Notes

Preface


2. Dutch is one of the few, if not the only, European language with a separate word, "gezin," for the nuclear family. Other languages have only the more general word, "family," which must be qualified to refer to the smaller family group of mother, father and children.


Chapter 1

1. For a review of medical licensure, see Roemer (1980).

2. Serber (1975) provides evidence of a similar relationship between regulator and regulated in his study of insurance regulation (see also Nader and Serber, 1976).

3. Issues like these are seldom studied because they fall in cracks between specialty areas. The lack of communication between scholars in different areas of study is a sad fact of academic life. There are several reasons for it. First, there has been a proliferation of "scholarly material" in the form of articles, monographs, research notes, and so forth that makes it difficult to keep current in one specialty, let alone others. Second, academic reputations are built within specialty areas, not in general disciplines. Once a reputation is built, its possessor becomes an "expert" who is unwilling to become a novice elsewhere. Finally, there is little support for research that does not fall in a specific area. Most granting agencies solicit proposals only within limited areas. These proposals are in turn reviewed by experts who reinforce a system that discourages broader investigations. Such confined
academic interests have harmful consequences. Because scholars do not communicate with each other, work is needlessly repeated, valuable insights are lost, and some problems simply remain unexplored.

4. Allopathy is defined as “treatment of disease by remedies that produce effects different from or opposite to those produced by the disease.” Allopathy finds its roots in an empirical philosophy of medicine. Markle and Peterson (1980: 154) outline the tenets of this approach to medicine: “The empirical tradition stresses the mechanistic nature of the organism and the foreign nature of disease. Viewing the patient as a complex machine (e.g., the heart as a pump), the physician treats localized symptoms and repairs or excises defective parts. Illness is an external imposition on the patient. Sickness is combated with drugs, and little emphasis is placed on nutrition. . . . In the empirical tradition the decisive factor in treatment is the physician himself, while the role of the patient in treating his or her own disease is downplayed.” For an examination of alternative medical traditions and the manner in which allopathic practice came to dominate Western medicine, see Coulter (1973), Starr (1982), Brown (1979).

5. See also Annas (1977).

6. The ambiguity of lay midwife licensing laws leads to different conclusions regarding its legality in various states. The National Center for Health Statistics (1979: 162, 475) reports that lay midwives can practice in twenty-seven states and jurisdictions, twelve of which no longer implement their licensing laws. The Health Resources Administration (1977: 75–78) reports that nineteen states and jurisdictions have licensing laws for lay midwives, while three states permit practice without a license. Evenson (1982) reports that sixteen states prohibit lay midwifery, seventeen have licensing or registration laws, and seventeen have no law that specifically allows or prohibits the practice (see also Cohn et al., 1984). Of course, some of the variation in these numbers reflects changes in regulations over the years, but much of the confusion is the result of the lack of clarity in the existing laws.

Chapter 2

1. Because my main interest is in presenting only enough information to make it possible to investigate the history of midwife regulation, the following is a brief and incomplete summary of the midwife’s history. For more detailed accounts see Forbes (1966), Donnison (1977), Donegan (1978), Litoff (1978), Kobrin (1966), Oakley (1976), Roush (1979), Wertz
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2. In 1960, midwives were responsible for only 2.0 percent of the nation's births, and by 1974 this number was reduced to just 0.3 percent. Although this trend appears to be reversing—in 1980 midwives attended 1.7 percent of the nation's births, and in 1981 they attended 1.9 percent—midwives are primary attendants at only a fraction of all births in the United States (National Center for Health Statistics, 1979: 161; 1982; 1983; see also Jacobson, 1956; Devitt, 1977; 1979a; Litoff, 1978).

3. The term "suppression" is in quotes because although the church had the power to discipline uncertified midwives, patterns of enforcement varied and the uncertified practice of midwifery remained fairly widespread (see Donnison, 1977: 7).

4. For a feminist interpretation of the relation between witchcraft and midwifery, see Ehrenreich and English (1973).

5. Note the use of the term "medical monopoly." Donnison assumes that midwifery licensure prevented a medical monopoly; evidence here and in later chapters suggests that it created a medical monopoly instead.

6. It has been suggested that in the early 1800s licenses were obtained from the church purely for the pretense of the official authority they conferred (Donnison, 1977: 22).

7. It is interesting to speculate on the outcomes of this early municipal regulation on the current status of midwifery. Although in all industrialized countries the midwife is under the supervision of physicians, she appears to have greater independence in those countries where municipal regulation came early. It is possible that early regulation allowed midwifery to grow with the obstetric specialty, rather than in opposition to it as in Britain and the United States, where the lack of regulation sent midwives and obstetricians on separate courses.

8. Litoff (1980) has reminded me that "we do not know how early twentieth-century American midwives felt about midwife licensing." However, she goes on to state, "In contrast, during the 1940s, 1950s, and 1960s, nurse-midwives worked long and hard to obtain legal recognition. In return for public acceptance and legal recognition, they lost a fair degree of autonomy."

