

Challenging Medicine: Law, Resistance, and the Cultural Politics of Childbirth

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Whereas most sociolegal studies concerned with hegemony and resistance focus on the resistances of ordinary citizens in everyday life, this article focuses on the development of a particular social movement—the alternative birth movement—and analyzes the process by which this movement emerged and has achieved significant legislative victories. The analysis makes several contributions to the literatures on hegemony, resistance, and the law. First, by demonstrating the importance of medicine's assertion of its authority for the expansion and mobilization of the alternative birth movement, we show that the mobilization of the law by a dominant group may trigger the emergence of social movements seeking to resist hegemonic understandings and arrangements. At the same time, by examining how birth activists' organizational resources developed over time and were rendered meaningful in legislative debates, our study demonstrates the importance of avoiding dichotomous conceptions of structure and culture. In addition, by analyzing culture as a process of meaning-making rather than an independent and hierarchical set of values, the analysis shows how cultural and legal hegemony—even that of modern medicine—may be destabilized, even as it sets the terms of the effort to destabilize it and shapes the nature of the hegemony that will replace it.

Much recent sociolegal scholarship focuses on hegemony and resistance to it. In this scholarship, hegemony is broadly understood as power that maintains and naturalizes existing social structures; resistance refers to actions that lay bare the historical and constructed nature of these social arrangements and the inequalities they generate and sustain (see especially Lazarus-Black & Hirsch 1994). This literature has generated many important insights regarding law as a source of both hegemony and resistance; yet, as McCann and March (1997) have argued, most such studies focus on everyday acts of resistance or the resistance of ordinary citizens in administrative settings such as courtrooms and welfare offices. As a result, the role of social movements as sources of

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resistance and sociolegal change is less well-understood. Furthermore, because individual acts of resistance are arguably less likely to have long-lasting or institutional effects, social actors' capacity to challenge hegemonic understandings, alter power relations, and effect sociolegal change may be underestimated.

This article analyzes the development and recent legal victories of a particular social movement—the alternative birth movement—in order to explore this possibility. Part I, “Getting Organized: Law and the Emergence of the Alternative Birth Movement,” draws on interview, archival, and secondary data sources to analyze the conditions under which members of alternative birthing *communities* have become part of an alternative birth *movement*. This analysis shows that the capacity of a dominant group (i.e., organized medicine) to mobilize the law on its behalf was the impetus for the emergence of a social movement that now endeavors to undermine medicine's cultural and professional authority over childbirth. In particular, the threat of legal harassment has stimulated the expansion and organization of alternative birthing communities; the establishment of local, regional, and national ties between these groups; and, later, the emergence of national and international organizations dedicated to the protection of birthing alternatives and midwifery. This analysis thus demonstrates that the assertion of power through law may trigger resistance to the social and legal hegemony upon which that power rests.

Over time, birth activists' resistance to medical hegemony has centered on the need to secure midwifery licensure, and some of these efforts have resulted in the passage of relatively favorable midwifery statutes. These victories are surprising, for several reasons. First, the alternative birth movement does not enjoy the institutional or financial resources of its medical opponents, and midwives lack the formal educational and professional qualifications touted by medical practitioners. Further, some have argued that the alternative birth movement is also disadvantaged by the cultural hegemony of the medical model of childbirth and the values and assumptions upon which it rests (Davis-Floyd 1992; Davis-Floyd & Sargent 1997; DeVries 1996). According to this argument, the “American way of birth” (Mitford 1992) is deeply rooted in Western and especially American culture, embedded in a modernist epistemological framework that conceives of the body in mechanistic terms and seeks to eliminate risk through the application of science, professional expertise, and technology. Midwifery's legal and professional marginality is thought to reflect this widespread cultural orientation (DeVries 1996:xvi, 180).

Part II, “Challenging Medical Hegemony in the Legislature,” explains why the alternative birth movement, decidedly less well endowed and prestigious than its medical opposition, and arguably

facing the cultural obstacles just outlined, has nonetheless enjoyed some success in achieving its legislative goals. Drawing on interviews, archival data, observations, and audiotaped records of legislative debates, we show that birth activists have developed organizational and associational resources to defend themselves against legal prosecutions, and that these resources have been crucial to their quest for licensure. Most visibly, the virtual, visual, and aural presence of an enthusiastic group of midwives and home birth consumers has had a powerful impact on these debates; in this case, the female identity of the resisters (and their association with a most powerful cultural icon, motherhood) has worked to their advantage. The existence of national and international organizations—especially the Midwives Alliance of North America (MANA), with its capacity to evaluate and certify qualified midwives—has also been crucial to efforts to make the case for midwifery licensure.

But these resources, in and of themselves, cannot explain birth activists' ability to persuade lawmakers to vote for their cause. Rather, the meaning that is attributed to them—and other aspects of home birth/midwifery—has been critical. Informed by scholarship that conceives of culture as “a sphere of practical activity shot through by willful action, power relations, struggle, contradiction, and change” (Sewell 1999:44) rather than a fixed and hierarchical set of values, and an understanding of hegemony as also potentially transformable (see Comaroff & Comaroff 1997; Hunt 1993; Merry 2000; Lazarus-Black & Hirsch 1994), our analysis shows how some of the cultural preoccupations thought to favor organized medicine have become resources for its antagonists. For example, although social hierarchies based on gender and education/professional status typically privilege groups who sit at the top of those hierarchies, birth activists have been able to transform the gender composition of the alternative birth movement, as well as the less-elite status of midwives, into resources.

This emphasis on agency and culture's indeterminacy does not imply that cultural meanings are infinitely plastic. As Sewell points out, the conceptualization of culture-as-practice presupposes that cultural symbols have meanings that are widely shared and understood (1999:47). In some cases, these meanings also have a fairly consistent normative component—that is, they are widely held as positive or negative. As a result, birth activists have learned to very carefully craft their arguments and appeals in ways that invoke dominant categories and symbols—while also giving expression to cultural ambivalence about them (where it exists) and realigning those cultural elements with their cause. Furthermore, there are certain cultural categories that birth activists must studiously avoid—namely, feminism. Thus, while birth activists have,

to some extent, destabilized hegemonic understandings and approaches to childbirth, the terrain on which these struggles unfold shapes both their terms and consequences. Furthermore, the process of strategically mobilizing cultural themes and icons in an attempt to generate support for their cause transforms birth activists and midwives, and a new hegemony—one that excludes those who do not aspire to the creation of a midwifery *profession*—is emerging. Both the players and the cultural field have been altered through the process of this contestation.

To summarize, our analysis makes several contributions to the literature on hegemony, resistance, and the law. First, by demonstrating the importance of medicine's assertion of its authority for the expansion and mobilization of the alternative birth movement, our analysis suggests that a powerful group's mobilization of the law may trigger the emergence of social movements seeking to resist hegemonic understandings and arrangements. At the same time, by examining how birth activists' organizational resources developed over time and were rendered meaningful in legislative debates, our study demonstrates the importance of avoiding dichotomous conceptions of structure and culture (see Polletta 1997). Finally, by analyzing culture as a process of meaning-making rather than an independent and hierarchical set of values, our analysis shows how cultural and legal hegemony—even that of modern medicine—may be destabilized, even as it sets the terms of the effort to destabilize it and shapes the nature of the hegemony that will replace it. Before turning our attention to these topics, however, a brief discussion of our data and methods is in order.

Data and Analysis

This article focuses on midwives who are not nurses, variously referred to as “direct-entry” midwives, “independent” midwives, and “home birth” midwives. Each of these terms captures some aspect of the social organization of non-nurse midwifery in the United States. The term *direct-entry* refers to the fact that these midwives do not enter midwifery after becoming a nurse; the term *independent*—currently favored by many practicing midwives—refers to the fact that the midwives seeking licensure today seek to work in a collaborative rather than subordinate position vis-à-vis physicians. *Home birth* midwifery captures midwives' commitment to serving women who choose to birth at home, a service that most states do not allow nurse-midwives to provide. Although some of the legislators interviewed mistakenly referred to the midwives seeking licensure as nurse-midwives, all subsequent references to

midwifery and midwives refer to non-nurse midwives unless otherwise indicated.

The analysis of the transformation of the alternative birth community from a hodge-podge of disconnected local groups to a semi-organized social movement is based on interview and documentary evidence, including midwifery newsletters, and secondary accounts of the birth movement's development in states across the country. The analysis of the legislative debates presented in Part II is based on observational, documentary, and interview data pertaining to the legislative process in six states. In winter 1999, one of the authors¹ observed the House Public Health Committee hearings and several floor debates regarding the legalization and licensure of midwifery in Indiana, and interviewed thirteen legislators (mostly members of the Public Health Committee) and a number of activists about the proposed legislation. Since that time, we have analyzed audiotaped records of legislative debates from five other states where midwifery bills were recently considered.² These legislative records were supplemented by interviews with legislators and activists and by extensive documentary evidence, including lobbying materials, records of phone conversations between midwives, e-mail communication between midwives and their supporters, public letters of support and opposition, legislators' internal memos, and secondary accounts of legislative processes in various other states (especially DeVries 1996; Edwards & Waldorf 1984; Lay 2000; Susie 1988; Tjaden 1987; Weitz & Sullivan 1986).

The audiotaped recordings of the legislative debates and the interviews were transcribed, and each paragraph of text assigned a unique record number indicating its state and sequence (e.g., CA-223). Each author then coded the data, identifying its narrative structure and themes. Narratives place events and issues in a temporal and normative context; they make sense of public issues and controversies by placing those issues in the context of a story, "plots that have beginnings, middles and ends, epiphanies and denouements, heroes and antiheroes, dramatic, comic, and tragic forms" (Alexander & Smith 2002:186; see also Sewell 1992; Schudson 1982; Somers 1992; Stone 1989). In the end, the records were coded for two main narratives—midwifery-as-tradition and medicine-as-progress—and fifty themes (such as nature, safety, and turf). Significant and recurrent themes were selected for the final analysis.

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² In these states, pro-midwifery legislation suffered quite different fates. In three of these states (Vermont, Tennessee, and Minnesota), licensing legislation was proposed and adopted; in Indiana, a midwifery licensing bill passed through the House but has been refused consideration by a key Senate committee chair. In Illinois, the proposed licensing bill was rejected in committee, and in California, a midwife-backed proposal to enhance midwives' autonomy passed out of committee but was subsequently gutted by its sponsor.

Like other analysts working at the intersection of law and social movements, we are interested in how movement participants "attempt to mobilize potential adherents and constituents . . . and to demobilize antagonists" (Snow & Benford 1988:198). However, we also seek to explain whether birth activists' "collective action frames" (Snow & Benford 2000) have become culturally viable—that is, were referenced by lawmakers when explaining their decision to support midwife-sponsored legislation. Although these justifications may or may not explain lawmakers' true motivation regarding their vote, legislators are undoubtedly concerned to legitimate their vote in a way that they believe is culturally acceptable, even persuasive. We therefore treat lawmakers' willingness to invoke these categories as an indicator of their cultural viability.

