CLAIMING RESPECTABLE AMERICAN MOTHERHOOD: HOMEBIRTH MOTHERS, MEDICAL OFFICIALS, AND THE STATE

Based on ethnographic research regarding public policy and grassroots organizing for midwifery in Virginia, this article explores how medical discourses around appropriate health care practices intersect with state discourses about what practices are considered “respectable” versus “pathological” for its citizens. In recent legislative debates about the legalization of direct-entry midwifery, medical officials have extended their criticism of midwifery and homebirth to mothers who resist state-sanctioned childbirth practices. This article examines how medical officials challenge the respectable mothering practices of homebirthers by linking them with women they deem pathological—child abusers, negligent mothers, and drug users—and placing them outside the cadre of “normal” American mothers who acknowledge the “logical” and “natural” superiority of biomedical childbirth practices. I also address homebirth mothers’ responses, which assert that their political advocacy for midwives is a respectable mothering practice because they are responsible citizens who desire what they deem the best care for their children. [medical discourse, motherhood, authoritative knowledge, health care activism, midwifery]

INTRODUCTION

Since medical licensing campaigns gained government support in the early 1900s, challenges and alternatives to the biomedical paradigm have fallen under the scrutiny and control of the state (Baer 2001; Morgen 2002:130). Through the regulation and licensure of health care professionals, judicial cases involving alternative practitioners, and legislative attempts to legalize the practices of alternative health care providers, medical discourses around appropriate health care practices have often intersected with state discourses about what practices are considered “respectable” versus “pathological” for its citizens. In particular, biomedical metaphors and beliefs about health that incorporate core American values, such as the authority of technological progress and mechanistic models of
the body and its repair (Davis-Floyd 1992; Martin 1987; Stein 1990), allow medical officials to assume an authoritative role regarding health care practices within the legislative arena. In this article, I address ways in which dominant biomedical and state ideologies around childbirth and mothering collude to regulate women’s reproductive options, in this case by restricting access to homebirth midwives.

Medical and state officials have historically justified state regulation and biomedical management of reproductive health care by highlighting the “pathological” practices of mothers—particularly mothers who challenge dominant American trends and ideologies around childbirth (Cruikshank 1999; Edwards 1999; Hyatt 1999; Lopez 1997; Morgen 1988; Whiteford 1996; Williams 1996). By accusing mothers of bad behavior toward or in relation to their children, medical officials join the state to contend that they are better equipped to make decisions regarding childbirth and mothering practices than the mothers they deem delinquent. Definitions of what constitute good childbirth decisions and respectable mothering practices, however, are not always in agreement. For example, conflicting advice from medical experts about the efficacy of breast-feeding versus formula feeding puts mothers in a precarious position; whether they choose to breast-feed or use heavily marketed infant formula, they are often castigated for not doing what is “right” for their children (Ward 2000:37). The construction of what is and what is not a respectable mothering practice and women’s responses to these categories and reprimands are issues of concern in this article.

In particular, I examine the presentation of respectable versus pathological motherhood in debates around the legalization and licensure of direct-entry midwives (DEMs), non-nurse midwives who specialize primarily in homebirths, in Virginia. Unlike the vocal midwives advocating for their profession in many states, Virginia midwives have been relatively quiet on the political front because of a statute that prohibited DEMs from receiving compensation for midwifery services between 1977 and 2003. After this statute was struck down in 2003, midwives became more public in legislative efforts (see the Epilogue for further information). Prior to 2003, however, it was primarily mothers who sought homebirth midwifery services who supported DEM in public debates with medical officials. I have followed these grassroots organizing efforts and the legislative developments around midwifery in Virginia since 1999 and have conducted interviews with 40 midwifery proponents throughout the state. In addition, I recorded and transcribed legislative hearings in the Virginia General Assembly where midwifery proponents, medical officials, and lawmakers have debated the efficacy of homebirth and the licensure of DEMs. The testimony I discuss in this article occurred between 2000 and 2002—when homebirth mothers were at the forefront of public advocacy for DEMs.

Published accounts of legislative debates in other states indicate that the assessment of good and bad midwives has been a primary concern during efforts to license midwives (Lay 2000b; Miller 1999). In the Virginia legislature, however, it has been activist mothers who have borne the brunt of the attacks against midwifery and homebirth in Virginia, as medical and state officials evoked the image of “bad mothers” and their “bad babies” to make a case against midwives. Conversely, homebirthers highlighted the links between bad, interventionist, corporatized biomedicine and what they perceived as ill-informed state sanctions against midwives. For homebirthers, claiming respectable American motherhood
also rested on core American values—those of self-reliance, independence, and pragmatism around their health care decisions.

In this article, I first analyze the testimony of medical officials opposing the legalization of DEM in Virginia’s state legislature to illuminate ways in which medical discourse undermines proponents’ efforts by challenging not just the childbirth practices but also the mothering practices of homebirth mothers. I highlight the pervasive use of pejorative stereotypes by medical officials to frame contemporary midwifery supporters as bad mothers for participating in homebirth and, thus, as bad citizens for participating in political advocacy for an illegal activity. I also examine homebirth mothers’ responses to this discrediting discourse within the state legislature and among their own community of midwifery advocates. I demonstrate how midwifery supporters link their negative experiences within the legislative arena to their disempowerment in medical settings. I draw attention to the self-presentation of midwifery advocates as volunteers and mothers in contrast to the paid lobbyists representing medical societies and the government. Even as midwifery advocates point out how medical discourses pathologize resistant and politically active mothers, they also identify individuals within state and medical institutions who support midwifery. By aligning themselves with lawmakers and health care officials who are sympathetic to their cause, midwifery advocates assert their respectability as mothers and citizens. In contrast to medical officials, who question homebirth mothers’ good citizenship practices, midwifery advocates see themselves as respectable citizens because they are active in the political process as mothers, pursuing what they believe is best for themselves and their children.

Authoritative Knowledge and Medical Discourse

Brigitte Jordan’s research on authoritative knowledge in obstetrics and midwifery (1978, 1989, 1990, 1997) describes how the ascendance and legitimation of the biomedical model as the authoritative knowledge system around health care and childbirth in much of the world has resulted in the devaluation of alternative knowledge systems as backward, naive, and potentially troublesome. The constitution of biomedical ideologies as authoritative knowledge is a social process—one through which “all participants come to see the current social order, that is, the way things (obviously) are” (Jordan 1997:56). Moreover, in the medical discourse between a doctor and a patient, participants are often not consciously aware of these assumptions.

