Epilogue:
The Trap of Legal Recognition

This book was, and remains, something of a curiosity. Reviewers of the first edition were, for the most part, bemused. They found the data interesting, accurately reported, even compelling, but they did not know what to do with my conclusions. My argument—that for midwives the cost of legal recognition would almost certainly be the end of a distinctive profession of midwifery—followed logically from the data, but many readers wanted to believe the data were anomalous. Surely, in other states at other times, midwifery would benefit from licensure.

Reviewers were left wondering if I was a friend or a foe of midwives. I often asked myself the same question. My goal, then as now, was to secure a place for a truly independent profession of midwifery. Unfortunately, my study of the most common avenue to professional independence, licensure, convinced me that it would not foster autonomous midwifery in this country. In the absence of other paths to legitimate practice, I had no choice but to recommend that midwives avoid licensure and look for new and creative ways to establish their profession (DeVries, 1986).

My discussion of "commonsense" understandings of medical licensure in chapter 1 anticipated the confused response of reviewers.
Physician reviewers, using “public common sense,” assumed that licensure was an unalloyed good and recoiled at my suggestion that the public might be better served if midwives remained unlicensed (see, e.g., Russell, 1987). They failed to appreciate how licensure primarily served the interest of the dominant profession and how it removed choice, hindered communication, and diminished the quality of care. Sociologists and midwives, employing their own version of common sense, could not understand my insistence that licensure would not benefit midwives in their competitive struggle with physicians. In their view, licensure is an effective tool in the contest between professions.

The publication of the second edition of this book gives me the welcome opportunity to revisit my analysis. Few social scientists have the luxury of testing their analyses against time, checking the relevance of their findings in a changed world. Have the events of the past ten years supported or disproved my earlier conclusions about the impact of licensure on midwifery? Have new facts come to light? Have more recent studies challenged my explanations?

In 1984, when I finished the first edition of this book, I was not optimistic about the future of licensed midwifery in the United States. Midwives here were caught in a true dilemma: legitimacy could be gained only by sacrificing the distinctiveness of their profession. Lacking the political power to shape and secure favorable legislation, midwives were at the whim of others. I suspected that all new attempts to create permissive laws would be met by organized opposition from the medical lobby. And if, over the objections of medical lobbyists, a licensing bill managed to become law, I was convinced that the details of its implementation would complicate the lives of practicing midwives and would, ironically, discourage growth of the profession.

I made these pessimistic predictions just over ten years ago. In the intervening decade our health care delivery system has changed in ways no one expected. How have American midwives fared since the mid-1980s? In order to answer this question we must consider
the condition of midwifery on several levels: its overall health, measured in terms of its size and participation in health care and medicine; developments in licensing; the treatment of midwives in the courts; and the "changing nature" of midwifery.

Health of the Profession

There are many ways to measure the vitality of an occupational group. The most obvious is a survey of its growth: an expanding profession is a healthy profession. In the case of midwives, however, the task of counting is complicated. Widely varying definitions of midwifery make it nearly impossible to get a precise count of midwives. Does a woman certified as a nurse-midwife but practicing as a nurse "count" as a midwife? What about a traditional midwife who attends only one or two births per year? Should she be included in our census?

In spite of these definitional problems, the number of practicing midwives is periodically tallied. Because there is a standardized legal definition of certified nurse-midwifery and because CNMs have uniform training requirements, it is easier to count nurse-midwives than it is to (find and) count traditional midwives. In 1982, the American College of Nurse-Midwives estimated that 2,500 CNMs were working in the United States; ten years later that number had grown to approximately 4,000 (see ACNM, 1993; National Commission on Nurse-Midwifery Education, 1993).

When it comes to traditional midwives, the best we can do is an estimate. Given the great variation in state laws and differences of opinion about who counts as a traditional midwife, all tallies of traditional midwives must be viewed with skepticism. The Midwives Alliance of North America (MANA) has long recognized the need for more accurate counts of practicing midwives. In 1989 they took a step in this direction with the creation of the North American Registry of Midwives (NARM). However, the primary purpose of the
NARM is not simply to provide a list of all active midwives. It is an effort to raise the credibility of midwifery, and, as such, all NARM-registered midwives must pass an examination intended to establish a minimum level of competency. Hence the NARM is a subset of all practicing midwives. In 1991, two members of a task force created by the Minnesota Department of Health surveyed all 50 states and found approximately 2,000 traditional midwives in practice (Barroso and Coffey, 1991). Others claim the number may be as high as 6,000 (Korte, 1995). Because these numbers are unreliable, and because there are no earlier estimates, it is impossible to speak meaningfully about growth or decline in the number of traditional midwives.

