

**EDUCATED, ELIMINATED, CRIMINALIZED & REDISCOVERED:
A HISTORY OF MIDWIVES IN VIRGINIA**
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AUTHOR'S NOTE & THANK YOUS

The list of friends, midwives, and midwifery supporters who shaped this history and were kind enough to join me in conversation about their successes and tribulations is far too long to print here. I will just skim the surface and acknowledge that any shortcomings or factual errors in what I have chosen to make of their comments are my own. I have been encouraged and inspired by many midwives and homebirth families throughout Virginia, many of whom have read drafts of my writing, sent me hard-to-find articles from their personal archives, included me in homeschool fieldtrips, and offered assistance in countless ways; particularly, I would like to thank Alice Bailis, Steve Cochran, Juliana Fehr, Ellen Hamblet, Marsha Jackson, Jessica Jordan, Leslie Payne, Brynne Potter, Katie Prown, Patty Ogden, D'Anne Remocaldo, Lois Smith, and Trinlie Wood.

Virginia's history of midwifery is rich with narratives from many published and unpublished accounts over the past decade. From the ethnographic research I conducted from 1999-2003 alone, I could have written a full-length book documenting the intricate stories and experiences of contemporary homebirthers and midwives in the state. In the interests of space, however, I have settled on drawing out a few of the important moments in the history of midwifery in Virginia, from the early 1900s to the present.¹ This history was originally published in - "Expectations of Motherhood: Citizenship & Political Mobilization for Midwifery in Virginia," my doctoral dissertation in the Department of Anthropology at American University in 2003 (the full dissertation is available for \$36 online through UMI Dissertation Services at www.umi.com/umi/dissertations/disexpress.shtml). In this updated version of Virginia's history of midwifery, I have made changes to reflect new information and added a final section, "Updates—Legislative Changes 2003-2005," which includes events that occurred after the completion of my ethnographic fieldwork. This history remains a work in progress. If you have further information, corrections, or additions, please email me at christa.craven@verizon.net.

INTRODUCTION

This history of midwifery in Virginia offers an overview of the education and elimination of African-American midwives during the early to mid-1900s and the subsequent criminalization and "rediscovery" of contemporary midwives that has stimulated recent grassroots organizing among midwifery supporters. In **Section 1**, I highlight how the movement to improve maternal and infant healthcare in the early 1900s prefigured later legislation designed to eliminate "lay midwives," who were (and remain) the primary practitioners who attend homebirths in Virginia.² In the **Section 2**, I review the state's decision to replace "lay midwives" with Certified Nurse-Midwives (CNMs) in 1976. Ultimately, this decision significantly reduced women's access to homebirth because CNMs were placed under the supervision of physicians who had control over how and where they could practice—most commonly, in the hospital. Only a handful of CNMs in Virginia continue to offer homebirth services in Virginia.

¹ In addition to the interviews I conducted with midwifery supporters at the turn of the 21st century, I relied upon several published historical accounts, which are useful for further reading: Claudine Curry Smith and Mildred Roberson's (1994) *Memories of a Black Lay Midwife* and their later, significantly revised version (2003) *My Bag Was Always Packed: The Life and Times of a Virginia Midwife*, Gertrude Fraser's (1998) *African American Midwifery in the South: Dialogues of Birth, Race, and Memory* based on her ethnographic fieldwork in Virginia, and Virginia Certified Nurse-Midwife Juliana van Olphen Fehr's (1998) *Diary of a Midwife: The Power of Positive Childbearing*.

² Medical officials in Virginia have used the term "lay midwife" throughout the 20th century to downplay midwives' training and their knowledge of childbirth. In a recent article directed towards lawmakers, a representative of the Virginia OB/GYN Society used the term "lay midwife" synonymously with "medically uneducated and medically untrained laypersons" (LeHew 2000:12). Consequently, I use this term in quotation marks as it has been used disparagingly by medical and state officials and unmarked when it is the term that a DEM has chosen to identify herself.

