of knowledge characteristic of our time, and the subsequent spawning of specializations, have created enclaves of knowledge that are (or are assumed to be) beyond the understanding of the nonspecialist. This creates a dependency within legal institutions on testimony offered by specialists. Such "legal dependency" is especially apparent in matters related to medicine. Several observers have noted that the power of medicine stems largely from its monopoly of knowledge (see Freidson, 1970: 108–10; Yedida, 1980).

The hegemony of medicine is supported by several legal opinions. In their report on the United States Supreme Court, Woodward and Armstrong (1979: 182–89, 229–40) detail the reliance of the justices on medical opinion in the Roe v. Wade abortion decision. Woodward and Armstrong (p. 182, emphasis added) claim that the author of the majority opinion, Harry Blackmun (former general counsel to the Mayo Clinic), "wanted an opinion that the
medical community would accept, one that would free physicians to exercise their professional judgment." More pertinent to the present study is the decision in Fitzgerald v. Porter Memorial Hospital (523 F.2d 716, 7th Cir. 1975), which held that parents' interest in having the father present in the hospital delivery room during birth was insufficient to invalidate hospital regulations preventing such access. In justifying this decision, Justice John Paul Stevens (now of the United States Supreme Court) stated that there were "valid medical reasons" for prohibiting fathers from access. He felt it undesirable to impose an "inflexible rule on all hospitals" that would substitute the court's judgment for the "professional judgment" (my emphasis) of hospital staff. Stevens also made reference to several medical articles that supported his contention that valid medical reasons underlay hospital rules. In his note on the decision, Newman (1976: 1305) asserts that "Judge Stevens bowed too easily to those persons within the medical profession who voiced objections to [natural childbirth] procedures." Newman cites evidence introduced by advocates of alternative birth methods that suggests there are no valid medical reasons for the exclusion of the father from the delivery room.

The judicial deference to the "professional judgment" of physicians in these and other legal opinions is significant, because the same deference has shaped legislation on midwifery. The advice of physicians has contributed to the failure of many midwife laws, and controlled those that do gain passage.

The supporters of midwifery and home birth, aware of the hegemony of medicine, have begun to employ the criteria of scientific medicine in defense of their cause (see Mehl et al., 1976; 1977; Mehl, 1977; Hazell, 1974; Epstein and McCartney, 1975). This new tactic is interesting in light of Goode's (1960: 904) observation that "rival professions are not willing to put their claims to the test, partly because to do so suggests that there is still higher authority than they." Yet the cultural power of scientific medicine is such that health practitioners seeking legitimacy have no choice (see
Some midwives, however, remain hesitant to use scientific criteria, claiming that midwifery is an art. As Goode (1960: 904) suggests: “Art is not testable.”

It is more than slightly ironic that the proponents of midwifery and home birth defend their position with data on rates of mortality and morbidity among mothers and infants. To do so suggests that quantity (was a positive medical outcome achieved?) is more important than quality (was the experience enriching for its participants?). Home birth advocates, after all, often point out that exclusive concern with “quantity” dehumanizes care. Recent studies have shown that the “humanization” of maternity care (to the extent that it has occurred) has come about not through a stress on statistical outcomes, but through a focus on qualitative aspects of the experience. For example, Klaus and Kennell’s (1976; 1981) innovative work on parent-child bonding has led to changes in obstetric routines once thought essential (that is, medically necessary) for the safety of mother and child. If Klaus and Kennell had not gone outside standard medical practice, they would never have concluded that the practice of separating infants and their parents to prevent infection was damaging to the process of attachment between a newborn and its mother and father. The dangers of maximizing medical outcomes are recognized by Zola (1972: 502–3):

Nor does it really matter if . . . we were guaranteed six more inches of height, thirty more years of life, or drugs to expand our potentialities and potencies; we should still be able to ask: What do six more inches matter, in what kind of environment will the thirty additional years be spent, or who will decide what potentialities or potencies will be expanded and what curbed?