The conventions for a traditional type of consultation between doctors and patients embody “common-sense” assumptions which treat authority and hierarchy as natural—the doctor knows about medicine and the patient doesn’t; the doctor is in a position to determine how a health problem should be dealt with and the patient isn’t; it is right (and “natural”) that the doctor should make the decisions and control the course of the consultation and of the treatment, and that the patient should comply and cooperate; and so on. [Fairclough 2001(1989):2]

Physicians who oppose the legalization of DEM rely on the biomedical model’s firmly entrenched role as the authoritative system for health care in American society, as well as their own unquestioned professional authority within this model in their lobbying efforts with the state. They do so in part by allying themselves with state concerns for public health and safety and by assuming the role
of arbiters of societal standards around mothering and childbirth. Thus, together with state officials, physicians create a shared authoritative knowledge regarding the management of health care for mothers and babies. Public commentary by these opponents of homebirth midwives not only addresses proposed legislation to legalize DEMs, but also makes broader pejorative statements about homebirth as an alternative knowledge system for childbirth and the mothers who support this alternative system. As Jordan and Fairclough propose, this discourse makes it “obvious” and natural that hospital birth is a norm to be maintained.4

In this section, I analyze several excerpts from medical officials’ testimony before the Virginia General Assembly regarding proposed pro-midwifery bills to show how ideas of pathological motherhood were constructed. The examples I present highlight three themes in this discourse and appear in chronological order to reflect the progression from commonsense discussions of medical authority around childbirth to an emphasis on homebirth mothers’ divergence from authoritative trends in American childbirth to the explicit construction of homebirth as an example of negligent and pathological motherhood.

Background: A Brief History of Midwives in Virginia and the Current Legislative Debates

In African American Midwives in the South, Gertrude Fraser (1998) reviews how state and medical officials worked in partnership to systematically eliminate midwives in Virginia, as well as in many other southern states, during the early to mid-1900s. Particularly during the movement to improve maternal and infant health care in the early 1900s, midwives came under the scrutiny of increasingly stringent public health regulations, and affluent and middle-class white women, and later affluent African American women, began to employ physicians to attend their births. Although it was primarily African American and low-income white women who had homebirths with midwives into the mid-1900s, homebirthers in Virginia now represent a primarily white constituency from a broad range of class backgrounds (Craven In press).

As Fraser (1998:103) reminds us, when African American women finally gained access to hospitals after being denied even basic medical care for many years, most rejected homebirth as a way to distance themselves from the pejorative racial stereotypes associated with the African American midwife. Conversely, after many middle-class white women became dissatisfied with hospital birth during the natural childbirth movement of the 1960s and 1970s, the subsequent “homebirth renaissance” in the 1980s prompted a resurgence of interest in midwives to attend childbirth in the home (Davis-Floyd, Pigg, and Cosminsky 2001:106).

By the 1990s, a cross-class movement for midwifery had begun to develop in Virginia, forming an unexpected, and at times uneasy, alliance between largely middle-class and affluent natural childbirth proponents and the low-income women who continued to rely on midwives for prenatal care and deliveries in many rural areas of the state (Craven In press). One rurally based Virginia nurse-midwife, who operated a homebirth service from 1984 to 1997, recalled her surprise at learning the diverse motivations for women who sought midwives in her published diary:

One of my first lessons was that many people who called for my services did not necessarily subscribe to the philosophy of the home birth movement. I learned
quickly that just as not all midwives are alike, not all people who choose home birth are alike. Not all of the people who called wanted the privacy, the dignity and the “naturalness” that come with having a baby at home. A lot of people called me because they didn’t have insurance and they couldn’t afford the doctor or the hospital. [van Olphen-Fehr 1998:103]

Although many underground midwives attended homebirths during the 1980s and 1990s in Virginia with little interference from the state, increased investigations of midwives in the 1990s and the prosecution of a prominent Virginia midwife escalated concerns for underground practitioners and their clients (Craven 2003:8–15). Homebirthers began to organize locally in many areas of the state and, by the late 1990s, homebirth proponents were actively pursuing legislation that would make DEM legal in Virginia. Responding to their constituents, lawmakers initiated the Joint Commission on Health Care (JCHC) Midwifery Study in 1999, which concluded that it was advisable to legalize DEM in Virginia and that the state should license certified professional midwives (CPMs) as a mechanism for doing so. However, during the following three years (2000, 2001, 2002), when midwifery proponents introduced legislation to that effect, the bills were rejected before even reaching the House or Senate floor. The strong lobby of various medical groups in Virginia was instrumental in effecting these decisions.

Each year, attending members of the Health, Welfare, and Institutions Committee (HWI Committee) listened to 15 minutes of testimony from both opponents and proponents of the bills before defeating the bills. Opponents included representatives of the Virginia Obstetricians and Gynecologists Society (VA OB/GYN Society), the Virginia Section of the American College of Obstetricians and Gynecologists (VA-ACOG), and the Medical Society of Virginia. Proponents included representatives of grassroots organizations supporting midwifery, CPMs who had practiced legally in other states, and supportive Virginia certified nurse-midwives. After each presentation, delegates were given time to ask questions of speakers regarding the specifics of their presentation and the bill in general. On several occasions, these questions provoked lengthy conversations among participants regarding three main themes: the safety and risks of homebirth, the training of midwives, and, as I highlight in this article, the rights of parents to choose appropriate health care for their children.

It would oversimplify the legislative process—as well as the persuasiveness of unregulated campaign contributions by well-funded medical organizations and individual physicians in Virginia—to account for any of these examples as the single defining argument that won the case for opponents of midwifery legislation. However, it was clear that legislators gave at least tacit approval through nods and affirmative gestures when medical officials presented “commonsense” arguments that linked the medical management of childbirth to government control over mothering practices. In contrast, legislators were generally inattentive to the presentations of midwifery proponents.