Following the national trend of the “homebirth renaissance” in the 1980s (Davis-Floyd, Pigg and Cosminsky 2001:106), renewed interest in midwife-attended homebirth in Virginia prompted women to seek homebirth practitioners—by this time mostly illegally practicing midwives, that had become referred to as direct-entry midwives (DEMs).³ **Section 3** addresses this trend and the resulting intensification of state investigations into the practices of homebirth midwives in the 1990s. The result has been a sharp decrease in the availability of practitioners to attend homebirths. **Section 4** addresses women’s various responses to these developments. Some have sought alternatives, such as unassisted homebirth, but by and large, women have been left questioning their declining options for childbirth. Further, the criminal prosecution of DEMs in the 1990s and the decreasing physician support for CNMs in recent years has catalyzed many homebirthers to support of their local practitioners by organizing grassroots networks and lobbying legislators to change laws restricting midwives. In **Section 5**, I review the recent grassroots organizing for midwifery and homebirth in Virginia—particularly the community-based organizations that have developed to support both CNMs and DEMs. I also discuss unsuccessful legislative attempts from 1999-2002 to decriminalize and license DEMs. In the final section, **Section 6**, I discuss successful legislation and other events which led to the decriminalization of DEM in 2003 and the licensure of CPMs in 2005.

SECTION 1 EDUCATION OR ELIMINATION? THE MIDWIFERY “PROBLEM” IN THE EARLY 1900s

Resembling the plight of midwives in the early 20th century throughout the United States, Virginia midwives found themselves at the center of a movement to “educate” and eventually eliminate non-medical healthcare providers.⁴ By the early 1900s, Virginia state officials and physicians were in agreement that midwives were detrimental to medical progress and would eventually need to be eliminated throughout the state (Fraser 1998:59-60). However, a question remained over whether to “educate” and supervise the practicing midwives who served communities where hospitals and physicians were not yet available (Plecker 1925:809), or to eliminate the “great army of ignorant women now practicing midwifery in this country” (Hardin 1925:347). Ultimately, a combination of both approaches succeeded in eradicating most community-based midwives in Virginia by the late 1900s, but government and medical efforts to license, regulate, and monitor these practitioners during the early 1900s has provided a peculiar legal and social milieu for midwives to the present day.

Between 1910 and 1912, Walter A. Plecker, a physician, county registrar, and later the State Registrar of Vital Statistics (from 1916 to 1946), instituted a pilot program to supervise midwives in a rural Virginia county. Plecker (1925) advised state officials that the limited availability of physicians and hospitals to rural, poor, white women and African-American women in both rural and urban areas made it impossible to completely eliminate midwives outright. Instead, a program to teach midwives “elementary safety rules” about childbirth allowed the licensure, and subsequent supervision of practicing midwives.

Plecker also instituted a standardized birth registration form—requiring information about the child’s sex, name, and date of birth, and the parents’ names, ages, occupations, marital status and skin color—which would enable him to compare the work of physicians and midwives. However, the requirement that birth attendants record the names, marital status and skin color of the infant’s parents ultimately put midwives in a precarious regulatory position—particularly after the state passed legislation for the “preservation of racial integrity” in 1924, paralleling the height of the national eugenics movement. A series of “Racial Integrity Laws” made interracial marriage illegal and supported the sterilization of those deemed “unfit” by the state.⁵ Thus, midwives’ reports of mixed-race children incriminated and risked violent repercussions on the African-American community (Fraser 1998:75). At the same time, the falsification of such information was a felony, punishable by a year in the state penitentiary for the midwife.

³ 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). Among Virginia midwives and advocates, as in many states, this phrase is commonly used to describe an often diverse group of birthcare providers. These often include nationally credentialed Certified Professional Midwives and Certified Midwives, as well as those who label themselves traditional midwives, domiciliary midwives, and community-based midwives.

⁴ For a more extensive review of this history, see Hans Baer’s (2001) *Biomedicine and Alternative Healthcare Systems in America: Issues of Class, Race, Ethnicity and Gender* and, specific to Virginia midwives, Gertrude Fraser’s (1998) *African American Midwifery in the South: Dialogues of Birth, Race, and Memory*.

⁵ Women of color and poor women were disproportionately affected by forced eugenic sterilizations in Virginia and over 8,000 women who the state deemed defective were sterilized between 1924 and 1979 (Lombardo 1982; Hardin 2000b:A13)

Further, Plecker—who had been instrumental in the passage of the Racial Integrity Acts—rescinded the classification of “Indian” for ancestors of native-born Virginia Indians in 1943 (Chickahominy, East Chickahominy, Mattaponi, Monacan, Nanesepond, Pamunkey, Rappahannock, and Upper Mattaponi). Plecker issued a list of surnames belonging to these “mongrel” families that initiated the reissue of birth certificates, reclassifying Indians from either “white” or “Indian” to “Negro” (Hardin 2000a).⁶ Consequently, Virginia’s Indian midwives were also threatened with imprisonment for indicating “Indian” as a racial classification on birth certificates for children in their communities (Hardin 2000a:A10). As Fraser has aptly summarized, laws regulating and supervising midwifery during the early part of the 20th century, “inevitably mixed arguments about the need to reduce maternal and infant mortality and to improve health care with those confirming the importance of maintaining the racial and social order” (1998:72).