As it turns out, activists' capacity to mobilize culturally viable themes and images and win the majority of votes is a necessary, but often insufficient, condition for the passage of legislation. For example, licensing legislation was adopted by the Indiana House of Representatives in a vote of 86-14 in 1999, but the chair of the Senate Health and Provider Services Committee has consistently refused to hear the bill since that time, and midwifery remains illegal in Indiana. Similarly, a midwife-backed California bill that would have permitted midwives to work autonomously was withdrawn by its sponsor *after* it passed out of committee—when groups opposing the bill threatened to circulate a videotape of a home birth "gone bad." Thus, our analysis does not seek to explain legislative outcomes. Rather, we analyze the process by which birth activists have attempted to persuade lawmakers to support their cause and explore legislators' justifications for their votes to assess the cultural viability of birth activists' rhetoric.

Part I: Getting Organized: Law and the Emergence of the Alternative Birth Movement

Although seemingly radical in the 1970s, home birth and midwifery were commonplace in the United States only a few generations ago. By the 1970s, however, hospital birth had become the norm. The relocation of childbirth was a consequence of a host of demographic, institutional, and cultural changes (Boorst 1995; Canton 1999; Leavitt 1986; Wertz & Wertz 1989), as well as the consolidation of medical authority and power (DeVries 1996; Ehrenreich & English 1973). Indeed, by the early 20th century, allopathic medicine had established itself as authoritative in virtually all health matters, and this authority was reflected in licensure laws that increasingly marginalized those who practiced alternative forms of health care (Conrad & Schneider 1986; Starr 1982; Weil 1983).

As childbirth moved to the hospital and under physicians' jurisdiction, the laws regulating non-nurse midwifery became quite varied. Under pressure from organized medicine, some states explicitly prohibited midwifery. Others allowed its practice but restricted it through licensure and other regulatory mechanisms; still others, especially those with large rural populations, tolerated but ignored its practitioners. In most regions, a declining number of midwives continued to attend births, but these marginalized and sometimes-illegal birth attendants (often referred to as "granny midwives") did not figure significantly in political or cultural discourse. Sporadic efforts to institutionalize midwifery training for nurses eventually led to the emergence of a new profession, nurse-midwifery, in the 1950s. Over time, nurse-midwives secured hospital privileges. Today, however, nurse-midwives in most states are prohibited by statute from working outside of hospitals, are required to work under the supervision of physicians, and are under the control of the state board of medical examiners (see Evenson 1982; Langton 1994; Rooks 1997). Nurse-midwives attend approximately 5% of all U.S. childbirths, mostly in hospital settings (Rooks 1997).

The development of midwifery in the United States differs from its trajectory in most other industrialized countries (Rooks 1997). For example, midwifery is and has been an integral part of the provision of maternity health care in Japan and most European countries. In these countries, the degree of autonomy with which midwives are allowed to work varies widely. In the Netherlands, midwives practice autonomously, and a significant proportion of all births take place in the home. In other countries, midwives are restricted to the hospital and work under the supervision of physicians, but they attend a large share of births. In recent years, consumer demand for alternative birthing options and midwifery services has led to the expansion of midwives' autonomy and practice in many countries, including the United Kingdom, New Zealand, Australia, and parts of Canada (Rooks 1997).

In the United States, a parallel development began in the early 1970s, when members of alternative birthing communities called for the revival of home births and (non-nurse) midwifery. These birth activists drew their inspiration from the women's health, countercultural, and civil rights movements, as well as from practicing midwives (Umansky 1996), although these sources of inspiration came together in somewhat varied ways. One of the first and best-known alternative birthing communities comprised a group of cultural dissidents from San Francisco who traveled via bus to rural Tennessee, where they established The Farm, a spiritual community dedicated to "natural living." At The Farm, Ina May Gaskin, author of *Spiritual Midwifery* (1975), and the other midwives

created an elaborate system of maternal-child health services and came to be a leading representative of counterculturally inclined alternative birthing communities. Another early and spiritually oriented birth collective was formed in Santa Cruz, California, under the leadership of midwife Raven Lang. Meanwhile, the Seattle-based Fremont Women's Health Collective, staffed by feminist health activists inspired by the Boston Women's Health Collective, began to learn midwifery and attend births. These activists were more strongly influenced by socialist feminism than by countercultural spirituality; as one early participant told us, "We wanted to write the counterpart: *Political Midwifery*" (January 12, 2001, WA Interview #1, WA-56).

Interestingly, although these groups emerged at roughly the same time, they were largely unaware of each other's existence. As one midwife informant from Oregon told us:

... It was not that a bunch of people decided to become midwives and went out and talked people into having their births at home. It was the opposite ... the home birth movement came first. And then the midwives rose out of the home birth movement. And, and the home birth movement rose out of what I would say, Howard Zinn called the people's democracy movement ... people were reacting to the amount of control you get in the hospital. (cited in Hoffman 2003:76)

Other early participants describe the early years in similar terms:

Culturally, there was this wave building ... it was a time when Raven Lang had just published *The Birth Book* describing the Santa Cruz Birth Collective, and soon after, Ina Mae founded The Farm and published *Spiritual Midwifery*, so it was all in the air at that time, and it was very organic, the birth of the birth collective. But you know, we really weren't very well-networked outside of Seattle. I mean we read books ... but it wasn't until 1977 when we were invited to present a paper at a national conference of NAPSAC [National Association of Parents & Professionals for Safe Alternatives in Childbirth] in Chicago ... and that was a huge eye-opener ... that conference helped us to see that there was a whole national movement out there ... (January 12, 2001, WA Interview #1, WA-23)

Thus, "[B]y the middle of the 1970s, little enclaves of women from coast to coast were doing home births—quietly and largely unknown to others" (Rooks 1997:63). Members of these groups expressed little interest in promoting midwifery as a profession: "There really was this ethic of, um, de-professionalization. I mean, we weren't seeking professional recognition of licensure or legitimacy ... it was very much: we are everywoman! And there's nothing mysterious about our bodies, and you can cure your own yeast

infection! [laughter]" (January 12, 2001, WA Interview #1, WA-88). Indeed, more than a few midwives suggested that their illegal status had some appeal: "I think there was an assumption that we were illegal, and that was almost appealing, frankly. I mean, we were young radicals, and a good struggle was right up our alley. Give us some adversity and we couldn't have been happier" (January 12, 2001, WA Interview #1, WA-102).

Despite their dispersed nature, birth activists offered a fairly coherent critique of the modern management of childbirth, one that stressed the importance of treating birth as an emotional and family event rather than a medical emergency, women's right to choose their birth setting and attendants, the inhumane and ineffective nature of many routine hospital procedures, and the counterproductive nature of the high-tech approach to childbirth. In all locales, out-of-hospital birth and midwifery care were identified as the alternative to the "American Way of Birth." As Ina May Gaskin put it, "[r]eturning the major responsibility for normal childbirth to well-trained midwives rather than have it rest with a predominantly male and profit-oriented medical establishment is a major advance in self-determination for women" (1975:11).³

Their humble beginnings notwithstanding, these dispersed alternative birthing communities were perceived at the outset as a serious threat by organized medicine (DeVries 1996; Edwards & Waldorf 1984).⁴ In 1971, for example, the local medical society in Santa Cruz, California, held a meeting to discuss the "midwife problem." Attending midwives were not allowed to speak, and the society voted unanimously to deny prenatal care to any woman planning a home birth (Edwards & Waldorf 1984:162). In 1980, the then-president of the American College of Obstetricians and Gynecologists (ACOG) referred to home birth as "in utero child abuse" (DeVries 1996:53).⁵ More direct medical opposition to alternative birthing practices and practitioners took different forms depending on the legal status of midwifery. In some states where

³ More recently, a small number of birth activists have identified unassisted birth as a more natural and empowering alternative to midwife-attended home birth (see <http://www.freebirth.com> and <http://www.unassistedbirth.com>).

⁴ In this context, "organized medicine" includes ACOG, the American Medical Association (AMA), and local and state medical (physician) associations. The term *organized* is important, as midwives were often able to secure the support of some individual doctors or splinter groups such as California's Physicians for Midwifery. In a few states, nurse and/or nurse-midwifery associations played a minor role in the debate, usually, but not always, siding with physicians. Other groups of health care providers, insurance industry representatives, and hospital administrators were noticeably absent from these debates.

⁵ Though rare in the 1970s, "in utero child abuse" has become a central legal category for the fetal rights movement (Daniels 1996). States such as Wisconsin have extended existing child abuse statutes to apply to maternal behavior harming "abused unborn children" (see *Wisconsin Statutes & Annotations, 1999–2000*, § 48.02(1)(am)).

midwifery was legal, doctors persuaded legislators to attempt to tighten statutory restrictions on midwifery. In other legal states, such as Arizona, the medical community successfully pressured state officials to revise the existing statute to make it more restrictive; the fact that the law was revised by administrative procedure made it more difficult for birth activists to contest (DeVries 1996:55).

In states where midwives' legal status was more dubious or clearly illegal, medical personnel began to report individual midwives to legal authorities (DeVries 1996; Edwards & Waldorf 1984). In a few states, these complaints did not trigger criminal action but rather prompted state authorities to clarify midwives' legal status and ensure that they practiced in accordance with state regulations. But in a significant number of other states, medical complaints led to the investigation and prosecution of midwives, typically on charges of practicing medicine without a license (see Suarez 1993). Prosecutions were ultimately attempted in nearly half of the fifty U.S. states, although California distinguished itself as a particularly hostile place for midwives. Doctors there complained to the Bureau of Medical Quality Assurance, itself dominated by physicians. Under pressure from the Bureau, the California Department of Consumer Affairs (DCA) subsequently undertook a series of sting operations that led to the arrest of practicing midwives beginning in 1974 (Edwards & Waldorf 1984:164).⁶ In others states, arrests occurred when physicians complained to local authorities, typically after a midwife transferred a laboring woman to the hospital.⁷

Interestingly, only a handful of these prosecutions resulted in conviction, suggesting that midwives won a good deal of sympathy from jurors and judges. Still, actual and potential prosecutions served as the main impetus for the organization of the birth movement as a movement. This was even true in states where prosecutions did not occur. In such states, midwives and their supporters organized to provide support for indicted midwives in other states and to protect themselves from potential prosecutions or the introduction of a restrictive licensing statute. For example, when California midwife Marianne Doshi was arrested in 1978, the Portland (Oregon) Birth Center intensified its organizational efforts (Hoffman 2003).

⁶ One California judge, outraged by physicians' refusal to work with midwives, complained, "You know, the only reason the D.A. is going on this sort of case is that he's getting the screws put to him by the medical profession" (quoted in Edwards & Waldorf 1984:168).

⁷ Many midwives complain bitterly about this, pointing out that the risk of being reported makes midwives more leery of transferring women to the hospital and thus renders home birth less safe.