“Birth Is, by Nature, a Medical Event”: Medical Authority as “Common Sense”

In the first HWI Committee hearing regarding CPM licensure in 2000, Dr. John Partridge spoke in opposition to House Bill 1470 (Commonwealth of Virginia 2000; hereafter House Bill is referred to as HB), representing the VA
OB/GYN Society and VA-ACOG. He began his presentation by touting the medical advances in maternity care over the past hundred years:

Modern medicine has brought maternity care to an ever-safer level and loosening the standard would place mothers and babies at risk. . . Birth is, by nature, a medical event. /In contrast, homebirth is/ a slippery slope, like driving a car without brakes. You may do okay on level ground with no turns, but when the road starts going downhill, and you start making some turns, it gets very dicey. . . Isn’t it logical to think hospitals and doctors have made birth safer? /I hope that you will/ preserve the public health of mothers and babies by preserving the current statutes. You’ ll hear mothers talk about preserving their right to choose, but I ask you, what about the baby’s choice? [John Partridge, HWI Committee meeting, February 8, 2000]

Drawing on an ideology of medical superiority embedded within his discourse (Fairclough 2001[1989]:65), Partridge primed his audience for his “commonsense” assertion: Birth is, by nature, a medical event. Thus, when Partridge invoked nature as an analogy for medicalized childbirth, he spoke to assumed societal standards of risk in childbirth, as well as the naturalization of the contemporary power of the biomedical model in the United States. Partridge’s analogy, which linked driving a car without brakes to the dangers he associates with homebirth, served as additional reinforcement of the authority and hierarchy of the biomedical system by applying to homebirth with midwives the long-established medical metaphor of the body as machine and the physician as mechanic (Martin 1987:56; Rothman 1989:55–57, 171). Clearly, Partridge suggested, CPMs lack the tools to deal with complications in labor. As Jordan reminds us, what is so persuasive about authoritative knowledge is that “it seems natural, reasonable, and consensually constructed” (Jordan 1997:57). Therefore, it came as no surprise when Partridge suggested, commonsensically, that homebirth mothers are unnecessarily risky in their choice to birth outside the hospital: Isn’t it logical to think that hospitals and doctors have made birth safer? In answer to his rhetorical question, Partridge asked delegates to join him to preserve the public health of mothers and babies, linking his role as a physician and the state’s role as protector of the health of its citizens. This strategy is doubly effective because the statement places the power and authority of good outcomes with physicians and the state, while bad outcomes remain the responsibility of the mother.

Further, Partridge countered women’s right to choose nonmainstream reproductive health care with a familiar slogan from the pro-life movement: What about the baby’s choice? This final statement draws attention to connections between advocacy to gain access to midwives and social movements around other reproductive health issues. As Pamela Klassen reminds us:

Arguments against homebirth that belittle women’s experiences of birth (of the “if you want an experience, ride a roller coaster” variant) and refuse to acknowledge women’s right and responsibility to choose their desired place to give birth, fit along a continuum with . . . fetal rights arguments. They downplay a woman’s role and experience giving birth in place of emphasizing the “outcome” of the baby. However, in a society that proclaims passionate interest in healthy babies, but then fails to find solutions to the problems of child poverty once those babies age, these are not so much positive arguments guarding the baby as they are negative arguments circumscribing the autonomy of the birthing woman. [2001:61]
The “logic,” “nature,” and “commonsense” of medical authority around childbirth was central to medical officials’ devaluation of homebirth and more importantly, homebirth mothers.

“In Homebirths Either Myself or My Children Would Have Been at Risk”: Biomedically Managed Childbirth as a Signifier of Respectable American Motherhood

Dr. Anne Petersen, commissioner of the VDH, coordinated the testimony of the opposition to the bill reintroduced to legalize the licensure of CPMs in the 2001 HWI Committee hearing (Commonwealth of Virginia 2001:HB 1582). She opened the opposition’s commentary by explaining her own position as a mother who made the mainstream choice to deliver her children in the hospital. It was an important feature in the personal testimony and childbirth narratives offered by female physicians that they were able to claim authoritative knowledge about childbirth and motherhood as both physicians and respectable mothers themselves.

Female medical officials relied on their own experience of childbirth and motherhood as a mechanism to question the legitimacy of homebirth mothers’ childbirth decisions. In this excerpt, Petersen uses her own experience in childbirth to reaffirm Partridge’s statement from the year before that the decisions of homebirth mothers are dangerous to themselves and their babies. Further, she places homebirth mothers outside the cadre of normal American mothers who accept the biomedical management of labor and delivery as the only way to reduce risks associated with childbirth.

I myself had low-risk pregnancies and high-risk deliveries and in home births either myself or my children would have been at risk. . . /Birth/ is a place where Americans have spoken very strongly about their willingness to take on risk relative to deliveries. OB/GYN doctors pay more malpractice than most other physicians and family practitioners who do labor and delivery services pay more than family practitioners who do not do it. So, Americans have really spoken to the amount of risk they are willing to accept in this arena. [Anne Petersen, HWI Committee meeting, January 30, 2001]

Petersen separates homebirth mothers’ from American mothers who acknowledge high risks in pregnancy by their willingness to go to the hospital (and to litigate when things go awry, as indicated by rising malpractice rates). She also implies that homebirth mothers do not accurately assess the risks associated with childbirth and do not uphold American values when they refuse to abide by the mainstream childbirth paradigm to lessen those dangers.

The strategy of rebuking homebirth mothers’ for their inability to assess risk was also common among physicians seeking the elimination of midwives in the early 1900s. For example, early 20th-century medical reports in Virginia impugned African American women for their “inattention” to their prenatal care, their “failure” to report “danger signals” during pregnancy, and their “insensibility” to the health of their newborns (Fraser 1998:132). These women’s “failure” and “insensibility” was often considered a result of their continued use of midwives, particularly among poor women as segregated hospital clinics became available to middle-class and affluent African Americans in the mid-1900s. Few of these reports ever addressed the economic impoverishment in African American communities
at the time as a factor in high infant and maternal mortality statistics (Fraser 1998:86). In contrast, medical reports at the turn of the 21st century rarely mention the relatively good health of most contemporary homebirth mothers, or the better-than-average health of their babies (Declerq, Paine, and Winter 1995:480).10

“It Only Takes One Bad Baby”: Constructing the Choice to Homebirth as Pathological Motherhood

Throughout the recent debate over legalizing DEMs in Virginia, physicians have maintained that mothers who choose homebirth were bad mothers. For example, the president of the VA-OB/GYN Society explained to lawmakers in 2000, “I call homebirth the earliest form of child abuse” (LeHew as cited in Forster 2000:A). As the public debates waged on from 2000 to 2002, the medical opposition became more insistent that it was indeed state and medical officials who were more competent than mothers and parents to judge the “best interests” of Virginia’s future citizens.