Although Plecker’s pilot program, as well as the 1918 legislation which instituted the compulsory licensure of all Virginia midwives under the Bureau of Vital Statistics, was ostensibly designed to monitor reproductive health and create a more accurate record of vital statistics in the Commonwealth, regulations also discouraged many midwives from practicing because of increased surveillance, literacy requirements, and bureaucratic structure of reporting births (Fraser 1998:63). In order to obtain a midwifery permit from the Bureau of Vital Statistics after 1918, midwives had to register with the local registrar, attend classes in safety and hygiene, provide one or more letters of recommendation from local physicians, agree to report all births within ten days to the local registrar, and promise to abide by the ten safety rules outlined in her “Midwife Manual” (provided by the Department of Health). Moreover, to maintain her permit, the midwife had moral and social obligations to the state:

(a) **MORAL:** A midwife should first of all be a conscientious woman. She should realize her responsibility to the mother and child and always remember that at every birth she has the lives of two people in her hands. She should be of cheerful disposition, patient, with a well balanced nervous system.

(b) **TRAINING:** She should realize that neither her training nor experience has fitted her to handle any case except a normal one. It is not only her duty, but the law requires her to call in a physician immediately when the conditions of labor are not absolutely normal. Even a doctor with his years of study and training frequently is unwilling to handle an abnormal case alone and calls in another physician to assist him.

(c) **HEALTH OF MIDWIFE:** It is very important that a midwife should be in good health. She should be free from disease, especially tuberculosis, syphilis, or any other that may be communicable. She should not attend a childbirth after attending an infected case or an acute disease without first having washed herself, including her hair, and put on fresh clean clothes.

(d) **CLEANLINESS:** A midwife should be exceedingly clean about her person, take frequent baths, keep her nails, hands, and hair clean, and change her clothes often. This is necessary because germs live in unclean things. [Midwifery Manual n.d.:6-7, as reproduced in Smith and Roberson 2003:155]

Through the enforcement of such regulations, public health officials, physicians, and local registrars had the authority to deny or revoke midwives’ permits if they were deemed “unfit” to practice (i.e., refusing to fill out forms, utilizing “unapproved” childbirth techniques, or, we can presume, not modeling a “cheerful disposition”). A midwife risked a fine for practicing without a permit (Virginia State Board of Health 1924). Ultimately, the federally sponsored public health programs and the increasingly stringent policing of midwives conducted by public health nurses precipitated the steady decline of midwifery in Virginia during the mid-1900s.

The elimination of midwives also had broader effects on the communities they served. For example, the written evaluations required for state-mandated midwifery permits encouraged older, often illiterate midwives to retire, and favored young midwives, whom medical officials viewed as more compliant (Bennett 1925:526). Over time, this eroded respect for elderly midwives, as Fraser has described within a rural African-American community in Virginia (1998:209-210). Additionally, physicians began to blame African-American mothers, not only their

⁶ In a letter to local registrars, physicians, health officers, nurses, school superintendents and clerks of the courts, Plecker argued: Now that these people are playing up the advantages gained by being permitted to give “Indian” as the race of the child’s parents on birth certificates, we see the great mistake made in not stopping earlier the organized propagation of this racial falsehood. They have been using the advantage thus gained as an aid to intermarriage into the white race and to attend white schools, and now for some time they have been refusing to register with war draft boards as negroes.... Some of these mongrels, finding that they have been able to sneak in their birth certificates unchallenged as Indians are now making a rush to register as white.... One hundred and fifty thousand other mulattoes in Virginia are watching eagerly the attempt of their pseudo-Indian brethren, ready to follow in a rush when the first have made a break in the dike. [Plecker 1943] Plecker’s mandate to reclassify “Indians” as “Negroes” remained in effect until the Racial Integrity Laws were repealed in 1975. Thus, as “Negroes,” American Indian women were also at higher risk of eugenic sterilizations in Virginia, as indicated in the Virginia Sterilization Act of 1924 passed in connection with the Racial Integrity Acts (Hardin 2000b). The Virginia Sterilization Act was not repealed until 1979 (Baskervill 2001).

midwives, for the high maternal and infant mortality rates in their communities (as much as three times that of whites in some areas), largely ignoring the economic impoverishment that most African-Americans faced at the time (Fraser 1998:86, 131).