Initially, midwives and their supporters established defense committees on behalf of the accused (DeVries 1996; Edwards & Waldorf 1984). These committees sought to generate publicity about attempted prosecutions and funds to support midwives' defense (Edwards & Waldorf 1984:170). With the support of the committees and groups that emerged in this context, some of the convicted were able to appeal their case, arguing that midwifery is not the practice of medicine. This argument was accepted by a number of state appellate courts, and midwifery is now legal in eleven states as a result of judicial rulings declaring midwifery to be distinct from medicine (see Appendix A). But in a number of other states, including Indiana and California, this argument was not accepted, and convictions were sustained.⁸

Over time, the continued threat of prosecution led many birth activists to seek or support midwifery licensure (see also DeVries 1996). As many have pointed out, licensure can be as much an instrument of control as of autonomy (DeVries 1996; Friedson 1970); much hinges on the definition of the profession's scope of practice, the composition and authority of its regulatory board, and the nature of the "rules and regs" (DeVries 1996:83). The fact that even favorable licensure laws entail some loss of autonomy helps explain why midwives were uninterested in licensure prior to the spread of criminal prosecutions. As legal harassment became more common, however, many birth activists were persuaded that the threat of criminal prosecution was a more serious cost than the limitations imposed by licensure (although debate over this issue has caused much tension and division among midwives).⁹ In Washington state, for example, midwives and their supporters decided to stop practicing illegally and establish a midwifery school after being informed by the state director of licensing that she was aware that they were practicing illegally (and being invited to attempt to remedy the situation in this fashion) (January 12, 2001, WA Interview #1, WA-135). In California, the newly formed California Association of Midwives (CAM) even expressed support for a licensing bill that required that midwives practice "under the

⁸ In a few states, birth activists attempted to secure the support of the courts by filing suit against state agencies that did not allow midwives to practice legally. In these cases, activists argued that the state is obligated to do so because birthing options—including midwife-attended home birth—are protected by the constitutional right to privacy. These efforts have been consistently unsuccessful, as judges have been unwilling to expand the constitutional right to privacy in this manner. Interestingly, one of the leading proponents of midwifery, Susan Hodges, president of Citizens for Midwifery, has argued that these decisions are appropriate insofar as the legislature must decide when considerations of safety and welfare outweigh certain individual rights and freedoms (Hodges 1997).

⁹ An unknown number of midwives do not support licensure and continue to practice illegally.

supervision of a physician" (DeVries 1996:75) in the wake of several particularly threatening arrests in which several midwives were charged not only with practicing medicine without a license, but also with homicide.¹⁰

For those convinced that the risk of prosecution outweighed the costs associated with state regulation, the quest for licensure required enhanced organizational efforts. The fact that midwives were at risk for criminal prosecution made the active involvement of home-birthers crucial to these efforts. Indeed, community members provided much of the time and energy needed. Defense committees, where they existed, often formed the organizational nucleus for such efforts (Edwards & Waldorf 1984).

Over time, birth activists in local communities began to develop connections and share ideas as they pursued state licensure. This is evidenced in midwifery newsletters and journals, which focused increasingly on legal issues, especially legislative tactics and strategy (Hoffman 2003). It was also in this context that national midwifery/home birth organizations were created or intensified their outreach efforts (Rooks 1997). Recent years have also witnessed the emergence of national and international organizations (such as Citizens for Midwifery and MANA) that have also played an important role in the quest for licensure. Through their newsletters and, increasingly, Web sites, these institutions enable activists to share ideas and resources and develop institutional and personal connections with one another. The creation of MANA in 1993 has been especially important to those seeking licensure. This organization provides not only support and assistance for state legislative efforts, but also the capacity to examine aspiring midwives and award successful examinees with the title of Certified Professional Midwife (CPM).

In sum, the threat of legal harassment, prompted by the complaints of medical practitioners and organized medicine, was the primary impetus for the expansion and organization of the alternative birth movement that seeks to undermine the medical profession's cultural and professional authority over childbirth. The prosecution of midwives had other effects that also aided birth activists' cause. For example, these cases attracted the attention of many sympathetic journalists who generated much favorable publicity and, many midwives felt, sympathy for their cause (Edwards & Waldorf 1984). Increased publicity and attention to the

¹⁰ Interestingly, some feminist groups expressed opposition to the bill on the grounds that it was too favorable to organized medicine: "S.B. 1829 is the type of legislation that would put too many restrictions on midwives [*sic*] and put it in the hands of the medical profession, especially male doctors" (letter from the Oakland Feminist Women's Health Center, quoted in DeVries 1996:76).

advantages of home birth also led many hospital administrators to establish birth centers, and in general, stimulated public discussion of the issue in question. For example, after a change in the governorship, the California DCA conducted a series of hearings on health and maternity care and endorsed a final report recommending that “California actively promote nurse and non-nurse midwifery services” (quoted in Edwards & Waldorf 1984:177).

Of course, birth activists continued to wage an uphill battle, as organized medicine vigorously contested any effort to loosen restrictions on midwifery. Indeed, in every state of which we are aware, representatives of organized medicine actively opposed birth activists’ legislative efforts, both behind the scenes and in public forums (see also DeVries 1996).¹¹ (A few state medical organizations did eventually withdraw their opposition to midwifery legislation, but only after years of negotiation and compromise.)¹²

At first glance, the intensity of medicine’s opposition to midwifery is puzzling; the financial implications of the relatively small numbers of home births cannot, by themselves, explain it. Although there was an increase in both the absolute numbers and percentage of home birth in the 1970s, the numbers of out-of-hospital births remained quite small. In 1970, an estimated 0.6% of all births were attended outside the hospital. This figure peaked at 1.5% in 1977—just under 50,000 births (DeVries 1996:49). However, when the debate over midwifery is put into its larger historical context, this opposition begins to make more sense. Institutionally, growing state and corporate control over health care financing was beginning to undermine medicine’s autonomy in the 1970s (O’Neill 1998; Starr 1982). Culturally, increasing distrust of experts in general (Huag 1988; Giddens 1990) and allopathic doctors in particular have given rise to both “self-help” and alternative approaches to health care that were virtually eliminated earlier in the century (Cant & Sharma 2000; Gabe, Kelleher, & Williams 1994; Illich 1975; Lupton 1994). Although these developments were just beginning when the alternative birth movement emerged, they have, over the years, multiplied and intensified battles over licensure, as physicians struggle to protect themselves from what they perceive as the encroachment of alternative health care providers

¹¹ Although organized medicine’s opposition to the practice and licensure of midwifery (as well as nurse-midwifery) has been constant, individual doctors have quite varied views on the question. Indeed, some physicians have worked to promote midwifery.

¹² In Tennessee and Minnesota, both state medical associations dropped their opposition to (although remained neutral on) the proposed laws after years of opposition and negotiation; in the other states we analyzed, medicine remained opposed until the bitter end.

and para-professionals on their turf. As one physician-legislator in Indiana explained:

[Legislator-physician]: The practice of medicine is a big issue now. Uh, again, when you talk about the practice of medicine, lay midwifery is not the only profession that is trying to erode and pick at it . . .

[Katherine Beckett]: Uh-hmm.

[Legislator-physician]: Prescribing practices by physician assistants, optometrists and expansion of surgical care and prescribing privileges there. . . . You know, what a physical therapist does, what a chiropractor does, you know, all sorts of issues. Acupuncturists—how do you license acupuncturists? Where else do I go. . . . CRNAs, um, respiratory therapists, sports medicine specialists . . .

[KB]: So you see these groups as . . .

[Legislator-physician]: Audiologists. . . . You know, where do you stop?

[KB]: Right. So are you opposed to licensing all of these groups?

[Legislator-physician]: Sure. (February 16, 1999, IN-Interview #3, IN-518)

The then-president of the Washington Medical Association explained his organization’s ongoing concern about midwifery licensure in very similar terms:

The whole range of licensure stuff frustrates the living hell out of me. We spend a lot of time on it, and most of us don’t want to . . . and yet every year there is another group running to the legislature, saying “Just change this little word in my statute. . . .” And I say to them [the legislators]: What do you think you do when you give them the same scope of practice and the same authority, to all those folks who don’t have the same degree of licensure in terms of entry to the profession, and if they get to do everything these folks spend three, four, five years of their lives learning to do, incurring way more debt . . . why would you do that? Why would you spend all those years to become a family physician? (October 8, 2001, WA-Interview #8, WA-72)

Thus, organized medicine’s opposition to midwifery is best understood as one component of a larger effort to protect and restore the professional and cultural hegemony it enjoyed for much of the twentieth century.¹³ Ironically, in the case of midwifery, the intensity

¹³ Many analysts of the professions and of professionalization projects have noted the intensity and importance of such boundary struggles among health care professionals (see Abbott 1988; Larson 1977; Light 1988; Starr 1982; Witz 1992). Of course, it is also likely that physicians who opposed midwifery believe that their efforts to restrict midwifery were an effort to protect the public welfare.

of these efforts facilitated the growth and organization of a social movement that is challenging medical authority over childbirth across the country. In the next section, we analyze how birth activists have mobilized these resources and rendered them (and other aspects of home birth/midwifery) meaningful in an attempt to protect and enhance midwifery.

Part II: Challenging Medical Hegemony in the Legislature

Birth activists' efforts to achieve their legislative goals have been surprisingly (though certainly not altogether) successful. Midwifery is now legal in thirty states (see Appendix A), and since 1999, victories for midwifery have become more numerous, with four additional states—Tennessee, Vermont, New Hampshire, and Minnesota—adopting or renewing relatively midwife-friendly licensing laws. Of course, birth activists have not been victorious in several other states, nor are the laws that have been passed ideal from their perspective. Still, all of the statutes adopted since 1999 were introduced by midwives and/or their supporters, were clearly intended to enhance midwifery, were opposed by organized medicine, and are now seen largely as victories by their sponsors in the alternative birth movement.¹⁴

These outcomes are surprising in light of the organizational and financial resources of organized medicine, as well as the argument that the cultural and political hegemony of modern medicine precludes the possibility that birth activists will prevail in legal arenas. Indeed, birth activists' victories suggest that this argument rests on an overly static conceptualization of hegemony. By contrast, many sociolegal scholars treat hegemony as subject to contestation and transformation. In this literature, hegemony is conceptualized as cultural conceptions, assumptions, images, and values that “go without saying because, being axiomatic, they come without saying” (Comaroff & Comaroff 1997:23, paraphrasing Bourdieu 1977:167; see also Hall 1988). As a result of their unconscious and obvious quality, hegemonic ideas dominate “other conceptions of the social world by setting the limit to what will appear as rational, reasonable, credible, indeed sayable or thinkable, within the given vocabularies of motive and action available to us” (Hall 1988:44). But while their taken-for-grantedness endows hegemonic ideas with power and seeming permanence, hegemonic ideas and ideals are nonetheless contestable. Indeed, by analyzing

¹⁴ For example, the Tennessee Midwives Association proclaimed, “Victory in Tennessee for the Certified Professional Midwife!” (Mosney 2000). Similarly, activists in New Hampshire announced, “Nearly ideal Midwifery Legislation has passed in both the House and the Senate in New Hampshire!” (Sanborn 1999).

change over time, many of these analysts highlight the impermanence of the hegemonic—the process by which it is established, resisted, and re-created—and the role of human actors in those processes.