9. Ramsey (1977) points to some similar reasons for the difficulty of repressing all types of illegal healers in nineteenth century France.
Chapter 3

1. The CNMs this physician was supporting were seeking permission to do deliveries in a hospital; had they been doing home births we could have expected a similar or even harsher reaction by the doctor's colleagues (see NAPSAC News, 1981a).

2. See Jordan (1978) and Buss (1980) for descriptions of the practice of parteras.

3. In the original version of the TMA proposal there was a general endorsement of basic educational programs, but that section was crossed out on the copy found in Mr. Uribe's files.

4. During this same legislative session the Medical Practice Act was being rewritten under the provisions of a sunset act—an act which forces periodic review of the state law—and a few midwives expressed concern that the TMA would use that occasion to create law prohibiting the practice of midwifery. The TMA was certainly committed to maintaining and perhaps expanding the authority of physicians. A spokesman for the organization is quoted ("Doctor Warns against Review of State Board," El Paso Times, September 23, 1979): "If continued, the Board of Medical Examiners may be altered drastically. . . . There could be consumer members of the BME. . . . Consumerism could go rampant. . . . With the Board of Medical Examiners up for review and modification, the entire Texas Medical Practice Act could be up for grabs. And I mean grabs, rivalling the Cimarron Land Rush—in this instance a grab for turf—by every paramedical outfit you can think of, all of whom would like to practice medicine." And in fact legislative approval of the new Medical Practice Act was denied in the regular session because of a dispute over a clause allowing optometrists to use diagnostic drugs.

Chapter 4

1. The development of the alternative birth center allows for the construction of an imaginary continuum to describe the birth experiences available to the individual. The continuum extends from standard hospital births on the one hand to home birth on the other, with the ABC located somewhere between. Although this conceptualization might appear simplistic, it has great utility. For example, consider the many views on the dangers associated with birth. Those endorsing hospital birth cite the dangers of
ABCs, and feel that home birth represents an unacceptable risk. On the other hand, those espousing home birth view the ABC as a questionable compromise, and feel the intense medicalization of birth in a "pure" hospital setting is hazardous to both mother and child. Indeed, many of those choosing home birth describe a previously unsatisfactory experience in hospital birth (see also Arms 1977: chapter 5; Mehl et al., 1976; 1977; Annas, 1976). And those involved in ABCs feel there are definite risks associated with both home and hospital births (see Brennan and Heilman, 1977: 48–51). Further, the likelihood of intervention in the birth process is practically nonexistent at a home birth and increases steadily as one approaches a "pure" hospital delivery (Mehl et al., 1976; 1977). Conversely, the responsibility of the parent(s) for “getting the child born” is near zero in a standard hospital birth and almost total in a home birth. Since the majority of midwives involved in this study do not participate in the “pure” hospital birth, that end of the continuum will not be given much consideration. However, the points mentioned here will be elucidated by the comparison between the CNM and the lay midwife. More information concerning the standard obstetric birth may be found in the following sources: Danziger (1978); Kovit (1972); Macintyre (1977); Nash and Nash (1979); Oakley (1976; 1979); Rothman (1977; 1982); Shaw (1974). For more detailed information on the alternative birth center see DeVries (1979a; 1979b; 1980; 1983; 1984).

2. Gill and Horobin (1972) offer a more thorough analysis of the role played by the state in doctor-patient interaction.


4. The desire to have continuous care provided by one practitioner has proved an important factor in the decision to give birth at home in Britain (Goldthorpe and Richman, 1974).

5. In his study of lawyers and their clients, Rosenthal (1974) suggests that client participation results in more favorable outcome.

6. When a woman’s cervix is dilated ten centimeters she is in the final stages of labor, ready to push her baby out. Linck is implying that in the middle of labor a woman’s choice is limited.

Chapter 5

1. The woman who ran Arizona’s licensing program told me it was important to have no unsuccessful suspension or revocation hearings: “If we
[initiate] proceedings and nothing happens, [the midwives] will have nothing to worry about."

2. The study is referred to by innumerable physicians, but not once have I been able to locate a reference to its place in publication.

Chapter 6

1. For similar statements see Hodgson (1977), Forgetson et al. (1970), and Forgetson and Cook (1967).

2. These social trends have caused some established midwives in Britain to question their role in birth. In 1976 a group of student midwives in Britain formed the Association of Radical Midwives (ARM) because they were "disappointed by the content of their courses, the treatment of the women they served and the role to which they were expected to adapt" (Thomas, 1978; see also ARM, 1978). Since that time their numbers have expanded, and they are active in trying to maintain a degree of independence for British midwives.

Epilogue

1. Russell (1987) claims the mortality rate for home birth is 50-100 times greater than for hospital birth! He fails to cite a source for this incredible statistic. See Tew (1990) for a detailed analysis of the safety of home birth.
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