No matter how one counts, or who one counts, the growth of midwifery has been far from explosive. Added educational programs (National Commission on Nurse-Midwifery Education, 1993) have allowed the number of nurse-midwives to expand, nearly doubling in ten years; but the total is below the expectations of the ACNM. A few years ago they coined the slogan, “10,000 [nurse-midwives] by [the year] 2000.” It is unlikely that number will be achieved. We gain some perspective on the growth of midwifery by contrasting it with growth in the number of specialists in obstetrics and gynecology: in 1980 there were 26,305 obstetrician/gynecologists in the United States; by 1992 that number had grown to 35,273 (Roback et al., 1993).

But sheer numbers is only one way to assess midwives’ success. Another, perhaps better method is to examine their contribution to the health care system or, more specifically, the number of births they attend. Here again we find the role of midwives expanding while their overall contribution remains small. In 1980 midwives attended 1.7 percent of the nation’s births; by 1992 that number had grown to 4.9 percent (National Center for Health Statistics, 1994; see also DeClercq, 1992). Significant growth, yes, but midwives remain underused. Following the numbers reported above, midwives
represent about 15 percent of the obstetric workforce, and yet they
attend less than 5 percent of the births.

Perhaps it is premature to expect midwives to be significant play­
ers in American health care. Before midwifery can be widely ac­
cepted, it must be proven in the crucible of research. After a heavy
dose of criticism and discrediting earlier in the century (see Devitt,
1979a; Litoff, 1986), it will take some time before midwives can es­
tablish themselves as necessary members of a health care team.

How is midwifery treated in the world of medical and public health
research? Is the profession creating a scientific foundation for prac­
tice? Is it gaining credibility?

In the past decade, evaluations of midwife care began to appear
more regularly in the pages of medical journals. A series of articles
appearing in the 1980s assessed the quality of care by midwives at
home births (Burnett et al, 1980; Hinds et al, 1985, Schramm et al.,
1987). The conclusions of these articles were nearly identical:
planned home births with trained attendants posed no special risk
for mothers and babies, while unplanned home births and untrained
attendants brought poor results. In a widely cited study published in
the New England Journal of Medicine, Rooks and her colleagues
(1989) verified the safety of nurse-midwife-attended births in birth
centers. Further research in the 1990s supported the safety of out­
of-hospital births (see, e.g., Durand, 1992; Tew, 1990). Research
also emphasized the value of midwives for reducing unnecessary
interventions. Both traditional midwives and nurse-midwives were
credited for cutting the rate of Caesarean sections (Sakala, 1993; But­
ler et al., 1993). Goer (1995) has collected a number of research ar­
ticles that question current obstetric practices and recommend mid­
wife care as the safest and least expensive approach to birth.

Why hasn't this small but well-placed body of scientific evidence
helped midwifery prosper? The answer to this question lies in a
closer look at the research itself, considering where and how it was
done and the reaction it provoked. Much of the work emphasizing
the value of midwives is done in health maintenance organizations (HMOs) and other managed care settings, a fact that underscores the importance of financial incentives for the future of midwifery. Midwives are popular in HMOs and government programs, environments where costs must be controlled. Because they are more often cared for in medicaid programs and HMOs, black, Hispanic, and Native American women are far more likely to have a midwife-attended birth than are white women (Parker, 1994). It ought to be enough to show that midwives generate high levels of satisfaction, promote confidence in their clients, and improve outreach to underserved communities. But it is not. Midwives are allowed to flourish to the extent that they improve the bottom line.

Furthermore, supportive research is not often done by midwives themselves. We learn of the value of midwifery from epidemiologists, physicians, and social scientists. Midwifery suffers when other professions develop and expand its knowledge base. As long as the expertise of midwives is founded in knowledge developed by others, they will be a subordinate profession. In other parts of the world, where midwives have more autonomy, they claim control over a body of knowledge unique to midwifery (see DeVries and Barroso, 1996).