Hegemony's double-sided nature is revealed in our analysis of birth activists' attempts to legitimate midwifery and home birth. On the one hand, the values, themes, and images that have historically underscored biomedicine's hegemony have played a central and structuring role in these debates. Birth activists are not free, for example, to ignore concerns about safety or the importance of medical technology in achieving it. However, their ability to appropriate these values, give expression to cultural ambivalence about them (where it exists), and combine them with other culturally powerful images and themes suggests the importance of conceptualizing cultural meanings and the hegemonies they sustain as subject to transformation. More specifically, our analysis shows how birth activists have destabilized established ways of thinking about and regulating childbirth—and helped legitimate new authoritative conceptions. We begin by showing how birth activists have invoked cultural themes and values that have historically buttressed medicine—safety, science, technology, and professionalism—and with the narrative in which these themes were embedded.

The Rhetoric of the Alternative Birth Movement: Midwifery-as-Tradition

Birth activists located their claims and arguments in a narrative of tradition and continuity, depicting midwifery (like motherhood) as an age-old practice and long-honored profession:

As long as mothers have been giving birth, they have enlisted the help of those around them to meet the unique physical, emotional, and spiritual challenges of birth. For many women throughout history this expert care and education, counseling, and support has been delivered by a midwife. Midwives have been practicing for hundreds of years. (March 13, 2000, CA Senate Business & Professions, CA-003)

These accounts also emphasize midwifery's continuing presence in the United States as a normal way of assisting at birth:

You know, midwifery has been here for a long time. It's one of the oldest professions, and it still has a place in our society. . . . We're talking about women helping women to deliver babies. Some of you were possibly delivered by a midwife, or if not you may have known of others who were delivered. Of our 95 counties midwives are actively delivering babies in 57 counties. (February 9, 2000, TN House Floor, TN-364)

In this narrative, midwives embody the long-standing tradition of women helping women. This way of framing the issue underscores midwives' expertise and distinctive care in a nonthreatening way, invokes maternalist imagery, and tempers the more adversarial tone of some of the alternative birth movement's rhetoric. Within this narrative structure, midwives are heroines, struggling against state and medical officials to serve pregnant and birthing women. The appeal of this narrative is clear: Midwives merely want to help women enact one of their most culturally sanctioned tasks (becoming a mother). Birth activists' invocation of cultural themes that have long been associated with modern medicine makes sense when they are located within this temporal and normative context.

Safety

Birth activists have gone to great lengths to assure lawmakers that their primary concern is maternal—and especially infant—safety. This has not only been the case because they anticipate safety to be the primary concern about out-of-hospital birth, but also because the avoidance of death and injury is an unmitigated cultural good. One simply must be concerned about safety in order to be seen as credible. For this reason, many activists have stressed that midwives screen their clients carefully and serve only those deemed “low-risk.” In fact, one of midwives' main concerns about licensure is that it necessarily limits the kinds of clients they may legally attend and requires them to refuse to serve a “high-risk” client, knowing that for personal or religious reasons, she may birth alone rather than attend a hospital. In this way, birth activists seeking midwifery licensure have been compelled to adopt a stance that many find objectionable.

Even as they emphasize safety and embrace the logic of risk assessment, though, birth activists offer an alternative route to safety. In particular, birth activists stress that childbirth is a normal and natural process, one that is, for the majority of women, low-risk. This emphasis is an implicit—and, occasionally, explicit—critique of what they characterize as the fearful, defensive, and “high-tech” approach that, they assert, prevails in hospital settings. Indeed, in the literature of the alternative birth movement, a strong case is made that medicine's preoccupation with risk and narrow definitions of “normal” actually cause harm to women and babies. In the legislative debates we analyzed, however, birth activists were more likely to sing the praises of midwifery care than to emphasize the dangers of hospital birth and medical intervention. In particular, birth activists emphasized that midwives provide more in-depth and personal prenatal care, stressed that midwives do more emotional labor than their affect-neutral medical counterparts,

and argued that this holistic approach better serves women and newborns.

Indeed, activists contrasted midwifery care to the perfunctory services provided by obstetricians in most of the states we examined. As one midwife in Vermont testified,

Midwives usually spend one hour during each prenatal visit, and this compares to a typical five- to fifteen-minute visit with a medical care provider. What this allows us to do is assess and address such aspects of a woman's life as her nutrition, her stress level, her pertinent psychological history, and these are all things that can have an important impact on her pregnancy. It allows us to support her to make lifestyle changes, such as quitting tobacco, re-arranging the work environments, that also promote a healthy pregnancy. And it also allows us to build a trusting and close relationship and this enhances our ability to guide the woman through natural labor. (February 3, 2000, VT House Health & Welfare, VT-0013)

And another activist reported,

When a midwife spends time prenatally with a woman she spends an hour of her time . . . your average OB consult on a prenatal exam is six minutes. That's the way it is and so the kind of care is far more detailed: not only do we do pathology care, measuring urine and blood and fetal heart tones and assessment of fetal growth; we are also doing nutritional consultations, psychosocial consultations because we know that birth is far more than just a physiological event. (March 13, 2000, CA Senate B&P, CA-242)

Midwives and their supporters thus work hard to associate themselves with safety in part by mobilizing the logic of risk assessment, but also by suggesting that their “high-touch, low-tech” approach is the more effective one.

Science

As sociologist Thomas F. Gieryn argues, “[s]cience’ often stands metonymically for credibility, for legitimate knowledge . . .” (1999:1). Medicine has long benefited from its association with this powerful cultural icon (Bynum 1994; Porter 1997). The problem for opponents of midwifery is that most of the scientific (i.e., epidemiological) evidence does not support their argument that home birth is inherently unsafe (see Goer 1995; Rooks 1997).¹⁵

¹⁵ Early studies on the safety of out-of-hospital birth demonstrated that hospital birth was safer for both mothers and infants. However, these studies did not distinguish between planned (intentional) and unplanned home births, nor control for the presence of trained midwives. Subsequent studies that considered these factors overwhelmingly indicate that planned home birth attended by trained midwives is as safe or safer than hospital birth for low-risk women (Goer 1995; Rooks 1997). At the time of our writing, however, one study

Midwives and their supporters have seized upon this irony to position themselves as the truly scientific ones. Toward this end, birth activists cite a seemingly endless supply of epidemiological studies that conclude that planned home births attended by trained birth attendants are “as safe or safer” than hospital birth for low-risk women. In fact, their lobbying materials consist largely of abstracts of such studies, occasionally accompanied by an article concerning high rates of cesarean section or rising medical costs.

Birth activists also call attention to the fact that their medical opponents cannot supply such “scientific” evidence. In a hearing in Illinois, for example, a proponent of licensure testified,

The opposition . . . is going to tell you that midwifery care is not safe. And they’re going to tell you that Certified Professional Midwives are not safe providers. Please: challenge them. Ask them for their evidence. I challenge the opposition to come up with one single study, one peer-reviewed study that planned out-of-hospital birth or midwifery care that supports their position. They cannot do it. (February 28, 2001, IL House Rules & Regulations, IL-032)

Supporter Dr. Marsden Wagner, former director of Women’s and Children’s Health for the World Health Organization, made this point more dramatically:

And the first thing and the most important thing I want to say today is speaking to you as a perinatal scientist, I can assure you that the scientific evidence is clear: Midwives are not **as** safe as obstetricians. Midwives are **safer** than obstetricians for the 70 to 80% of all births where there has not been a serious medical complication during the pregnancy. There was a study done in the United States by the Centers for Disease Control which is an outstanding scientific organization. They looked at every single birth in this country in one year, over 4 million. They eliminated the high-risk, you know, women with problems during the pregnancy, and looked at all the other pregnancies and they compared the births with a midwife with the births with a doctor. The births with a midwife had 33% less newborn babies dying. . . . So safety as an issue is a non-issue and if people come before you and start expressing their concern about safety . . . look at them and say to them “show me the data.” (March 13, 2000, CA Senate B&P, CA-184, emphasis added)

Through such statements, birth activists have positioned themselves as the truly scientific ones, calling attention to the contradiction between medicine’s popular association with science and

has been published suggesting that “planned home births in Washington State during 1989–1996 had greater infant and maternal risks than hospital births . . .” (Pang et al. 2002:253). The validity of the study’s methods and measures were quickly challenged by the midwifery community (van Roojen 2002).

highlighting the fact that the “scientific” evidence does not support medicine’s claim that home birth is unsafe.

Technology

Western and especially American culture is often said to be characterized by an undying faith in and fascination with technology (Davis-Floyd 1992; DeVries 1996; Payer 1996; Postman 1993). But faith in technology is only part of the cultural story; discourses expressing fear of technology gone awry also abound (Beck 1992; Gamson 1992; Giddens 1990), and many contemporary social movements—especially the environmental movement—highlight the risks associated with modern technology to great effect (Beck 1992). The idiom of “the natural” has proliferated in this context, and the spread of natural foods, natural clothing, and natural medicine suggests that this rhetoric has significant cultural appeal. The importance of living and giving birth “naturally” has likewise been a key theme for the alternative birth movement.¹⁶

Birth activists finesse this cultural tension by both invoking the ideal of the natural and acknowledging that technology can, indeed, be lifesaving. This introductory statement from a birth activist in Illinois was typical in this regard: “The midwifery model of care is fundamentally different from the medical model. The midwifery model of care recognizes pregnancy and childbirth as normal and natural life events which rarely need medical intervention” (February 28, 2001, IL House R&R, IL-028). However, birth activists simultaneously stress midwives’ technological expertise, the fact that they carry oxygen, drugs, and IV and suturing equipment that they will use only if natural birth becomes impossible. A proponent in California responded to concerns about potential emergencies as follows:

Now if troubles develop at home you don’t need to think that there is nothing to do. There’s all kinds of things to do and the women—and the midwives today have oxygen and they know how to resuscitate. As a matter of fact, midwives are better at certain emergencies than obstetricians. For example, when the baby’s head comes out and the shoulders get stuck . . . the favored maneuver now [is] in this country is called the Gaskin maneuver which is a midwifery—Gaskin is a midwife—it’s a midwifery maneuver. So midwives have all kinds of things that they can and do do if there is an emergency . . . (March 13, 2000, CA Senate B&P, CA-204)

¹⁶ This worries some feminists who fear that an emphasis on “natural birth” reinforces the age-old association of women with nature, and leads women with different aspirations or experiences to be identified as “unnatural” (see Michie & Cahn 1996).