[Medical investigators judged maternal and infant deaths as] the woman's "failure" to properly interpret and act on the physical "danger signals" of her body, or her negligence in not seeking out adequate prenatal care. Again, the flawed assumption held by investigators was that these were deliberate or avoidable actions on the part of women who "failed" to take advantage of readily available health resources. As I have argued, few African Americans had access to affordable medical care even after the passage of the Sheppard-Towner Act and the lobbying efforts of the Children's Bureau. [Fraser 1998:132]

Even when African-American women and other women classified as "Negro" were admitted to segregated clinics, many were appropriately fearful of the eugenic sterilization forced on many women of color at that time (Lombardo 1982; Hardin 2000b).

While Virginia kept no official records of midwives at the turn of the 20th century, medical officials suggested that thousands of midwives were serving various communities around Virginia prior to the widespread use of physicians and hospitals for childbirth. One physician praised the local health departments that had "done a splendid piece of work by reducing the number of midwives in the state from nine thousand very ignorant and dirty creatures, to four thousand eight hundred and forty [by the 1920s], only one thousand two hundred and thirty-three of whom are really active" (Baughman 1928:749). These numbers continued to fall to around 1000 in 1950 and approximately 600 by the 1960s (Commonwealth of Virginia, Department of Health, Center for Health Statistics, as cited in Commonwealth of Virginia, Joint Commission on Health Care 2000a:4; hereafter referred to as JCHC). Although this decrease corresponds with national trends, the transition reflected different developments among different constituencies of women.

Not surprisingly, early campaigns against homebirth and midwives were directed at the white women who could afford physicians' services and it was indeed urban, white women of all classes and rural, affluent and middle-class, white women who were the first to choose physicians over midwives in Virginia (Fraser 1998:95). For these women, physicians and hospitals would alleviate pain in childbirth (through medication) and maintain an appropriately sanitary environment. As hospital birth became more mainstream for white women, middle-class urban African-American women began to deliver in hospitals as physicians allowed,⁷ and it was mainly the rural, poor, white and African-American women who continued to use midwives into the mid-1900s (Fraser 1998:88). Even into the 1950s and 1960s, Claudine Curry Smith, the last African-American lay midwife to practice in the Lower Northern Neck of Virginia (near the Chesapeake Bay), explained how the racial divide in healthcare continued:

Most of the White people had their doctors come to the house—they had the money to pay the doctor. Black people just didn't have the doctor's money. Midwives were cheaper. Insurance didn't cover having a midwife come. So, they'd pay out of their pocket. I delivered some white too, but the ones that did it said they'd rather have a midwife than go to the hospital. [Smith and Roberson 1994:23]

During the 1950s, health departments also began to require pregnant women to get a card from a physician to approve a midwife-assisted delivery (Fraser 1998:157; Smith and Roberson 2003:26); these new requirements began to limit poor women's access to midwives because of the mandatory cost of one or more prenatal visits with a doctor. As one physician summarized in 1966, "the old-fashioned uneducated midwife is fast disappearing, prenatal clinics have educated the poor who once employed them, and the ease of getting to a hospital where an intern or staff doctor will deliver them has eliminated the granny almost completely in many areas where she was popular even a decade ago" (Jones 1966:173). Smith, who had practiced as a lay midwife for 31 years in the Northern Neck, explained how this shift was also impacted by physicians' financial interests:

The doctors stopped coming to cover for the midwives, for mothers to be delivered at home, in those last ten years I practiced [the 1970s]. I don't know why. I've never known the reason, but they stopped coming to midwives.... But I think the doctors here was still supportive with the midwives. But see, the thing of it is that a