Finally, the response of physicians to this body of research is instructive. Their instinctive reaction is to protect the current system. In his editorial review of an article on the safety of out-of-hospital births in Missouri, the executive director of the American College of Obstetricians and Gynecologists, Warren Pearse (1987), reluctantly agrees that home birth can be safe, but he insists there is no reason to develop a system to serve the few women who choose this option. He fails to consider the documented advantages of midwives and home birth in terms of cost, accessibility, satisfaction, and the reduction of unneeded interventions. Ignoring research demonstrating how midwives save money, Pearse illogically argues that it would be prohibitively expensive to develop a system that licenses and regulates midwives.
Measured in terms of its growth and presence in health care, the situation of nurse-midwives is improving very gradually: their numbers are growing, educational programs are expanding, and they are attending more births. The future seems less bright for traditional midwives. Their contribution to maternity care is small and is seldom recognized. Although several states have considered midwife legislation over the past ten years and although MANA is making an effort to standardize credentialing procedures, the legal status of traditional midwives remains uneven and problematic. We turn next to a detailed review of recent legislation regulating the practices of midwives. Our focus in the following section is on the varied laws governing traditional midwifery, not on the (more or less) uniform rules for nurse-midwives.

Midwifery in the Legislature

Among the many conclusions generated by my review of midwife legislation in the first edition, two stand out: 1) midwives themselves have little control over proposed and enacted laws; and 2) what appears to be legislation favorable to midwives often turns out to be more restrictive than the laws replaced. Over the past ten years several new pieces of legislation concerning traditional midwifery have been introduced in statehouses across the country. Do any of these differ dramatically from the laws I evaluated ten years ago?

We begin with a review of the legal status of traditional midwifery. Just after the first edition of this book was published, Wolfson (1986) reported that lay midwifery was clearly legal in 11 states, clearly illegal in 10 states, and "effectively illegal" in 12 states; the other 17 states had a variety of old and ambiguous laws. One year later, Butter and Kay surveyed a variety of state agencies and came to a slightly different conclusion: "As of July, 1987, 10 states have prohibitory laws, five states have grandmother clauses authorizing
practicing midwives under repealed statutes, five states have enabling laws which are not used, and 10 states explicitly permit lay midwives to practice. In the 21 remaining states, the legal status of midwives is unclear" (1988: 1161). Using yet another classification scheme, Korte (1995: 57) gave the following report of the legal status of traditional midwives in 1995: 14 states “legal by licensure, certification or registration”; 11 states “legal through judicial interpretation or statutory inference”; 7 states “not legally defined but not prohibited”; 8 states “legal by statute but licensure unavailable”; and 10 states “prohibited through statutory restriction or judicial interpretation.”

Two things become evident when we compare these reports. First, traditional midwives have gained some ground in the recognition of their practice, moving from 11 (or 10) "clearly legal" states in the mid-1980s to 14 in the mid-1990s. Second, the differing totals and the different ways of counting used by the researchers reveal significant confusion over the definition of legal and illegal. This second observation should cause us to rethink our first. Have traditional midwives actually gained ground? The difficulty in distinguishing legal and illegal, permitted and unpermitted, reminds us that there is a difference between "law on the books" and "law in action." Before we celebrate the expanding role of traditional midwives, we must explore this distinction further.

The three surveys summarized above relied on reports from official agencies: departments of health, state licensing boards, and the like. They represent surveys of laws on the books, the official view of the legal status of midwives. Barroso and Coffey (1991) surveyed traditional midwives practicing in each of the 50 states, asking them to describe the laws governing their practices. Their report gives us a view of midwifery laws in action, the way laws are experienced by working midwives. They report 14 states where traditional midwifery is clearly legal, 31 "gray" states where the practice is undefined, and 16 states where traditional midwifery is clearly
illegal. If you are counting, you will notice that there is something suspicious about their numbers: somehow they arrived at a total of 61 states! The reason for the inflated total is that several states were counted in both the "clearly legal" and the "clearly illegal" categories. In these states, the laws allow for licensing, but licenses are difficult or impossible to obtain, hence many midwives there choose to work illegally. In Arizona, for example, where Barroso and Coffey counted 40 traditional midwives, 25 are licensed and 15 are working without a license; of the 41 traditional midwives working in Arkansas, 20 remain unlicensed. What appears to be an advance in the recognition of traditional midwifery is not regarded as such by many practicing midwives.