Another reassured legislators, “There would not be a midwife amongst us who would attend a birth without using, without going with Pitocin or Methergine”¹⁷ (February 3, 2000, VT House H&W, VT-0072). One midwife even brought and displayed her own handheld electronic fetal monitor to legislators as if to demonstrate midwives’ familiarity and comfort with modern medical technology.

In sum, midwives work hard to identify themselves as competent, if more careful, users of medical technology, while at the same time characterizing birth as a normal rather than medical event and valorizing the virtues of natural childbirth. In this way, midwives give expression to both the ideal of “the natural” and faith in technology.

Professionalism

Insofar as licensure demarcates professional from nonprofessional groups (Friedson 1970; Starr 1982), it is hardly surprising that midwives draw on the language of professionalism to make their case for licensure. Midwives seeking professional recognition today have a distinct advantage over their predecessors: MANA. Formed in the early 1990s, MANA defines and promotes “professional” midwifery, and has worked with other organizations to create and promote a new concept, *The Midwifery Model of Care*. According to this model, professional midwives adopt a holistic and individualized approach to prenatal care and childbirth, possess a unique body of specialized knowledge regarding out-of-hospital birth, and are trained to identify medical conditions and developments (i.e., risk factors) that necessitate referral to an obstetrician (Midwifery Task Force 1996).

This definition of professional midwifery is quite useful to those seeking licensure. First, it neatly distinguishes midwifery from medicine to bolster the case that midwives are neither medical practitioners nor para-professionals, but rather autonomous health care providers with a distinct area of expertise (i.e., out-of-hospital birth). Second, the inclusion of knowledge of pathology and abnormality in *The Midwifery Model of Care* legitimates midwives’ efforts to retain the authority to screen and diagnose their clients and to respond to unforeseen, medical emergencies (even as it blurs the boundaries between midwifery and medicine). This training was often featured in the hearings we analyzed:

The Midwifery Model of Care protects normalcy. It is focused entirely on normal people. And Certified Professional Midwives are trained professionals who are taught through excellent

¹⁷ These drugs are used to stop hemorrhaging that occasionally occurs after delivery.

prenatal care to prevent complications. In the event that complications are not preventable they are trained to identify them early on and refer to a physician. (February 28, 2001, IL-House Bill 577)

Midwives’ knowledge in these areas is now primarily assessed by MANA’s North American Registry of Midwives, NARM, which examines midwives and acknowledges successful examinees as a CPM. Midwives working for licensure in recent years have stressed MANA’s qualifications as a certifying body and the rigorous nature of the exam itself. As an advocate in Illinois reported,

The opponents . . . are also going to tell you that Certified Professional Midwives are poorly trained. Again, I ask you, what is their evidence? I have very good evidence to the contrary. This is written testimony from the Ohio State University. The Ohio State University is the lead university in our country in evaluating industry certification and testing. The Ohio State University reviewed the NARM process . . . the CPM passed with flying colors. (February 28, 2001, IL House R&R, IL-034)

Yet even as they tout their professional qualifications, midwives are (more quietly) modifying what it means to be a professional. Many in the midwifery community have been concerned that the extensive educational requirements associated with professionalization will exclude midwives already trained through apprenticeship, as well as aspiring midwives who are unable to relocate and/or pay for a formal education. In order to include such women, MANA acknowledges “multiple routes of entry” to the profession and allows applicants for the CPM degree to acquire their knowledge and skills through *either* formal education or apprenticeship; a woman whose education ends with high school can therefore be certified as a CPM. In public and political forums such as state capitol buildings, most midwives do not stress that they may be certified without extensive formal education, although they will defend apprenticeship enthusiastically if needed:

Now, the midwives’ education process, which you really need to understand, is based on the Certified Professional Midwife. It is actually, not founded really on lower education from CNM’s [Certified Nurse-Midwife], it’s just a different type of education. The Certified Professional Midwife is one who has met all the certification and standards set forth by the North American Registry of Midwives. The NARM process is a competency-based evaluation and education equal to institutionally based education but no less rigorous than the strictly institutionally based education. . . . It’s equal! It’s different but it’s equal! (April 5, 2000, VT Senate H&W, VT-0781)

Even more frequently, birth activists downplay the potentially negative consequences of professionalization by depicting midwives as

a more folksy kind of health care provider, assuring the audience that although extensively trained and rigorously examined, midwives remain committed to serving populations ignored by (more elitist) others. Toward this end, birth activists point out that many women lack access to obstetrical care. In Oregon, midwives made this case quite dramatically by having a woman telephone all obstetricians serving the Salem area, identify herself as a pregnant Medicaid recipient, and request an appointment. The results of this experiment—enthusiastically reported to legislators—indicated that no doctor in the area was willing to provide prenatal care to women on Medicaid (personal communication, January 5, 1994). The solution, of course, is midwifery. As one proponent put it in Tennessee, “Access to prenatal care and delivery services is limited by an inadequate number of providers and . . . the practice of midwife—midwifery will help to reduce the shortage” (March 23, 1999, TN House GO, TN-002).

In sum, the cultural valuation of safety, science, technology, and professionalism has required that midwives work hard to associate themselves with these values, although, in the case of professionalism and technology, they also give expression to cultural ambivalence about them. Birth activists combine references to these cultural values and symbols with a number of other, also very powerful themes and motifs that are more indigenous to the alternative birth movement and are subsumed with the narrative of “midwifery as a time-honored tradition.” We identified five such themes that, like safety, science, technology, and professionalization, permeate and structure birth activists’ rhetoric. These more indigenous themes include choice, turf battles, grassroots motherhood, safety through regulation, and legal harassment. Interestingly, the potential cost savings associated with midwifery was not among these. Birth activists generally mentioned this issue only in passing, and when supportive legislators occasionally highlighted this aspect of the debate, they were often rebuffed by opponents who suggested that cost to infants trumped any financial benefit derived from the use of midwives:

And if we’re talking about saving money, how are we going to save money? Let me tell ya. You have one baby, one baby that’s born brain-damaged because that baby did not have oxygen, or a baby or mother and that has serious, serious problems or even death because of a sudden hemorrhage during delivery, that dies because there’s not a blood bank there, you know, that costs the State of Tennessee. (February 9, 2000, TN House Floor, TN-362)

The relative lack of emphasis on cost seemed to reflect the desire of midwives not to be construed as a substandard alternative suitable only for the poor, and was unexpected, particularly given evidence

that the adoption of managed care has facilitated the expansion of nurse-midwifery (Hartley 1999).

Choice

Midwives and their supporters consistently frame this debate as one centrally about individual choice, arguing vigorously that women have the right to choose where and with whom they will give birth. As the legislative sponsor in California stated, “At the core of this issue are two simple beliefs: first, that childbirth is a natural process of the human body and not a disease. And second, that a parent has the responsibility and the right to give birth where and with whom the parent chooses . . .” (March 13, 2000, CA Senate B&P, CA-004). Another supporter said,

I am not a mom—I wish I was—but I’m regretfully not one. But I truly believe every mother has a right to choose to have a midwife that is not going to be astronomically demanding or costly or infringing upon her having the right to decide about what she needs to do to care for that child in the best way that she can. (April 20, 1999, TN House Health & Human Resources, TN-044)

This argument is often made by women who have previously given birth at home: “For myself and my babies, the right to choose the most appropriate attendant for my pregnancy is a basic freedom” (February 28, 2001, IL House R&R, IL-046). Notably, birth activists avoided linking this choice to the right to choose abortion by avoiding more general terms such as *reproductive choice* or the *right to choose*.

Turf Battles

Birth activists further justify their emphasis on choice by arguing that planned home birth with a midwife is a safe choice for most women. As was discussed previously, the claim that midwife-attended out-of-hospital birth is relatively safe is supported by references to scientific studies and to midwives’ professional qualifications and expertise. But it is also supported by the suggestion that the doctors who oppose midwife-attended births are engaged in a “turf battle,” and thus that medical claims about lack of safety are suspect. For example, an activist in Illinois concluded, “This is not a safety issue; safety is a smokescreen. This is a turf issue” (February 28, 2001, IL House R&R, IL-032). In California, a supporter put the turf issue in historical perspective: “For the last hundred years organized medicine has assumed that if they could block the practice of community-based midwives, then childbearing families would, on their own accord, all come to hospitals to be

cared for by doctors. However this has never been the case” (March 13, 2000, CA Senate B&P, CA-025). Through such statements, birth activists invoked a kind of David and Goliath imagery, raising suspicions of opponents’ veracity by highlighting organized medicine’s professional and economic interests in the outcome of these debates.

Grassroots Motherhood

Although birth activists lack the financial and organizational resources of their opponents, they are remarkably successful in mobilizing what they do have: extensive grassroots support, and their (gendered) identity as mothers. Their grassroots network communicates regularly with their legislators via e-mail and letters, and this communication was frequently referenced in the hearings themselves and in our interviews with lawmakers. But the support of many families, especially mothers, was expressed most powerfully through the somewhat incongruous bodily presence of mothers and their babies in legislative meetings and floor debates. Birth activists made their already obvious presence even more felt by interjecting themselves into the proceedings through their applause, laughter, or sounds of disapproval; a recurring theme was the lighthearted correcting of legislators who stammered over the pronunciation of “midwifery” and various anti-hemorrhagic medications. Organizers, too, were quite aware of the symbolic significance of their supporters. A message sent to supporters in Indiana is typical: “Hope to see you there with KIDS AND BABIES! Let’s PACK the chamber!” (Indiana Midwifery Taskforce, personal communication, February 8, 1999). The support of mothers and families is also used in the promotional materials of legislative sponsors, sometimes with great visual impact.¹⁸

In this case, then, grassroots mobilization is not just grassroots mobilization; it is the mobilization of motherhood itself. The flip side of this emphasis on motherhood is the obliteration of that which is often perceived to be its opposite: feminism. Although many activists on this issue identify themselves as feminist, they are quite careful about where and when they do so, and do not refer publicly much to the National Organization of Women’s 1999 endorsement of the midwifery model of care.¹⁹ One midwife described their strategy:

The leftist [lobbyist] pushed the women’s angle and worked the legislators on the left. . . . On the right, a man whose wife is a midwife lobbied from the perspective of the family. He kept his

¹⁸ See, for example, <http://www.visi.com/~sandyappas/midwifery.html>.