In the 2002 HWI Committee hearing regarding several bills to license DEMs through different state regulatory structures (Commonwealth of Virginia 2002a:HB 889; Commonwealth of Virginia 2002b:HB 890; Commonwealth of Virginia 2002c:HB 891),11 a state delegate asked Dr. Steven Bentheim, a representative of VA-ACOG and the VA-OB/GYN Society: “But doctor, any patient has the right to consent to treatment, and if it is a minor child, then I, as the parent, am the one responsible for giving consent for that minor unless you want to go through a legal process to take my parental rights away. That is the current law, am I correct?” In response, Bentheim constructed the mother’s choice to homebirth—not just the practice of midwifery—as a pathological behavior by linking it with criminal acts, such as negligent motherhood and illegal drug use.

I think that sometimes uh- that the mother’s decision to deliver at home is not always in the baby’s best interest, although, I think she might think it is. I’m not sure it is. . . . I do think that we also have to have minimal requirements over parents in the care of their children. We don’t let them be-, in the news, a parent that goes to the store and leaves her child at home, the house burns down, she, you know, it was her prerogative to leave the child at home while she went. She thought that it was okay for the child to do so, but she is then-, you know Social Services or whoever may come in and investigate that. She may be /responsible/ or something. So, I think, once again, we have to-, hopefully try to find what we think is in the best interest of the mother and also in the best interests of the child. . . . But life is precious. And I’m telling you that these are children and it only takes one bad baby, or two bad babies to make you realize-. . . . I’m trying to think of how to say this uh, I’m not sure that just because it is going to happen that you have to-, you have to go along with it. Just the same way that we don’t legalize drugs and I mean we don’t say “okay, you know what, people are going to use drugs” and again this is probably a bad analogy again, but people are going to make decisions for themselves and they’re going to do it even though it isn’t in their best interest. [Steven Bentheim, HWI Committee meeting, January 24, 2002]

In his answer to a delegate’s question about the rights of parents regarding their children’s health care, it is notable that Bentheim shifts to the use of a feminine
pronoun in his response; he invokes the idea of the pathological parent that goes to the store who leaves her child unattended, thereby specifying the mother as the negligent or bad parent. Bentheim also transitions from a parent leaving her child at home, to best interests of the indefinite the child and the mother, effectively removing the individual mother’s agency, possibly because of her “bad choices” for her child. This strategy serves to legitimize the state’s and medical system’s responsibility for the welfare of their citizens, both mother and child, and delegitimizes those mothers who do not follow their regulations.

The mother’s departure from the private space of the home is also important when she leaves her child at home to go to the store. Ultimately, a public state body, Social Services or whatever, must intervene in the mother’s private space to investigate whether she may be held responsible and ensure her good mothering behavior. This admonishment effectively argues against women’s legal rights to make mothering and childbirth choices in the home by linking homebirth mothers to negligent mothers. Notably, Bentheim’s testimony contradicts the current state regulations around homebirth, that he wishes to uphold, which maintain it as a legal choice for Virginia women (albeit without a compensated practitioner).

Additionally, Bentheim’s use of oppositional discourse against an unidentified them in the beginning of his answer extends his personal testimony against midwifery to evoke the responsibilities of both physicians and the state as a whole to protect Virginians: we have to do what is in the best interests of the mother and the child. Bentheim emphasizes the role of the state and physicians in regulating the mothering practices, and by extension the birthing practices, of potentially negligent mothers. Bentheim also transitions from talking about the mother neglecting her the children in the last passage, to return to the potential hazards mothers pose to their babies. Similar to ways in which pro-life advocates humanize babies (as opposed to fetuses) whose lives are ended by abortions, Bentheim draws on the sympathies of the audience against a mother who would choose alternatives to mainstream childbirth practices that he deems unsafe for her baby. In fact, he cautions against producing bad babies, instead of, perhaps, bad outcomes, which conveys the pathology ascribed to homebirthing mothers further onto their children. As Susan Hyatt suggests in her study of the medicalization of motherhood among poor women in Britain, medical and state officials often identify the mother “not primarily as an individual in her own right but . . . rather, as someone who [stands] in a metonymic relationship to the entire population . . . the conduit through which her children [are] to be made into productive and healthy citizens of the state (or not)” (1999:103). Therefore, if a mother is risky or otherwise deemed unfit, her unfitness could potentially be passed along to her children.

Further, Bentheim’s equation of people who are going to use drugs and people who are going to make decisions for themselves, presumably to homebirth, shows how he links negligent mothers, illegal drug users, and homebirth mothers. Ultimately, Bentheim implies a metonymic connection between individual women’s “bad choices” in childbirth and the health of society at large by likening homebirth to practices that most audience members (including delegates and homebirth proponents) would agree are indeed bad choices. This strategy allows Bentheim to mark homebirthing simultaneously as a symptom of pathological motherhood and a practice to be restricted, if not abolished, by the state.
The state’s regulation and punishment of women whom it deems pathological mothers is hardly a new phenomenon—consider the discrediting discursive constructions that have become emblematic of “undeserving” women in the media, such as “welfare queens,” “crack moms,” and “promiscuous unwed mothers” (Cruikshank 1999; Edwards 1999; Morgen 1988; Naples 1998; Whiteford 1996; Williams 1996). It is also nothing new that women who do not follow mainstream childbirth norms are labeled bad mothers and bad citizens (Feldstein 2000; Fraser 1998; Gordon 1994; Hyatt 1999). In one example, Linda Whiteford shows how drug-addicted mothers (and their fetuses) are punished “for being poor, pregnant, and drug addicted in a society that denigrates each of those conditions” (1996:249). Particularly, she argues that drug-addicted women who attempt to protect themselves and their fetuses from going to jail by avoiding prenatal care are identified as pathological criminals if it is proved that they have used certain drugs in pregnancy. Ironically, the state punishes these women (and their fetuses) further by denying them both prenatal care and addiction treatment while they serve jail terms. Although I would not equate homebirth with drug addiction during pregnancy, as Bentheim seemed content to do in front of the Virginia General Assembly, both examples illuminate how pejorative stereotypes about mothers who attempt to protect themselves and their children outside of state-sanctioned models are used to devalue their status as good mothers and good citizens.