The Dilemma of Licensure

The issue of midwife licensure remains a dilemma. It is commonly argued that certification is necessary for public protection, but at least one group of lay midwives has observed (Carson et al., 1977: 519):
A license isn't really a guarantee of expertise: Anyone graduated from medical school can legally deliver babies, even if they've had the experience of only three or four deliveries. Yet we, with much more experience, are barred legally. . . . Medical licensing diminishes any accountability to people, the "consumer," in favor of accountability to a licensing board.

For the most part, certification eliminates consumer evaluation of medical practitioners. The typical client simply accepts a state-issued license to practice as a judge of ability. Where such licensing systems do not exist, as with California's lay midwives, this responsibility remains with the client. Recognizing this, certain advocates of lay midwifery have proposed alternative means of regulation. Allen Solares' (n.d.[a]; n.d.[b]; 1983) proposed "Health Responsibility System" is perhaps the most well-thought out. He says that systems of regulation must seek a balance between consumer self-determination, competition, and consumer protection. To achieve this balance he suggests assessing health practitioners on the "degree of hazard" their practices pose to the public. Once assessed, the least restrictive degree of regulation that is consistent with safety should be applied. Solares envisions that a number of health practices that are noninvasive—including midwifery—could be regulated through a voluntary certification program that is controlled by consumers and that provides the information necessary to make an informed choice of practitioners. The weakness in Solares' system lies in the determination of "degree of hazard." We can expect that the medical professions would exert themselves to show that all alternative health practices are hazardous to the public.

Midwives in some areas with no licensing laws have begun systems of self-regulation, thereby imitating the history of the medical profession. In Massachusetts, where lay midwifery is prohibited by a legal decision that defines assistance at birth as the practice of medicine, lay midwives are formulating a peer review program.
This voluntary program would allow a committee of midwives to review the credentials and performance of individual midwives. An "Initial Peer Review Form" distributed by the Massachusetts Midwives Association (MMA) asks for information on a midwife's training, statistics from the births she has attended, details of a plan for medical backup, as well as a discussion of her "role at birth" and her "strengths and weaknesses as a midwife." A midwife who successfully completes this review can claim certification by the MMA. The issue of peer review came up in California following complaints about a specific midwife. After receiving a letter of complaint, the Steering Committee of the California Association of Midwives appointed several midwives to review both the midwife and the birth in question. A description of the review was published in the *CAM Newsletter* (Rosenberger, 1983) and that description generated a debate on peer review in the next several newsletters. Some midwives supported peer review as a way of forestalling action by state agencies and as a necessary device to insure competency. Others saw peer review as potentially divisive and expressed a reluctance to pass judgment on another midwife. The editor of the newsletter summed up the issue by quoting the minutes from a meeting of midwives in the San Francisco area. The consensus of that meeting was that midwives "need" both peer review and some type of standards (*CAM Newsletter*, 1984: 13).

Although midwives recognize the need for regulation of their practice, the dilemmas inherent in the regulation of health care discourage concerted action in that direction. The problem of licensure for midwives is perhaps best summarized by a lay midwife (Ehrlich, 1976: 126):

Certification of nonmedical midwives is something of a paradox. While responsibility for quality care must be assumed by its practitioners, much of the value of lay midwives is that they are nonmedical attendants who approach birth as a natural process. They have learned to midwife by midwiving, not by seeking de-
Midwifery is an art as well as a science. Intuition and sensitivity are prime requirements of a good midwife. How can a woman be trained in and measured for these subtly elusive qualities? Requirements for licenses and credentials, while meant to safeguard the consumer, often become bureaucratic roadblocks to practice. Also, institutionalizing professionals leaves the consumer out of the process of evaluating care. The likelihood of midwifery falling into this trap is especially high since medicine sees birth as its domain, and would regulate all birth attendants.

This study of midwifery licensure has demonstrated that legal recognition of a medical occupation may prove unfavorable both to the occupation and the public. On the other hand, the ability of law to control alternative forms of care is limited. In fact, even if lay midwifery falls "into the trap" of legal recognition, there is comfort in the knowledge that law has been unable to exterminate alternative forms of care when people really want them.