¹⁹ On file with the authors.

focus on this single issue, and never discussed the more politically charged issues [like reproductive rights in general].” (personal communication, January 5, 1994)

Safety Through Regulation

Not too surprisingly, birth activists and their supporters stressed that although they seek to improve access to midwifery services, it is important to ensure that those services are safe. “Through this proposed legislation all these safeguards will put in place, again, the necessary tools to raise the bar for midwifery here in the State of Tennessee” (February 9, 2000, TN House Floor, TN-366). Similarly, the legislative sponsor in California introduced her bill by arguing that it would “provide mothers choosing home births with greater information with which to make their decisions and improve the quality of care they and their newborn will receive” (March 13, 2000, CA Senate B&P, CA-009).²⁰ Others argued that licensure would attract more midwives to the state, thereby increasing access to midwifery, and some emphasized that where midwives operate illegally, it is more difficult for them to collaborate with other health care professionals. Thus, a legislative sponsor in Minnesota argued,

What this will allow is, when something goes a little awry in childbirth, which they do from time [the] time in the best of circumstances, then these licensed traditional midwives can go to the hospital and then the doctor on duty can then have a some comfort of least talking to these, mostly women, who will come in and accompany the women who’s in birth and having a very traumatic time. Before this, they almost have to drop them at the curb and leave for fear of some kind of legal action against them. (April 8, 1999, MN House Ways & Means, MN-0350)

Thus, for birth activists, licensure has made a good practice better, providing the state with greater control over midwifery training, creating a more favorable economic and legal climate for midwives, and enabling the consumer to assess midwives’ training and education.

Legal Harassment

In these debates, reference was frequently made to the injustice of criminalizing women for helping other women to have the births they desire. As a legislative sponsor in Illinois argued, “It should

²⁰ Although this emphasis on the capacity of licensure to improve midwifery care is predictable, it is nonetheless troublesome to some birth activists and midwives, who feel that unlicensed midwives are denigrated by it—sometimes intentionally so (see Lay 2000).

not be our intention to make criminals out of these women who just want to be having births at home” (February 28, 2001, IL House R&R, IL-132). Activists further suggested that such actual or potential harassment leads many midwives to relocate or cease their practice, which in turn means that more women who give birth outside the hospital are unassisted when they do. In Illinois, for example, a supporter testified that the numbers of midwives practicing in the state was declining because so many had received cease-and-desist orders from the Department of Licensing: “Five years ago we had fifty [midwives], we had fifty five years ago, and they’ve all fled because of the harassment that’s been going on in the last few years” (February 28, 2001, IL House R&R, IL-106). Like invocations of turf battles, references to the legal harassment experienced by midwives were clearly intended to generate sympathy for the underdog.

The Rhetoric of Organized Medicine: Medicine-as-Progress

In sum, birth activists attempted to persuade lawmakers to support midwifery licensure by combining (qualified) appeals to the values historically associated with medicine (safety, science, technology, and professionalism) with references to choice, turf, motherhood, safety through regulation, and legal harassment, and situating appeals to these themes and values in the “midwifery-as-time-honored-profession” narrative. Of course, representatives of organized medicine vigorously contested this narrative, challenging birth activists’ claims in an attempt to persuade legislators that efforts to expand and legitimate home birth and midwifery are misguided. These rhetorical appeals were embedded in a narrative we call “medicine-as-progress.” In contrast to midwifery-as-tradition, medicine-as-progress depicts the twentieth century as the triumph of technology and medicine over maternal and infant mortality:

I would like to know the difference in the infant mortality growth—infant mortality rates for the 1899 to 2001 because I don’t think anybody can dispute that with modern technology, modern medicine that the infant mortality rates in the State of Illinois and throughout the country have constantly gone down because of medical professionals, certainly not from midwives
(February 28, 2001, IL House R&R, IL-112)

Despite the fact that midwives are an important part of the maternity care system in most industrialized countries, midwifery is depicted by organized medicine in the United States as a return to a dangerous and anachronistic past: “Again Mr. Speaker, I don’t know why this bill is here, I don’t know why we want to roll the

clock back to the turn-of-the-century medicine. That’s what we’ve tried to advance from, that’s not what we should be advancing to!” (February 7, 2000, TN House Floor, TN-322). Similarly, opponents sought to associate midwifery practice with poorer regions and less-developed nations. In this story, both medical technology and those who use it to protect women and babies are the heroes; those who willfully reject the benefits of progress, the anti-heroes. This narrative structure has served to strengthen the link between medicine, progress, and safety, while portraying midwifery as an unsafe and archaic choice.

Safety and Science

Given this narrative structure, it is hardly surprising that representatives of organized medicine argue unequivocally that out-of-hospital birth is unsafe. However, the results of epidemiological studies make this argument a difficult one to support. As a result, midwifery opponents emphasize the dangerous nature of childbirth by listing the various things that can go wrong, and by suggesting that doctors will be ill-prepared to deal with these situations when they arrive at the emergency room. As an opponent in Illinois argued,

I beg to differ with the ladies that just made this testimony that doctors are going to want to take these cases when there’s a cord wrapped around the baby’s neck and they’re in the middle of delivery, or when fetal meconium that gets in the baby’s lungs because they’ve broken the water and they’ve got this problem in their lungs from a bowel movement, or when a baby is breech and they can’t turn it around, or when a baby needs an emergency C-section and there’s no one there that knows how to do it, or when a baby needs some sort of care to make sure that they get the baby out on time, you know, before their, the heartbeat stops. There are so many issues here. (February 28, 2001, IL House R&R, IL-056)

To make this testimony credible (and dramatic), doctors highlighted their clinical experience with such matters, telling vivid stories about cases in which such conditions did develop. Anticipating that birth activists would respond by stressing midwives’ capacity to screen their clients, opponents emphasized that many of these conditions cannot be foreseen. As one such opponent testified,

Many of the problems are very insidious and very difficult to identify and it requires emergency action. It could be a blood bank, it could be oxygen, the standard of care in a hospital or a birthing center is to be able to deliver a baby by C-section within minutes, within minutes. How do we do that with a nurse-midwife who can’t perform a C-section, performing the service in somebody’s home, they’re going to call 911 and transfer? Now

they'll say yes, but we'll screen the patients so that we'll know which ones are having problems. Even licensed physicians who do this for a living cannot identify in advance all of the complications. . . . (February 9, 2000, TN House Floor, TN-360)

The implicit, and sometimes explicit, logic is of this argument is this: Because hospitals house well-trained and highly educated doctors and medical technology, and because doctors and technology save lives, out-of-hospital birth must be unsafe. The testimony by the health commissioner in Indiana was fairly typical and captured many of these arguments:

As state commissioner, I also bring to this discussion personal experience as a practicing family physician who earlier in his career delivered many babies. From that experience, I know that delivering a baby is most often a happy, positive experience. . . . I also know that in a moment, events can go very badly, not necessarily without any warning. A ruptured uterus, an inverted uterus, premature separation of the placenta, a hemorrhaging mother or a cyanotic baby, a woman who suddenly seizes or develops congestive heart failure, an unborn baby's heart rate suddenly drops or a baby stuck in the birth canal. As a physician, I have experienced all of these things. And as a physician, I know that these situations demand immediate action—the right action—by well-trained health care professionals and medical specialists. I worry about a physician, let alone an individual with little or no medical or nursing background or knowledge who delivers babies at home—isolated in time and distance from optimal facilities, personnel, and equipment. (February 10, 1999, IN House PHC, IN-605)

Through statements such as these, opponents of licensure attempt to discredit the results of studies indicating that midwives have as good as or better safety outcomes than doctors.

Education and Training

Highlighting the differences between physicians' educational status and the fact that one can be credentialed as a CPM without attending a formal educational institution—or even graduating from high school—has also helped shift the focus to midwives' alleged educational inadequacies. As one legislative opponent (a nurse) in Tennessee argued,

I've done [a] medical mission trips all over the world. When I was in Guatemala two years ago, I assisted a physician with a cesarean section. He then said to me when we got ready to do another cesarean section, "Here Diane, you do this one." I said "Dr. Monel I cannot do a cesarean section. I'm not a physician." He said, "Well here in our country you see one, you do one, you teach one." That's basically what these nurses are doing. They do

not have formalized education. They see one, they do one, they teach one. When they talk about being taught, they're taught by a preceptor. They're not someone who has formalized education. (February 9, 2000, TN House Floor, TN-371)

Similarly, a representative of the Illinois Medical Association testified,

We're here today to try to hopefully explain the difference between nurse-midwifery and lay midwifery. The difference being education and training. They don't have to have any education in this bill, not even a high school degree! We have nurses that we support that do midwifery work and they have two to four years as an R.N., three more years as an Advanced Practice Nurse, and those people work in collaboration with physicians, they work on their own but if something goes wrong they have a referral (February 28, 2001, IL House R&R, IL-055)

In this way, medical opponents of midwifery have sought to undermine birth activists' claim that midwives are well-trained health care professionals.

Turf

Contra the claims of birth activists, opponents of midwifery licensure often suggest that it is not doctors but midwives who are encroaching on professional turf and seeking, illegitimately, to establish a monopoly. In the first instance, opponents argue that midwives are illicitly practicing medicine without being properly trained to do so, and that rewarding such efforts would set a dangerous precedent for the state:

Mr. Speaker, I've served for ten years on the House Health and Human Resources Committee. . . . And a large part of the time that's spent in that committee is what many of us refer to as turf battles. We have seen through the years time and time again groups of individuals who want to come into the State of Tennessee and begin the practice of medicine. But unfortunately, they want to come in and be designated as professionals by the State of Tennessee, but they want to achieve the recognition not through education but through legislation. (February 9, 2000, TN House Floor, TN-359)

Other opponents contrasted midwives with the ideal midwife—the nurse-midwife—to make this point:²¹

We have certified midwives in the State of Tennessee. They have a bachelor of science degree in nursing. Four years of nursing

²¹ Such statements obscure the fact that organized medicine opposed the licensure of nurse-midwives for many years, just as they now oppose the licensure of independent midwives (Hartley 1999; Langton 1994).

training plus a master's degree. Two years of postgraduate training, and even then under the laws of the State of Tennessee these truly trained professionals are required to work under the direct supervision of a physician. (February 7, 2000, TN House Floor, TN-316)

The intended effect of such claims was to group non-nurse midwives with any number of poorly trained practitioners seeking recognition by the state, negating their claims of a distinctive expertise and undermining their rationale for autonomy.

Other opponents focused on the financial and professional interests at stake in midwives' bid for licensure:

[Legislator (sarcastically)]: So in part this bill . . . part of the momentum for this bill is to create an environment in which you can get reimbursed by HMOs.

[Midwife]: Um . . . that would be a byproduct of the bill, but I think the safety issue is number one. That is paramount. (March 13, 2000, CA Senate B&P, CA-225)

Still others evidenced a concern that midwives were knowingly or unknowingly seeking to establish a monopoly over home birth at the expense of unlicensed midwives. This proved to be a particular concern in Minnesota (see also Lay 2000), where some legislative opponents were concerned that mandatory licensure would run unlicensed midwives (many of whom are Christian and serve rural, Christian populations) out of business:

What will the midwives that have talked to me before, that want to continue to be midwives, what will they call themselves then, they can't call themselves midwives anymore? Or can't they practice midwifery anymore? And if we pass this, is that the initial step of fencing these people out from doing their practice? (March 11, 1999, MN House Health & Human Services, MN-0115)

In these ways, opponents of midwifery have attempted to counter the image of medicine as an aggressive competitor in the health care market with one that depicts midwives in much the same light.