Midwifery Advocates’ Responses to Medical Discourse in the Legislature

Midwifery advocates’ testimony during legislative hearings and their subsequent accounts of the hearings in conversation with each other were important features of the political mobilization around midwifery in Virginia. During the hearings, speakers in favor of the legislation presented studies on the safety of homebirth, outlined CPMs’ extensive training, and responded to claims by medical officials that they were pathological mothers. Afterward, in my interviews, many participants cited their attendance with other advocates at legislative hearings as one of their most important contributions toward gaining access to DEMs in Virginia.

Midwifery advocates’ frustration with state and medical officials’ portrayal of homebirthing women as pathological mothers and the disregard of their rights as citizens were dominant themes in their narratives. Participants exposed medical officials’ attempts to link state and medical ideologies around childbirth and mothering practices. They challenged medical claims to authority with the state over the stewardship of mothers and babies. Further, midwifery advocates challenged medical claims that their desire to homebirth negated their status as respectable mothers. In fact, many homebirth mothers argued that their choice to birth at home actually reinforced their claims to respectable motherhood, as they protected their babies from what they deemed unnecessary medical and state interventions.

“We’ve Decided for Ourselves and Our Babies”: Reclaiming Respectable American Motherhood

Speaking for the grassroots pro-midwifery organization, Virginia Birthing Freedom (now Virginia Friends of Midwives), Ellen Hamblet formally challenged
opponents’ claims against homebirth and homebirth mothers in the HWI Committee meetings. Like female doctors who relied on their own status as mothers as well as their professional credentials to bolster their claims to authoritative knowledge, Hamblet presented herself as a mother concerned with the safety of her children alongside her professional credentials—her service in the U.S. Navy and her position as the codirector of a grassroots pro-midwifery organization. Challenging physicians’ assumptions of what normal Americans desire in childbirth, Hamblet argued that women who desire homebirth are indeed concerned with the health and safety of babies, and by extension, are also normal respectable American citizens.

When it comes down to the bottom line, we are all, everybody in this room, concerned with the health and safety of babies. So, we should be able to start with this bottom line and build something that we all can be proud of as a way, as Dr. Peterson said, to support midwives in Virginia, and also to allow families to make the informed legal choice to have their babies at home, to be able to hire a midwife. . . . Most of us never have the occasion to even wonder about whether the hospital is a safe place to be in birth. That’s the way we do it in this country. That’s the way most of us did it for our first pregnancies. Most women never have a chance to come back and question that decision, never have reason to come back and question it because their experience in the hospital is great. They have a great doctor, they have a great hospital, everything works the way it’s supposed to be, they feel well served by the system. Those are not the women in this room today. We are mostly women who have gone and have had bad experiences with hospital birth and feel that these experiences were unnecessarily dangerous, that they were at a minimum disrespectful, and they scared us and made us feel that this is not the place we wanted to go necessarily for birth. . . . I’ll tell you, we’re a bunch of Moms here and what we know is that we’ve done a lot of research, that we’ve decided for ourselves and our babies that we want to have a homebirth. We’re telling you that we need to be able to hire a midwife to do that. We’re telling you that we can’t hire midwives right now because there is no path, there’s no way to do that in Virginia . . . legally. And so, we’re telling you that we need your help. [Ellen Hamblet, HWI Committee meeting, January 30, 2001]

Unlike physicians’ accounts of risky and ill-informed mothers, Hamblet portrays homebirth parents as normal American moms who have rationally chosen to question childbirth in the hospital, especially after their negative experiences in hospitals during previous births. Hamblet challenges the commonsense logic that all births are medical events and need to be attended by physicians in hospitals. By focusing on the logic and rationality of homebirth mothers’ concerns, Hamblet effectively pleads for the protection of the state regarding women’s legal right to choose homebirth. By countering medical challenges that suggest the negligence or insensibility of homebirth mothers toward the welfare of their children, Hamblet attempts to legitimate not only homebirth, but also the responsible decision-making strategies of homebirth mothers. Hamblet characterizes homebirthers as respectable American mothers, precisely because of their pragmatic decisions around childbirth and the health of their children, particularly after experiencing dangerous and disrespectful treatment in the hospital. Just like all respectable American mothers, homebirth mothers want what they deem the safest for themselves and their babies.
Hamblet was not alone in her dissatisfaction with medical officials’ portrayal of homebirth mothers in the legislature. Although other advocates did not respond formally within the General Assembly, many wrote letters to lawmakers, newspapers, and even the opposing physicians themselves. Midwifery advocates also responded privately to the charges leveled against them, both on listservs and in conversations with other advocates. What follows is a selection of these responses from my interviews with midwifery advocates.

“I See It Very Clearly as Rape Now”: Homebirth Mothers versus Medical and State Officials

Nearly all of the participants in my study expressed a sense of disempowerment by both the state and the health care system as homebirthing mothers. Indeed, as discussed above, their choice of homebirth is contested publicly in the Virginia legislature. Many midwifery supporters explained that their role as mothers, and certainly as homebirthers, seemed insignificant in this domain; many felt too insignificant, too fringe, too extreme, too ignorant, radical, stupid, naive, and not sophisticated enough to demand rights through political actions as citizens. The following narratives illustrate how midwifery advocates’ feelings of disempowerment, anger, and frustration surrounding medical and state discourse also present challenges to societal standards around medicalized motherhood.

Throughout my fieldwork and interviews, I heard again and again from homebirth mothers that they felt disregarded by both doctors and legislators. For example, Paula Queen uses the metaphor of being raped—both through medicalized childbirth in the hospital and through the big hand of government regulating her childbirth options—to indicate the collusion of state and medical ideologies of childbirth against homebirthing women.