The state of New York provides a recent example of "favorable" legislation that works against the interests of midwives. Korte (1995) considers New York a state where traditional midwifery is "legal by statute, but licensure unavailable." In June 1992 the New York legislature passed a bill that unifies nurse- and lay midwifery, acknowledging the legitimacy of different approaches to midwifery training. The bill established a 15-member board of midwifery charged with setting standards for education and practice.

Traditional midwives worked hard for the passage of the bill, but by early 1994 several of these same midwives felt betrayed. The midwifery board, set up in the Department of Education, included several nurse-midwives but no traditional midwives, creating doubts that less-medical, home-based practices would be protected in the new regulations. Two years after the law was passed, the mechanism to allow traditional midwives to obtain licenses was still not in place, but the prohibition on unlicensed midwifery was being enforced with a new rigor. In 1993 and 1994 several midwives were investigated by the Department of Education's Office of Professional Discipline. This heightened scrutiny caused several midwives to voluntarily stop practicing. The codirector of New York Friends of Midwives reported that four midwives in the Albany area stopped
attending births for fear of being charged with practicing medicine without a license. "They are laying low," she said. After an investigation in October 1993, a midwife in eastern Long Island signed an agreement to stop attending births until she was licensed. She told a reporter, “I was working on this law day and night, I feel like I got sold out” (Karlin, 1994). Korte (1995) describes more severe actions against two upstate midwives: in 1994 Julia Kessler and Karen Pardini, with a total of 32 years' experience and 2,500 births (with no infant deaths) between them, were charged with practicing both midwifery and medicine without a license. Midwives who once practiced freely in the margins of an old law, are in clear violation of the new law.

One of the older licensing laws for traditional midwives, and one that is considered "friendly" toward midwifery, is found in the state of Washington. Passed in the early 1980s, the Washington law offers licenses to graduates of a state-accredited three-year educational program. Lay (i.e., unlicensed) midwives are allowed to practice if they do not advertise or charge for their services, a rule that allows friends or members of religious groups to assist each other at birth without fear of prosecution. How have midwives fared in this favorable environment? In 1989 two faculty members of the Seattle Midwifery School complained, "formidable barriers . . . stand in the way of full practice . . . for state licensed midwives: lack of (affordable) malpractice insurance, inability to obtain hospital privileges, incomplete reimbursement from third party payers and excessive restrictions on the scope of practice" (Myers and Myers-Ciecko, 1989). Three years later, Baldwin et al. published the results of their study of the professional relationships of Washington's midwives, concluding, "Only certified nurse midwives have forged mutually satisfying relationships with the physician community. . . . Licensed midwives, despite their status as licensed birth attendants, have been dissatisfied with their consulting relationships with physicians" (1992: 262, 264). Many midwives choose to remain outside the law. A study of unlicensed midwives in Washington state revealed that
several are, in fact, practicing illegally, charging for their services (Myers et al., 1990). As I noted earlier, "state certification does not ensure medical endorsement" (115). Even though the state has acted in their favor, licensed midwives in Washington are limited by the unwillingness of the medical community to incorporate them fully.

Situations like these in New York and Washington demonstrate the need for more uniform and more credible licensing legislation, legislation that will allow midwives to become a legitimate and recognizable part of our health system. At their best, current models of licensure allow a minimum number of midwives to survive, meeting the needs of a small group of women seeking to give birth outside the hospital. In response to uneven and confused local legislation, several state organizations of traditional midwives have initiated programs of self-certification (see DeVries, 1986; Butter and Kay, 1990), but these have done little to promote the profession or shape legislation. In whatever form, licensure as it exists today has decidedly not brought the benefits of midwifery to a larger group of women.

Several advocates of midwifery have stepped forward with plans for the promotion and regulation of midwifery:

1. Writing in a well-known alternative birth periodical, the \textit{NAPSAC News}, Mehl Madrona and Mehl Madrona (1993) angered a number of traditional midwives when they argued that even the "good" licensing laws were inadequate, failing to advance midwifery in America. After a lengthy analysis of the current condition of midwifery in the United States and elsewhere, they insist that traditional midwives will remain marginal unless they jettison apprentice-based education in favor of rigorous formal education programs. They derive many of their suggestions for reform from their study of Dutch maternity care.