Legislators' Accounts

Despite the efforts of the opposition described above, many legislators (and a majority of those we interviewed) voted in favor of midwife-sponsored legislation. In what follows, we draw on interview and archival data to analyze the ways in which legislators legitimated their decisions to vote for or against these bills, beginning with those who voted in favor of midwifery. As we will see, lawmakers primarily invoked the image of midwives as competent

health care providers working to ensure that families are able to exercise consumer choice in order to explain their votes.

Safety

Supportive lawmakers came to believe that midwifery is safe in a number of different ways. For some, the studies cited by midwives were persuasive; others emphasized the rigorous nature of NARM's certification process; still others made vague references to midwives' "impressive" qualities. Most frequently, though, when asked to explain how they adjudicated competing claims about safety, legislators suggested that doctors' claims could not be trusted because they were solely concerned with protecting their turf. For example, when asked why she thought the Indiana Medical Association was opposed to the bill, one legislator told us, "I think there is a turf battle, you know, doctors are afraid that if midwives are used more, then doctors lose part of their business . . ." (December 8, 1999, IN Interview #8, IN-408). This interpretation was put even more strongly in a memo from the Republican Caucus of the California House Public Health Committee:

. . . the various special interests in the medical industry who opposed the bill because *it would mean greater competition for hospitals and doctors for the almighty buck*. . . Both the California Medical Association and the trial attorneys oppose this bill. CMA argues that the safety of the patient is their chief concern. However, let's face it, *it's really a turf battle*. (Republican Analysis of SB 1479, May 25, 2000, emphasis in original)

Similarly, when asked if she was concerned about the issues raised by the medical association, one legislator told us, "Oh, it's just docs, I mean they, everybody controls their turf . . . it's just a big turf battle, I really believe . . ." (October 5, 1999, IN Interview #1, IN-050). And when asked if he was persuaded by doctors' claims about safety, a Republican legislator from Vermont answered, "You've heard of turf? That's what that was. In fact, I was not only not persuaded, I was rather irritated that they even came in and said that" (February 2, 2002, VT Interview #3, VT-1685).

Thus, physicians were *not* accorded a high degree of trust and respect by lawmakers of either party; the idea that they were primarily motivated by their economic interests was reiterated by many. Some even expressed their frustration at doctors quite openly in the hearings themselves: "Interesting that you're making political at the tail-end. If this bill has been in process for eight years, why is it that you coming today and, perhaps it was yesterday, with this information, wasn't there an opportunity for physicians to register their concerns earlier?" (April 5, 2000, VT Senate H&W, VT-0939).

Conversely, numerous legislators with whom we spoke found midwives to be credible and trustworthy; only a few legislators applied the “turf battle” logic to discredit midwives’ statements regarding safety. Thus, it appears that physician opposition to efforts by non-physician health care providers to secure licensure, as well as growing cultural mistrust of experts in general and medical authorities in particular, has engendered a more cynical view of physicians among lawmakers (see also Cant & Sharma 2000; Gabe, Kelleher, & Williams 1994; Huag 1988; Giddens 1990; Illich 1975; Light 1988; Lupton 1994). Midwives are thus able to tap into a kind populist animosity toward the “big guys” and the medical monopoly they have historically enjoyed.

Choice

The most consistent reason given for supporting efforts to expand midwifery was respect for the individual’s right to choose, often referred to as “consumer choice.” In fact, all of the supportive legislators with whom we spoke cited the right to choose home birth as their primary consideration, one that often trumped other reservations. One legislator explained,

I actually tend to agree with hospitals. . . . My final judgment was that the hospitals probably tend to be more accurate, but the midwives have data and justification to back up their feelings and, uh, as long as those are presented to the consumer, um, that’s their choice. I mean, some of us take herbs for colds and some of us take flu shots. (November 17, 1999, IN Interview #5, IN-293)

Other legislators also went out of their way to indicate that this was a choice that they would not make, but one that they nonetheless felt strongly that other people should have. One told us:

I’m an advocate of consumer choice, and this is a choice some people want to make. I don’t think I would want my wife to make this choice, because of the mess and everything, but like I said, it’s a lifestyle choice . . . some people really want to have a natural childbirth at home, and they have that right. (January 28, 2000, IN Interview #12, IN-524)

The rhetoric of choice even struck a chord with legislators who identified themselves as “anti-choice” on the abortion issue. In Indiana, for example, a legislative supporter couched her support in terms of “choice,” but then quickly explained the difference between this choice and the right to choose abortion:

I really think people should have some choice in giving birth. . . . I mean, it’s their birth! And you shouldn’t have to go to the hospital if you don’t want to. . . . As I’m saying this I realize that people might say, well, you don’t want to give them a choice to

have an abortion. But this is a choice to give life! And it’s a safe alternative, and I trust the midwives (October 5, 1999, IN Interview #1, IN-008)

The related notion that family and consumer choices should be free from government intervention was often articulated, especially by conservatives. As one Republican legislator put it, “I think too often the government puts up roadblocks, and I think this is one of the choices people should be able to make in terms of their own health care” (January 28, 2000, IN Interview #12, IN-514). The appeal of birth activists’ emphasis on consumer choice is not too surprising, given the strength of individualism—and consumerism—in American culture (Bellah et al. 1996; Carbaugh 1989; Gans 1988; Scheingold 1991).

Experiential Knowledge

Many legislators also cited personal connections to midwives or experience with childbirth as a factor in their decision. One supporter in Tennessee explained,

It happens that my daughter-in-law is, she’s a, has a master’s I believe it is from Vanderbilt Nursing School and she’s also a licensed practicing [. . .] she’s a resident nurse, but whatever you call it, midwife, she does . . . midwife things. And, I’ve been aware of these folks for a long time, it seems to me that they can provide a nurse’s [. . .] service much less expensively than an M.D. can, just to be frank about it. (April 28, 1999, TN Senate GW, TN-213)

Another Tennessee legislator whose family owned one of the few cars in town reported that:

I have a, birthed a lot of babies, because we would take people to the hospital and they would have the babies, you know, before we get ‘em out of the house in the ambulance, and I’m gonna tell you. The first time, I mean I was scared, I didn’t know what to do. You know, and you learn how to do things. And I’m going to be quite frank with you. I had no formal training, Didn’t know nothing at all about it. It all happened by accident. [laughter] . . . So what I’m saying is that, if you read what we have here, we’s had no formal training, they’re going through some rigorous training these midwives over here. (April 28, 1999, TN Senate GW, TN-221)

Others cited personal experience with safe and happy home deliveries as a basis of their support. Here, the fact that home birth became the norm in the 1940s and remained common in some rural areas until fairly recently became quite relevant. At a hearing in Tennessee, one legislator joked,

Now Mr. Speaker, when this bill was in the committee, I told the committee two or three things that was factual. One is that there's twelve in our family, nine who was born by midwives. And the midwife whose name is Tilla. Mrs. Tilla did not have any of these training. Nine children was born. . . . Out of that nine there are lawyers and physicians and MBAs. The last three, I love my brothers, they have college degrees, but none are lawyers, MBAs, and doctors. They were born in hospitals with physicians [laughter]. (May 6, 1999, TN Senate Floor, TN-265)

In Indiana and Vermont, too, several supportive legislators were born at home or had children or grandchildren born at home. Experiential knowledge was thus often cited by legislators expressing their support for the midwifery cause.

Safety Through Regulation

In explaining their votes, some legislators, particularly Democrats, reiterated the argument that while safe, the practice of midwifery could be made safer through state regulation. For example, one liberal Democrat told us that there were two reasons he supported licensure: "One is additional choice in health care, and two, my biggest concern, was safety considerations" (November 24, 1999, IN Interview #7, IN-349). A legislator in Tennessee concurred: "What we're really talking about is giving security to a mother and father . . . the mother for sure, in her selection of assistance of who she wants to have help her with this child" (April 28, 1999, TN House Floor, TN-148).

While some supporters accepted the idea that regulation is a way of making a good practice even better, others saw "raising the bar" as a way of increasing state control over unsafe birthing practices, allowing consumers to distinguish qualified midwives from those who did not necessarily receive training. A supporter in Indiana stated,

And certainly it's gonna happen whether it's legal or not, so why not make it legal, make sure midwives are trained in a licensed program and hopefully keep out the people who are—the midwives told me this, that there are women out there who read one book and attend a home birth and say "I'm a midwife!" And that's scary. (October 5, 1999, IN Interview #1, IN-040)

Another explained his reluctant support:

The practice in reality of midwifery by no stretch of imagination comes up to the standards that we would expect of a well-educated, well-trained physician-pediatrician-obstetrics physician, nor the standards that are available in a modern hospital. We're not talking about that level of service or those levels of standards.

But in reality those simply don't exist in a large part of our state. . . . What this bill is attempting to do is establishing a licensing process to recognize those who are practicing midwifery to have met some level of standard with performance and capability. And I think that's important for us to do. (February 9, 2000, TN House Floor, TN-377)

Legal Harassment

In a different vein, the injustice of the fact that midwives often risk prosecution or legal harassment was also reported to be an important consideration for some lawmakers. In Illinois, where the state health department has aggressively targeted practicing midwives, a legislator expressed her concern: "How many births have we read about in the newspaper where a baby has died and there was never a cease-and-desist order placed on a doctor. But yet, for these midwives, there is" (February 28, 2001, IL House R&R, IL-067). In Indiana, a legislator explained her support: "By not voting for this I am saying they are doing something illegal, and why would I deliberately put them in that position?" (December 8, 1999, IN Interview #8, IN-416). Even some who opposed licensure did not feel that practicing midwifery should be a crime. For example, a doctor in Indiana who was staunchly opposed to the bill reported that:

An argument that I said I think has validity is, is it this level of crime. I mean how criminal is it. And are these people people that should be put in jail. And you know, do we therefore decriminalize it. And I think that's a little bit of a valid argument. So should we make it like, I don't know, seat belt violations or something like that, a misdemeanor, then it's just the cost of doing business. (October 22, 1999, IN Interview #3, IN-206)

Thus, although criminalization weakens midwives' position at the negotiating table and renders their organizational tasks more daunting, it also serves as a powerful symbolic resource, one that highlights the injustice of current arrangements and generates support for efforts to transform them.