Well, to have a child, you have to play it their way and I see it very clearly as rape now. I’ve been through it I know and that really makes you a certain person, and it also makes me question myself that I was so blinded that I thought—that I was raped, okay? And I can’t even mourn it. I could mourn it by myself, but there’s not that many people that understand it. It’s not like I can go report it to let you know you’re standing up for yourself. It’s really a laying down of one’s self and that’s it. It’s perversion to a very high sense. If you erase it, then you have the other feeling of the baby that makes it all worth it. So, I’m sorry, I see it as a crunch of the big hand of government coming down and doing that and women not even knowing it. That’s the whole thing . . . they really are missing a part of them. You can see it, it’s not there. [personal interview, Paula Queen, April 17, 2002]

Most important to Queen is that women are not even recognizing that both the medical system and the big hand of government have taken their power away from them. She links the disavowal of the mother’s childbirth experience as rape to the positive outcome of having a baby that makes it all worth it (see also Jordan 1997). She attributes this disjuncture to the state itself, not only the medical system that she feels raped her during hospital-based childbirth. In essence, Queen feels that women are being doubly raped by being forced to “choose” hospital birth—both by the politics of doctors in the hospital and by her government that denies her the right to legally choose a midwife to attend her homebirth.
Midwifery advocates also contrasted themselves with lobbyists and state officials by highlighting their status as mothers and demanding their rights as women, mothers, and citizens. In response to my questions about her motivations for political activity around midwifery, Fern Jackson told me an extended narrative about being disempowered by health care workers during her first birth in the hospital and her ensuing efforts to hire a homebirth midwife for her second birth. This process motivated Jackson to become politically active and to examine her role as a reasonable citizen.

I think pretty highly of myself as being very well educated, very concerned about my children and their health and well-being, very well informed, the idea that I could go and do all that research and make my decision, okay, this is what is best for me and for my family, umm, and then to have the state tell me, “No, you can’t make that decision because you can’t hire a midwife for homebirth.” “We think that homebirth is too dangerous,” which has been their stated objection. . . . It’s so anti-American, it’s anti—everything this country stands for and I umm, am pretty committed to the kind of ideals that the country stands for. . . . And I don’t think I can point to a specific place where it [the Constitution] says it, but it certainly implies in there that reasonable citizens should be able to do their own research and make their own decisions about something like who they want to hire, where they want to give birth to their baby. And the state has no business in standing in the way of that. That’s not why states were founded or constructed to basically, ya know, to protect the monopoly on health care by the medical system. [personal interview, Fern Jackson, September 13, 2002]

Jackson argues that she, as a reasonable citizen who is well educated and well informed, should be able to choose where and with whom she gives birth. Further, she challenges medical claims that the choice of homebirth is un-American: I am pretty committed to the kind of ideals that the country stands for. Rather, she contests that it is anti-American, it’s anti—everything this country stands for for the state to restrict citizens’ access to the health care practitioners of their choice and protect the monopoly of health care by the medical system.

Likewise, Evie Diaz expressed her frustration that citizens, in contrast to paid lobbyists, were dissuaded from participating in the legislative process. The narrative below followed questions I asked regarding Diaz’s attitude toward political activity. Her initial response was brief: “Um, let me see how to say this, um, that our freedoms are for sale to the highest bidder?” In turn, I asked: “How do you see that impacting what is being done politically [for midwifery]?”

We would have to sit through so many other issues and we were the only citizens down there. Everyone else—, were lobbyists who—, hired guns to go get something for their, um, um, industry that was paying them to be there. And we were a buncha moms with an occasional dad. . . . And h—how insignificant we were viewed. I mean, it has been, well it’s, it’s, it’s obstetrics all over. /We were/ so disrespected. They really did not want to see us and then somebody would pull a boob out or a baby would cry (laughing) or you know and they’re just like “Oh, God?” I mean, [Linda Darner] posted [to a listserv] that you know “this is called confrontational po—, um lobbying” or whatever that for the governor’s office and I’m like (smacks tongue on the roof of her mouth in a chiding manner), I’m thinking we’ve been pretty confrontational from the beginning just cause we showed up. They have not known what to do with us. We were told we had bad manners. [personal interview, Evie Diaz, February 3, 2001]
Diaz initially sets up we broadly as midwifery advocates, and more specifically as citizens. By downplaying the political importance of citizens as a buncha moms with an occasional dad against lobbyists, everyone else, and hired guns who are paid to go get something for their industry that was paying them to be there, Diaz highlights the importance of advocates as volunteers.

It comes as no surprise that it is (mainly) women who are participating as volunteers, in contrast to (mainly) male legislators and lobbyists who are paid to attend these hearings. The implicit valuation of wage work in Diaz’s narrative, and also in larger societal discourses around women’s citizenship (Hyatt 2001; Kessler-Harris 2001), forces anthropologists to consider how women’s status as mothers, homebirthers, and grassroots volunteers contribute to and restrict their claims to rights as citizens. As Susan Hyatt (2001) indicates, the recent public celebration of “volunteering” and the “spirit of service” for the United States—see, for example, State of the Union addresses by Bill Clinton and George W. Bush around the turn of the 21st century—suggests a new kind of political subject. Volunteers under this political rhetoric do not share both rights within and responsibilities to the state as the citizen does. Rather, they function only in obligation and service to the state—effectively removing the state’s obligation to protect the freedoms and social, political, and economic rights of these individuals (Hyatt 2001:205). Women have been the primary volunteers under this new model of political subjects (Hyatt 2001:208).

Echoing the concerns of other advocates that medical lobbyists and legislators saw midwifery advocates as mothers with bad manners, Diaz uses adjectives, such as insignificant, disliked, and confrontational to describe midwifery advocates in contrast to hired, paid medical lobbyists in the General Assembly. Michael P. Brown (1997) suggests that activists often identify themselves in contrast to state officials: “In the citizens that we imagine, the voters, grassroots volunteers, and clients are recipients of urban services, while the bureaucrats are paid employees, professionals, and experts inside of, and embodying, the state” (1997:85). Diaz first identifies they as lobbyists and then they become an amalgamation of medical lobbyists and legislators when she suggests they really did not want to see us. And then somebody would pull a boob out or a baby would cry (laughing) or you know and they’re just like ‘Oh, God?!’ Diaz alludes to both medical lobbyists and state officials in this instance by suggesting their joint discomfort with an openly nursing mother, and more specifically when she likens her experiences within the legislature to the disrespect she and other women have faced during childbirth experiences in the hospital, it’s obstetrics all over. /We were/ SO disrespected. Diaz’s equation of these groups is hardly surprising, as she and other midwifery supporters have witnessed legislators side with the powerful medical lobby again and again in past years. At the same time, the dichotomization of mothers against state and medical interests in childbirth poses challenges to advocates as they attempt to work within the legislative system to legalize homebirth.