2. In 1994 the Women's Institute for Childbearing Policy (WICP) issued a position paper, "Childbearing Policy within a National Health Program," calling for a "primary maternity care
system" that is centered on midwife care delivered in birth centers and homes. They suggest extending existing education and licensure programs (WICP, 1994).

3. The Midwifery Communication and Accountability Project (MCAP), founded in 1990, is seeking to make state regulation of midwifery uniform through the use of "Model State Legislation" (MCAP, n.d.).

4. As noted above, MANA established a registry exam, designed to "determine whether entry level knowledge has been achieved, and assist in fostering reciprocity between local jurisdictions" (MANA, n.d.).

5. MANA and the ACNM cooperated in the "Interorganizational Workgroup" (IWG), developing guidelines for midwifery certification in the United States. The guidelines allow for two types of midwives: the "certified midwife," credentialed through the MANA system, and the certified nurse-midwife, approved under ACNM guidelines (see WICP, 1994: 66-68; Burst, 1995; Rooks and Carr, 1995).

The number and diversity of suggestions for the regulation of midwifery coming from advocates of midwifery does not bode well for the future of the profession. Continued disagreement among midwives and their supporters—I saw the same thing in the early eighties—makes difficult the kind of coordinated and innovative effort needed to effect change. In an environment where midwifery faces persistent and strong opposition from physicians (see, e.g., Giacoia, 1991), factionalism among midwives extinguishes any hope of meaningful reform. Tjaden observes that "without state licensure, lay midwives have no true professional autonomy" (1987: 42). Unfortunately, it is also true that with the sort of licensure traditional midwives have experienced in the United States, created in the context of disagreements between midwives and power imbalances with the medical profession, there is no true professional autonomy either.
Midwives in the Courts

Where there are no clear regulations governing the practice of midwifery, an "uneasy truce" between midwives and the medical community continues: midwives are free to practice until they attract the attention of medical professionals. If a client of a midwife comes to the attention of a physician and the physician believes something improper was done, then the law is invoked as a regulatory mechanism and courts become the arena of regulation.

Over the past ten years, stories of this sort of regulation, many of them dramatic, have accumulated. Korte (1995) recounts the story of a Missouri midwife whose office was ransacked by seven law enforcement officers (wearing bullet-proof vests). They removed all her computer disks and destroyed her files and other materials. She was charged with eight felonies and several misdemeanors for practicing medicine without a license. The charges were eventually dropped in exchange for a five year probation period. Mitford (1992: 221-40) describes similar incidents in California, and the homepage of Midwifery Today on the World Wide Web, a new medium for generating support for midwifery, includes an appeal for help for an Indiana midwife in legal trouble for practicing medicine without a license.

These cases and cases described by Hafner-Eaton and Pearce (1994) and DeClercq (1994) follow the pattern of legal actions reviewed in chapter 5: they are initiated by physicians; they draw media attention; courts are unwilling to levy too heavy a penalty; and the midwives involved receive support from sister midwives and clients.

A pair of recent cases, however, indicates that the character of legal actions against midwives might be changing. In late 1994 a Michigan couple whose baby died three weeks after it was born sued the two traditional midwives who attended the birth. The couple, who chose to give birth in the midwives' clinic, claimed
that the supervising midwife failed to recognize an emergency and waited too long before calling the hospital. The case is remarkable because it is the parents (not physicians) who are bringing charges in the form of a civil (not criminal) suit for monetary damages. The father of the dead child acknowledges that "the midwife experience was beautiful," but goes on to comment, "she [the midwife] way overstepped her bounds" (Niemiec, 1994: 3A). It is worth noting that the birth took place in a clinical setting where the midwife-client relationship tends to be formalized. In the clinic the client is just that, a client, not a "coconspirator" in the resistance to American obstetrics. When midwifery becomes established, it often adopts the form of clinical medicine, including more routinized relationships with clients. When the relationship between midwives and clients becomes more formal, legal actions like this—unheard of in the 1970s—become more common.