Grassroots Motherhood

Finally, the presence of women—who, other than their choice of birthplace and birth attendant—appeared to conform to social expectations by visibly embracing motherhood, had a powerful impact on these debates. Reference was frequently made to the presence of these "ladies"—and, often, their audible babies: "Is there anybody in the audience who would like to testify. . . . I hear some babies crying, does anybody want to come up and state the success of the program? [laughter]" (March 17, 1999, MN House

Government Operations and Veterans Assistance Program, MN-0269). Some lawmakers clearly relished the chance to defend “these ladies” from the machinations of the medical establishment. A supportive chair in Indiana, for example, interrupted the state health commissioner, demanding: “The room is filled with ladies who support this bill, whose home births were safe. What do you have to say to them?” (February 10, 1999, IN House Public Health Committee, IN-612). Birth activists’ lobbying activities were also frequently cited by supportive lawmakers. When asked how he had been persuaded to support the bill, for example, one representative told us, “Some constituents visited me, and they think it’s safe and more human and less expensive and, uh, and I agree with their argument, and I think there ought to be some alternatives. . . . People ought to have more choices, I guess is the bottom line” (February 7, 2000, IN Interview #13, IN-536).

In sum, many lawmakers justified their votes in the very terms offered to them by birth activists, suggesting that activists have successfully forged a culturally viable interpretation of what is at stake in the debate over midwifery licensure. Of course, broader cultural and institutional developments help explain the appeal of birth activists’ rhetoric at this historical moment. In particular, the fact that organized medicine routinely opposes the licensure of a wide range of alternative care providers and para-professionals appears to reinforce the image of physicians as primarily motivated by the “almighty buck,” and helps explain lawmakers’ responsiveness to birth activists’ invocations of “turf battles.”

Legislators’ Opposition

Of course, not all legislators voted in favor of midwifery licensure bills. Opposition to midwifery-sponsored legislation was frequently couched in terms of safety, and was strongly associated with the expression of a favorable view of doctors and the idea that medicine is responsible for improvements in public health. Like some supportive legislators, these lawmakers also drew on their own experiences with or knowledge of birthing to explain their vote. Finally, a number of legislators explained their opposition not in reference to arguments put forth by either side, but in terms of features related to the legislative process.

Safety

Legislators who opposed licensure bills reiterated medical claims regarding the unpredictable and dangerous nature of birth and the fact that midwives’ educational and training requirements

are, in their view, minimal. One explained her opposition to the bill in this way:

It’s basically a concern about health care in Indiana, by people who are not trained as a physician. And you know, it’s not only for the mother, but for the baby as well. You end up with a child with premature—who has medical complications, I mean, they could die before they get to the hospital. And, I mean their training is not the same as a physician, or even a nurse. (December 10, 1999, IN Interview #9, IN-434)

In Illinois, a legislator cautioned,

And that’s one of the problems with, with midwifery, and in fact our own person—I forgot the other lady that was in my office last week—she had performed at three hundred deliveries and her career and she quit after the last one because of the fact that she had a hospital that was too far away when the complications arose. Maybe if that situation was at that hospital they could have, you know, saved that baby’s life. (February 28, 2001, IL House R&R, IL-099)

The fact that midwives can acquire their CPM (increasingly used as the standard for licensure) without obtaining formal education was emphasized by many opponents of midwifery. One warned, “I just don’t think that they have the actual expertise and medical background that they need. And yet they want to be licensed” (December 10, 1999, IN Interview #9, IN-430). A Tennessee lawmaker made a similar point:

I have reread this bill, I can’t tell you how many times, and I want to express to you my concern. I think that we are going to allow the public to believe that these folks who have a license have an education. They do not. . . . What we have done successfully in this country is lower our mortality rate because we have highly educated and trained individuals who provide a certain level of care. This bill concerns me. (May 6, 1999, TN Senate Floor, TN-258)

Experiential Knowledge

For some, personal experiences inclined lawmakers to oppose midwifery. For example, one opponent revealed that his wife had had a very difficult birth, and that he felt strongly that she would have died if she had been at home (personal communication, October 5, 1999). Other legislators drew on their own experiences: “I want all the drugs I can get when I’m having a baby! It’s just, even though I’m a woman and I’m supposed to be akin to all of that, my better side was goin’: hospitals, drugs, doctors, nurses . . . you know” (January 12, 2000, IN Interview #10, IN-473). Another

told us, “I had a great deal of trouble before I could have any children. I had endometriosis and other problems, and I just know how grateful I was when I could have my children. And I just feel like someone else without proper training . . . that’s taking a chance with the child” (October 22, 1999, IN Interview #4, IN-229). Thus, while experiential knowledge was often cited by those who supported midwifery legislation, it was also cited by some of those who opposed efforts to expand midwifery.

Legislative Process

Other legislators who opposed midwife-sponsored legislation remained aloof from the debate and explained their lack of engagement in terms of the legislative process. A central concern here was the amount of time spent by birth activists pursuing licensure: Many legislators felt strongly that legislation should be an “incremental” and “educative” process; the fact that a bill has been negotiated across several legislative sessions is assurance that all voices have been heard and problems worked out (October 14, 1999, IN Interview #2, IN-105). As one legislator in Indiana explained, “Most issues that have strong feelings on both sides take a couple of sessions to get through. And its pretty much the tenor, particularly of the legislature, not to force things through. When there’s a lot of opposition, we tend to allow time, for everyone to have their full say. And, um, there is some here” (November 17, 1999, IN Interview #5, IN-319). Even a legislator who told us that she was likely to vote for licensure in the future explained her current opposition as a “knee-jerk reaction” to new legislation, a distrust that the necessary “infrastructure” had been built: “Oh no, I don’t think this should be a crime. . . . I just thought it was an issue that needed more . . . to be brought before us just a little bit more” (January 12, 2000, IN Interview #10, IN-479).

Other legislators attributed their opposition to birth activists’ failure to negotiate the support of medical associations or state medical boards. In several states, these legislators charged birth activists of attempting to circumvent the political process by avoiding this negotiation: “Better to work with them and find out their motivation, which might be very, very real reasons why they’re acting as they are than to step around the process. We’re only going to approve things that the bureau approves” (February 28, 2001, IL House R&R, IL-075). Some explained their opposition in ways that reveal the complexity of the institutional structures in which they work: One legislator suggested that even supportive lawmakers voted against licensure in an attempt to win favor from a strategic committee chair; another member whose support was expected “used the opportunity to send the message that he wasn’t,

you know, just going to always vote with the party” (October 5, 1999, IN Interview #1, IN-042). These accounts express a deeply held belief in the equalizing nature of the legislative process, as well as a reminder that these struggles take place in a highly structured institutional—and political—process.

Conclusion

This analysis of the development of the alternative birth movement and legislative debates over midwifery licensure supports several conclusions. First, medicine’s effort to assert its power and authority through the law triggered the expansion and organization of a social movement dedicated to challenging its authority over childbirth in a public and systematic way. Sociolegal scholars increasingly note that the law serves as both an instrument of control and of transformation (see especially Lazarus-Black & Hirsch 1994); the analysis presented here paints a detailed, empirical picture of how, precisely, the attempt to mobilize law as an instrument of social control may create the conditions in which it becomes an object and mechanism of social change. In addition, by analyzing the process by which key organizational and associational resources—such as extensive and active networks of home-birthing mothers and the institutional capacity to examine midwives and certify successful examiners—developed over time and were rendered meaningful in legislative debates, this analysis demonstrates the inseparability of culture and structure, and of conceptualizing culture as a process of meaning-making rather than a separate or independent variable.

Finally, the analysis of the legislative process presented here illustrates hegemony’s double-sided nature. The fact that many legislators explained their decision to vote in favor of midwifery licensure in terms of the very categories that are thought to privilege medicine indicates that hegemony is indeed contestable and transformable. Cultural meanings, images, and associations are not fixed, but (somewhat) fluid; this fluidity is an important resource for movement activists resisting sociolegal hegemony and helps explain the recent adoption of relatively favorable licensure laws. At the same time, it is quite clear that this transformation does not occur on a terrain of activists’ choosing. As was discussed previously, some have argued that the widely shared and deeply held values that underpin modern medicine and culture—safety, science, professionalism, and technology—ensure the medical domination of midwifery. Our research confirms the centrality of these cultural values to this debate and indicates that contestants in this struggle ignore them to their peril. It also identifies other cultural

constraints: Birth activists are not free to align themselves with feminism or reproductive rights more generally, and they are on much safer ground when they attack organized medicine for seeking to augment its professional well-being than when they attack medical practices themselves. Thus, there are indeed limits to what is culturally viable, and these limits constrain those seeking to challenge (and reconfigure) medical and legal power. In these ways, the potential cultural and political impact of the birth movement is muted, and a new hegemony in which a “legitimate” and professional midwifery is pitted against its “illegitimate” counterpart appears to be emerging (see also Lay 2000). Hegemony, then, may not be permanent, but it clearly shapes the terms and terrain of struggles for change, limits what is realizable, and transforms those who seek to dismantle it in fundamental and long-lasting ways.

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Appendix A. State-by-State Legal Status of Independent Midwifery

| State | Legal in: (30 states) | | | Legal Status Unclear (12 states) | | Prohibited by: (10 states) |
|-------|--|---|--|---|--|-------------------------------|
| | Licensure (L) Certification (C) Registration (R) Documented (D) Permit (P) | Judicial Interpretation or Statutory Inference | Not Legally Defined, but Not Prohibited | Statute Exists, but Licensure Is Unavailable | Statute, Case Law, or Stricture of Safe Practices | |
| AK | L | | | | | |
| AL | | | | X | | |
| AR | L | | | | | |
| AZ | L | | | | | |
| CA | L | | | | | |
| CO | R | | | | | |
| CT | | | X | | | |
| DE | P | | | | | |
| DC | | | | | X | |
| FL | L | | | | | |
| GA | | | | X | | |
| HI | | | | X | | |
| ID | | X | | | | |
| IL | | | | | X | |
| IN | | | | | X | |
| IA | | | | | X | |
| KS | | X | | | | |
| KY | | | | | X | |
| LA | L | | | | | |
| ME | | X | | | | |
| MD | | | | | X | |
| MA | | X | | | | |
| MI | | X | | | | |
| MN | L | | | | | |
| MS | | X | | | | |
| MO | | | | | X | |
| MT | L | | | | | |
| NE | | | X | | | |
| NV | | X | | | | |
| NH | C | | | | | |
| NJ | | | | X | | |
| NM | L | | | | | |
| NY | * | | | X | | |
| NC | | | | | X | |
| ND | | X | | | | |
| OH | | | X | | | |
| OK | | X | | | | |
| OR | Voluntary-L | | | | | |
| PA | | X | | | | |
| RI | * | | | X | | |
| SC | L | | | | | |
| SD | | | X | | | |
| TN | C | | | | | |
| TX | D | | | | | |
| UT | | X | | | | |
| VT | L | | | | | |
| VA | | | | | X | |
| WA | L | | | | | |
| WV | | | X | | | |
| WI | | | X | | | |
| WY | | | | | X | |

*Denotes states in which statutory law permits licensed midwives to practice but licensure is unavailable without a CNM degree (counted in "legal status unclear" category). Table adapted from MANA, the Midwifery Education and Accreditation Council, and the North American Registry of Midwives. Data retrieved August 18, 2003, at <http://www.mana.org/statechart.html>.