“My Friendly Policeman”: Complicating Midwifery Supporters’ Views of State and Medical Communities

In addition to advocates’ apt consideration of the links between medicine and the state, and the monolithic, bureaucratic power structure, which appeared
unbending to their desires for legal homebirth with midwives, many midwifery supporters also observe cracks and contradictions within this structure. For example, the chief patron of pro-midwifery legislation, Delegate Phil Hamilton, was quite skeptical of homebirthers when midwifery advocates first approached him about pro-midwifery legislation. Terri Jacobs explained: “[Hamilton] is the one who carried the study and who carried the bills. And at first he seemed to be very disinterested, he was just doing it. But he turned into the most interested person in the issue. I can’t believe that he’s taken the stand that he has” (personal interview, August 7, 2001). Many supporters spoke about the importance of sharing personal narratives with legislators at public hearings and in letters. Supportive lawmakers, such as Hamilton, also publicly credited the passion of these narratives as the reason they came to support midwifery legislation (HWI Committee meeting, January 24, 2002).

Outside of the General Assembly, midwifery supporters also recognized both state and medical officials who influenced their institutional system in their support of underground midwives. Even as midwives and their supporters spoke of being harassed by “the state,” they also indicated sympathetic individuals within that structure, such as individual police officers—one midwife even described an officer as “my friendly policeman”—and health department officials who allowed the statute of limitations to run out on investigations to warn, but not actually prosecute, midwives.

Ultimately, homebirthers and midwifery advocates saw themselves as both respectable mothers and upstanding citizens, alongside those sympathetic lawmakers and police officers who agree that midwifery should not be a crime. However, they also recognize themselves as a minority within lawmakers’ constituencies, where female voters are largely satisfied with hospital-birth childbirth; as Ellen Hamblet so aptly put it, “everyone just assumed that . . . families who chose home birth were, well, a little kooky” (Hamblet 2000).

**Conclusion**

I have shown how official medical discourse around midwifery argues that women are not competent to make the choice to have a homebirth because they do not participate in good American mothering practices, particularly by eschewing the mainstream choice to deliver their children in a hospital—where, as both advocates and scholars have argued, they are also devalued and infantalized (Davis-Floyd 1992; Hyatt 1999; Kahn 1995; Martin 1987). This argument enables both physicians and state officials to arrogate to themselves authoritative knowledge around childbirth, as well as the responsibility for the protection and regulation of mothers and babies, thus protecting a monopoly by the mainstream medical industry. Further, this strategy challenges homebirth mothers’ respectability as American mothers and links them with other “pathological” mothers who are at variance with dominant medical and state ideologies around appropriate childbirth and mothering practices.

In response, midwifery advocates have begun to reclaim the notion of respectable motherhood and justify their choice to homebirth as a part of their good mothering practice. Like medical officials, midwifery advocates understand the collusion of medical and state controls over women; they identify the state and
medical community as men wielding power against a group of disempowered homebirth mothers. They also recognize medical and state officials as a group of paid professionals, in contrast to themselves as volunteers and citizens.

Taken together, the dissatisfaction and disempowerment that many advocates feel from both medical and state authorities evidence an understanding of the state and the medical community in coalition—in opposition to a group of women vying for their right to make particular childbirth choices. However, midwifery advocates also see certain contradictions in this hegemonic medical and state power structure, most notably, the state investigators and legislators who have become sympathetic to their cause. Joining these other “good citizens” within the ranks of the bureaucratic structure of the state, midwifery advocates continue their attempts to convince lawmakers of their commitment to both “respectable motherhood” and “respectable citizenship.” Ultimately, it is in relation to the state and medical opposition that midwifery supporters define their political mobilization as mothers and citizens.

Epilogue

In 2003, Virginia legislators struck down the 1977 statute that had made it illegal to accept compensation for midwifery services without a license (granted only to CNMs). Notably, the decision was made relatively quietly, with little opposition from medical officials, and without the public debates that characterized legislative hearings regarding previous midwifery bills. The reasons for this shift have been open to speculation among midwifery supporters, but state and medical officials have subsequently made it clear that rescinding the 1977 law does not protect midwives against charges of practicing medicine without a license or practicing nurse-midwifery without a license. Midwives and homebirthers continue to share concerns over the legal safety of DEMs, especially because medical officials have fought diligently against subsequent bills to license CPMs and legislators rejected bills aimed at licensure in 2003 and 2004.

Since the legislative change in 2003, DEMs have become more politically visible and have been the primary speakers advocating for their licensure at legislative hearings. A bill to license DEMs as CPMs made it through Virginia’s House of Representatives in 2004, but was rejected by the Senate Committee on Education and Health after a physician’s testimony asserting, familiarly, that licensing midwives “would not be in the best interests of the women and children of Virginia” (Robert McBride, Senate Committee on Education and Health hearing, February 24, 2004). One senator also told a personal story before the vote. She explained that her friend had desired a home delivery in 1969, but had had to come to the hospital because both women were in labor at the same time and planned to have the same obstetrician in attendance.13 The senator’s friend had complications, but was treated successfully in the hospital. Afterward, the physician credited the coincidence of the senator’s labor, which required the other woman to come to the hospital, with saving the homebirth-bound woman’s life. The senator closed the story by relaying the physician’s decision never to attend another homebirth.

By the senator’s account, her prudent childbirth choices saved the life of her un-knowing friend, as well as any other homebirthers who might have followed in her footsteps with this physician. She characterized her vote against the bill to license CPMs as an extension of her efforts to protect Virginia women from such choices.
It is clear that despite the increased participation of midwives in the legislative debates over their practice in Virginia, anecdotes implying that women who choose homebirth are uninformed, or must be reckless, remain convincing arguments in efforts to restrict the practice of midwives.

Despite these continued setbacks, as this article goes to press, legislation to license CPMs has just passed through both the Virginia House and Senate and awaits the governor’s signature, to go into effect in July 2005. Midwives and advocates are ecstatic and see the passage of this legislation as evidence that their hard work lobbying legislators over the past eight years has been worthwhile. As Virginia midwives now face the daunting task of negotiating regulations with the Board of Medicine and as homebirthers struggle for access to midwives in other states, the interrogation of claims to respectable American motherhood remain essential to the analysis of health care policy debates, as well as the implementation of laws promising enhanced reproductive rights.