⁷ Even as African-Americans were admitted to Virginia hospitals in larger numbers during the mid-1900s, they still faced segregation in childbirth clinics until after the passage of the Civil Rights Act in 1964 (Smith and Roberson 2003:6). The largest public hospital, the Medical College of Virginia Hospital in Richmond (MCV) had a separate building for African-Americans, the St. Phillips Hospital, until 1965. Even after the official end of segregated hospital care, Claudine Curry Smith recalls one African-American woman's reaction to the persistence of "separate" waiting rooms: "Doctors then had two waiting rooms.... I knew one woman in her twenties who said it made her so mad that she intentionally sat on the side where everybody else was waiting. She said that people stared at her like she was in the wrong place and she shouldn't be there, that was in 1980" (Smith and Roberson 1994:24).

lot of people wasn't able to pay the money the doctors were charging and if the midwives could do it, they were still the family doctors, so I think they didn't mind having a midwife. [Smith and Roberson 2003:120-121]

Nevertheless, Virginia's confidence in the progress of medically managed childbirth prompted the General Assembly's 1962 decision to move regulation of midwives to the Virginia Department of Health (VDH)—in an attempt to further limit midwifery practice to “rural, underserved areas, minority women, and poor, uninsured women” (Stern 1999:4). The VDH granted midwifery permits to individuals who presented two letters of reference from practicing physicians, observed and assisted with ten or more hospital deliveries, passed an examination, and conformed “with acceptable moral reputation and adhere[d] to high standards for personal cleanliness, neatness and demeanor” (JCHC 2000a:2). Shortly after this transition, in 1965 the federal introduction of Medicaid reimbursement for deliveries performed by physicians opened doors for poor women to access healthcare in the hospital and ultimately eliminated the need for low-cost midwives in many areas (Smith and Roberson 2003:46). Following these developments, few records of the practices of midwives exist—either in local health departments or at the central offices of the VDH in Richmond.

In the Virginia Department of Health central offices in Richmond, the repository for what few records remain of midwives and their history, there is simply a folder containing a smattering of names of midwives in practice in selected counties, in specified years. Most records have been lost or destroyed. It is apparent that no one has maintained records in the central VDH office in Richmond on an on going basis. Staff now in the county health departments say that all required records were sent to Richmond, and all local records were destroyed for lack of space. The story is the same elsewhere in the South. As Debra Anne Susie (1988[:viii]) commented in her book about Florida midwives: “The American midwife's misfortune was to lose not only her vocation but her history as well.” [Roberson in Smith and Roberson 2003:115]

SECTION 2 CRIMINALIZING “LAY MIDWIFERY”

In 1974, the VDH restricted applications for a midwife permit to “registered nurse[s] in good standing [who had graduated from] a school of midwifery accredited by the American College of Nurse Midwifery [sic]” (JCHC 2000a:3).⁸ In 1976, the General Assembly enacted legislation that limited the practice of non-nurse midwifery to those who were permitted by the VDH prior to January 1, 1977—in effect, only non-nurse midwives who had been permitted prior to the change in regulations in 1974. After 1977, a family in Virginia remained legally entitled to have a homebirth with whomever they chose, though it became illegal for a midwife who was not a CNM to accept compensation for childbirth assistance.⁹ Thus, a DEM who desired to be paid for her services was practicing outside the law.¹⁰ The law also made it illegal for a non-nurse midwife to receive any “gifts” as a means of recompense; “‘compensation’ means anything of value received before or after the labor attendant to childbirth, with or without an express agreement between the person so assisting and the patient or anyone in the patient's behalf” (Commonwealth of Virginia 2002a:§32.1-145).

The “success” of this legislation was well documented by the VDH, the number of permitted midwives in Virginia hovered around 100 in the 1980s and slowly decreased to just five in 1999 (JCHC 2000a:4). Of the five non-nurse midwives who had permits in 1999, one was living out of state, three were retired (JCHC 2000a:4), and the one lay midwife who practiced in Virginia until 2001 has since retired and moved out of the state.¹¹

In order to replace these practitioners, the 1976 legislation introduced the licensure of the nurse-midwives as CNMs, who would henceforth be allowed to practice through joint regulation by the Boards of Medicine and Nursing. CNMs would not be allowed to practice autonomously, but rather under the supervision of a physician. The Code stipulates that a registered (nurse-) midwife or a licensed nurse practitioner may only administer medical

⁸ The American College of Nurse-Midwifery was incorporated in 1955. In 1969, the American Association of Nurse-Midwives merged with the American College of Nurse-Midwifery to form the American College of Nurse-Midwives (ACNM), as it is currently known (American College of Nurse-Midwives 2003).