A second case reflects an expansion of the use of law as a tool of regulation. In this situation, described by Korte (1995: 56–57), three CNMs faced felony charges in association with an emergency breech birth (assisting at a breech birth is outside the permitted scope of practice for nurse-midwives) at a birthing center. One of the three was handcuffed and jailed. Although the charges were later dropped, the use of law to control the practices of midwives already regulated by licensing laws represents a major departure from earlier custom, and suggests a new level of scrutiny and control by physicians.

The "Changing" Nature of Midwifery

Although midwifery has not blossomed in the United States, it has been a persistent presence in American maternity care. What are the results of its proximity to medicine? The model of care represented by midwives has the power to change medical practice, but
the medical setting also exerts pressure on midwifery, encouraging accommodation to the American way of birth.

There are several ways midwifery has influenced obstetric practice over the past two decades. The enormous popularity of LDRs (combined labor, delivery, and recovery rooms) can be credited to midwives and their supporters in the alternative birth movement (see Mathews and Zadak, 1991). The pioneers of parent-infant bonding research, Drs. Klaus and Kennell (1976) acknowledge lay midwives and home birth as their inspiration. Although obstetricians were able to control the implementation of "bonding," they were pushed to change their practices by the presence of an alternative form of maternity care (see DeVries, 1984). More recently, Pel and Heres (1995: 95–105), studying obstetrics in the Netherlands, demonstrated the power of midwives to alter care given by individual obstetricians. Their research showed that, controlling for "risk" factors, obstetricians who work with midwives have lower rates of intervention.

But midwifery is also changed by medicine. When midwifery enters the world of obstetric technology, it runs the risk of having obstetric knowledge replace midwife knowledge. Barroso and I observed this in our survey of fetoscope use by CNMs (1996). We found that the fetoscope, a simple mechanical tool for finding fetal heart tones, is now rarely used by CNMs. The preferred tool is a "doptone," a device that uses sonar technology to make the task of finding heart tones easier. This seems an innocent development, but some midwives argue that valuable knowledge, unique to midwifery, is lost when the doptone is traded for the fetoscope. For example, a midwife using a fetoscope is able to find the point where the heart tones are the clearest and loudest, allowing the precise position of the child to be identified. With an amplified doptone, subtleties in the heartbeat are impossible to notice. Furthermore, the fetoscope brings the midwife much closer to the woman, allowing the caregiver to assess level of relaxation, skin tone, and overall condition.
Considering that medicine is supported by both structural arrangements and cultural ideas, the "corruption" of midwifery by medicine seems much more likely than its opposite. Lacking power and authority, midwifery must adapt to succeed. An "adapted" midwifery, using the tools and techniques of medicine, has little to offer obstetrics. It is significant that the research demonstrating the potential of midwives to reduce obstetrical intervention (Pel and Heres, 1995) was done in the Netherlands. Dutch midwives remain outside of medical control and thus offer an independent perspective on maternity care. Pel and Heres (1195: 104) comment, "[because] midwives show patience and stimulate confidence, as opposed to physicians who act faster and anticipate pathologic events, the reduction in anxiety might explain the decreasing effect of the employment of midwives on the rate of obstetrical interventions."

The challenge for midwives is to find a way to practice that preserves the unique body of knowledge and method that is theirs. For some midwives this involves remaining outside the world of medicine; this is the choice made by many traditional midwives. Other midwives choose to subvert the medical setting. Nurse-midwives report a variety of techniques for getting around restrictive hospital and physicians policies: smuggling lubricants for perineal massage into "sterile" delivery rooms, removing monitors so laboring women can walk around, speeding labor with warm baths or massage rather than oxytocin, violating rules that limit food intake (DeVries and Barroso, 1996). If midwifery is to be an agent of change rather than the subject of change, this sort of resistance and subversion is necessary.

The Last Word

Checking my work against empirical reality is only one way of assessing its quality. Another measure of a book's merit, one that we professional researchers sometimes find more important, is its re-
ception by colleagues, its place in the body of recognized knowledge. For many of us "How did they like it?" becomes a more important question than "Was it true?"

Before closing this book for a second time, I must take note of the work of several other scholars who have joined the study of midwives since 1985. For the most part, their scholarship confirms and extends my research.