NOTES

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1. Although the term medical discourse has been used almost exclusively to refer to dialogue in the practitioner–patient interaction (Kuipers 1989:109), scholars have also begun to look at how medical discourse is constructed and resisted in discussions among health care recipients (Hamilton 1998; Leap 1991) and within health care policy debates and political activity (Gal 1997; Ginsburg 1987; Lay 2000a). For the purposes of this article, I use this expanded definition of medical discourse to refer not only to the doctor–patient relationship or the interactions among medical staff within and without the hospital but also to the ways in which medical officials talk about health care practices to state policy makers.

2. Direct-entry midwifery is a term that originated in Europe to describe midwives who entered directly into the profession, often through apprenticeship, as opposed to those who entered through nursing schools (Davis-Floyd 1998). The legal status of DEMs varies from state to state and the recent increase in state investigations of DEMs on a national scale has led to debate over the interpretation of existing laws—in some states DEMs are clearly regulated and licensed, in others DEMs are prohibited by law, and in still others DEMs are unregulated and their legal status is vague. For the most current information on the legal status of DEMs in each state and a review of the legal challenges DEMs face under different state laws, see the following websites: http://www.fromcallingtocourtroom.net and http://www.mana.org.

3. My ethnographic research has focused on grassroots organizing for midwifery in Virginia. I have not conducted interviews with opponents of legislation to improve access to midwives, because collective politicization against midwifery comes almost entirely from professional medical organizations. Unlike the independent grassroots organizing by groups such as pro-life and pro-choice activists, there is currently no articulated grassroots movement against midwifery in the United States.
4. Recent research on childbirth and authoritative knowledge has highlighted the construction of alternative models of authoritative knowledge (Davis-Floyd and Sargent 1997), particularly through the practice of midwifery (Davis-Floyd and Davis 1997; Davis-Floyd, Pigg, and Cosminsky 2001). In the second half of this article, I consider how homebirth mothers are also constructing alternative authoritative knowledges about respectable motherhood, in the context of state and medical discourses against both midwifery and themselves.

5. The CPM is a professional credential conferred by the North American Registry of Midwives (NARM), a national certifying body for DEMs. It is a competency-based certification: as Robbie Davis-Floyd explains, “where you gained your knowledge, skills, and experience is not the issue—that you have them is what counts” (1998). Nevertheless, a CPM must “complete a clinical component that is at least one year in length and equivalent to 1,350 contact hours under the supervision of one or more approved preceptors” and must pass a written and clinical examination (North American Registry of Midwives 2003). Additionally, recertification is required every three years.

6. CNMs, who practice primarily in hospitals and must be supervised by a physician in Virginia, are mixed in their support of autonomously practicing DEMs. In 1999, the Virginia chapter of the American College of Certified Nurse Midwives (ACNM) supported legislation to legalize DEMs. As a result of pressure from physicians’ organizations, however, ACNM rescinded their public support in subsequent years. A handful of CNMs, particularly those who have practiced in out-of-hospital settings, continue to support DEMs in their legislative efforts (for additional discussion, see Craven 2003:18 and Craven In press).

7. In fact, during the 2000 HWI Committee hearing, proponents of the legislation to license CPMs spoke first. At the beginning of the proponents’ testimony only 4 of the 22 delegates were in the hearing room. Fourteen others trickled in as the presentations proceeded, but less than half heard any testimony from the bill’s proponents. In subsequent years, proponents opted to give their testimony after the opposition to ensure that delegates were at least present.

8. All transcriptions are mine, with the assistance of Asan Askin, Anna Inazu, Robbie Kaplan, Janet Gallay, and Emily Tumpson on selected interviews and hearings. I identify speakers by name when quoting public discourse, but all references to interviews I conducted with midwives and midwifery advocates are referenced with pseudonyms for their protection. I use the following transcription conventions:

   [brackets] indicate text inserted for clarity
   /backslashes/ indicate unclear portions of recording; transcription is based on field notes
   (text) within parentheses indicate the actions of the speaker, such as (laughing)
   . . . indicates a pause by the speaker
   . . . indicates the omission of text by the author
   text- indicates a word that was abruptly cut off by the speaker
   italics in the body of the article indicate excerpts from transcribed testimony or interviews

9. Two of the three female physicians who spoke in opposition to bills in 2000, 2001, and 2002 mentioned their status as mothers, while none of the six male speakers acknowledged any connections to fatherhood.

10. A stark racial divide continues to exist between the outcomes of homebirths for white women and African American women in the United States. Eugene Declerq, Lisa Paine, and Michael Winter’s (1995) study of U.S. homebirths, as they were reported on birth certificates between 1989 and 1992, found that the majority of homebirths in the United States occurred among white women who tended to have better birth outcomes than those of other white American women. Homebirths among African American women, however, resulted in poorer birth outcomes than those of other African American women (Declerq, Paine, and Winter 1995:480). As Pamela Klassen summarizes, women of color in the United
States still struggle harder for good quality, accessible health care than most of their Euro American counterparts (2001:20; see also Fraser 1998; Whiteford 1996; Williams 1996).

11. In 2002, midwifery supporters strategized with supportive delegates and lobbyists to introduce three bills to regulate DEMs. Their strategy was to show flexibility around requirements, allowing the state to choose which option was most viable within the existing health care system and ultimately pass only one (for additional information, see Craven 2003:21).

12. The medical lobby is powerful in a variety of ways in Virginia (echoing national trends): most specifically, many physicians are socially involved with lawmakers and the health care industry is one of the most substantial financial contributors to lawmakers’ campaigns. According to the Virginia Public Access Project, the “health care industry” was the largest candidate donor industry in Virginia in 2000, the second largest in 2001, and the third largest in 2002 (2003; personal communication, David M. Poole, executive director of VPAP, September 4, 2003). There was no record of campaign contributions by midwifery advocacy groups during this time.

13. A handful of obstetricians attended homebirths in Virginia into the late 1900s. In this case, the senator described the pro-homebirth obstetrician as very avant-garde.

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