In their book *Labor Pains*, Sullivan and Weitz explored many of the same issues covered in *Regulating Birth*. They looked at midwifery in the United States, England, and New Zealand and came to conclusions nearly identical to mine, observing that "the rise of all modern midwifery . . . [might] be a false labor" (1988: 214). Where they disagree with my analysis (109–11; 205–6), it is often the result of their oversimplification of my arguments: they ignore my emphasis on the way law interacts with other social forces, suggesting that I saw licensure as the only operative factor in midwifery's demise.

More interesting for the future of my work and the future of midwifery are studies that explore the role of culture in the decline of midwifery. Davis-Floyd's (1992) important study of birth as an American rite of passage illustrates how cultural values sustain American obstetrics. She deconstructs our American birth practices, calling attention to the need we have as a culture to affirm our values at the transitional time of birth. She reminds us that we live in a culture that values, among other things, technology, the control of nature, and patriarchy. We should expect our birthing rooms to be dominated by men and technological devices that impose their timing and regulation on the natural process of birth.

Borst's (1988, 1989, 1995) careful historical studies of Wisconsin midwives give further evidence of the cultural roots of birth practices. Her research challenges the simplistic notion that physician resistance led to the extinction of midwifery. She shows that as immigrant women assimilated, the culture that supported midwifery disappeared, and along with it the midwives: "In the end midwifery,
practiced by immigrant, working class women, remained rooted in the cultural life of traditional ethnic communities. When these communities began to assimilate and adopt American ideas, there was no place for the midwife" (1989: 48).

In his study of the rise of man-midwifery in England, Wilson (1995) adds his voice to those emphasizing the role of culture in the fading fortunes of female midwives. He observes that "male practitioners were turned into midwives not by their own desire, but through the choices of women. . . . the making of man-midwifery was the work of women" (192). His conclusions, which challenge conventional histories of midwifery, rest on an analysis of the role of "fashion" in shaping medical practice: "Fashion was in general the symbolic reflection of a new culture of class; in the world of women, for which childbirth was so crucial, fashion dictated the need for the man-midwife. . . . fashion offered a bridge by which those of intermediate or ambiguous status could symbolically climb the ranks" (191).

For the most part, the first edition of this book focused on the structures that constrained midwives. If culture was part of the analysis, it was as a dependent variable: I showed how political and legal structures influenced the culture of midwifery, how the structural setting of care shaped the culture of the midwife-client relationship. But the work of Davis-Floyd, Borst, and Wilson, and my own work in the Netherlands (DeVries, 1996) shows culture to be an important independent variable, promoting or discouraging midwifery.

"Cultural analysis" of birth is at once liberating and depressing. Liberating because it offers the knowledge we need to transform birth practices; depressing because the transformation requires changing deeply held values. Consider, in conclusion, an illustration. Martin (1987) presents a discussion of the metaphors we use to talk about birth, showing how these words—reproduction, labor, progress—reflect an industrial, capitalist mentality. True, and a bit disheartening when one realizes how our birth practices are tied
to deeply ingrained economic ideas. But there is the hint of liberation here as well: it is freeing to learn that not all Western cultures use these same metaphors. The Dutch, for example, use different images when speaking of birth. Reproduction is *voortplanting*, literally “forward planting,” an agricultural metaphor. When a Dutch woman is in labor, she is *aan bet bevallen*, “in the act of birthing.” Labor pains are *weeën*, the same word found in *beimwee*, homesickness, or more literally, the “aching” (*weeën*) for home. And the Dutch, you will recall, still use midwives and support birth at home.

In the preface I pointed out that twenty years ago we members of the alternative birth movement were full of hope, convinced we could change American obstetrics, convinced by the “rightness” of our quest. The intervening years have been discouraging, but, oddly (naively?), I am convinced that the changes we sought are inevitable. More and more the wisdom of midwifery is confirmed by epidemiology, and, more important, social and historical research is providing new understandings of the forces that prevent the wisdom of midwifery from being realized. The reestablishment of independent midwives in the United Kingdom and Canada and the use of nurse-midwives by managed care organizations in the United States are preparing the cultural soil needed to sustain a new obstetric system, a system that is characterized by love and justice, a system that makes prudent use of our resources, a system that supports women, babies, families.