⁹ The Code of Virginia (Commonwealth of Virginia 2002a, henceforth referred to as the Code) defined a midwife as, “any person who, for compensation, assists in delivery and postnatal care by affirmative act or conduct immediately prior and subsequent to the labor attendant to childbirth in conjunction with or in lieu of a member of the medical profession” (§32.1-145).

¹⁰ My interviews with women utilizing and/or offering midwifery services during the 1970s indicate that most were unaware of the passage of this legislation. In fact, some midwives, both in rural and urban areas, continued to provide homebirth services well into the 1990s before becoming aware that receiving compensation for their services was a criminal offense.

¹¹ The last legally permitted lay midwife in Virginia was Adella Scott Wilson, who assisted in approximately 2,000 births in the Virginia Beach area during her 34 years of practice (Forster 2000:A4).

procedures and conduct “their usual professional activities which shall include the taking of blood, the giving of intravenous infusions and intravenous injections, and the insertion of tubes *when performed under the orders of a person licensed to practice medicine*” (Commonwealth of Virginia 2002a:§54.1-2901, emphasis added). Physicians are currently the only practitioners “licensed to practice medicine” in Virginia (Commonwealth of Virginia 2002a:§32.1-249),¹² so this requirement made CNMs available only in areas where a local physician was willing to supervise their practice, a matter of considerable variation throughout the state. A survey conducted by the Task Force on the Study of Obstetric Access and Certified Nurse-Midwives (Commonwealth of Virginia, Department of Health Professions and Virginia Health Planning Board 1992; hereafter referred to as the Task Force) found that overt resistance to CNMs was common among Virginia physicians:

More than one-half [of CNM respondents] indicated that a physician had at least once tried to exclude them from providing care in their role as a nurse-midwife, and more than one-third had been exposed to a physician who refused to refer patients to them. More seriously in terms of public protection, nearly one-third reported that physicians had refused to accept patient referrals from the nurse-midwife. These rejections ostensibly include high risk cases which are inappropriate for CNM care. [Task Force 1992:20]

One physician cited the high malpractice risks that go along with supervising a CNM and told a newspaper reporter that he would “run in the other direction” if a CNM approached him about collaborating (Heneghan 1990:34). In the late 1990s, CNMs had to close practices or were unable to practice in Richmond, Charlottesville, northwestern Virginia and the Tidewater area because local physicians were not willing to supervise their birthcenter, homebirth, or even hospital practice.

Nevertheless, CNMs in Virginia increased from around 80 practitioners in the early 1990s to over 126 in 2000 (Heneghan 1990:33; Task Force 1992:iv; American College of Nurse-Midwives 2000). Most Virginia CNMs in the early 1990s practiced in hospital clinics that provided care for primarily indigent patients (Heneghan 1990:33), though throughout the decade, middle-class and affluent patients began to demand access to CNMs in hospitals, birthcenters, and the home. During the late 1990s, CNMs also began to practice in more urban and suburban areas (Task Force 1992) and according the American College of Nurse-Midwives (2002a) more than 180 CNMs were licensed in Virginia during 2002. Not all of these CNMs practice as nurse-midwives (see next Section), but CNMs have consistently attended 4-5% of Virginia births since the mid-1990s—primarily in the hospital (Commonwealth of Virginia, Department of Health, Vital Records & Health Statistics 1995, 1996, 1997, 1998, 1999, 2000; hereafter referred to as the VDH-VRHS).

The operation of CNM-run birthcenters and home-based practices, however, has declined in recent years (Forster 2000:A4). Not surprisingly, the numbers of homebirths attended by “Other Midwives” (a category designated by the VDH to distinguish both legally and illegally practicing non-nurse midwives from legally practicing Certified Nurse-Midwives) increased from a low of 35 in 1985 to 155 in 1995, 303 in 1997, and to 500 births in 2000 (VDH-VRHS 1995, 1997, 2000; JCHC 2000a:5). The Joint Commission on Health Care also noted that:

The actual number of deliveries by direct entry midwives may be higher, as it is possible that some of the deliveries in the “other attendant” or “unknown” category were delivered by direct entry midwives. Clearly, the current legal status of direct entry midwifery creates a disincentive for a family in registering a birth to highlight that the birth was attended by a direct entry midwife. [JCHC 2000a:5]

SECTION 3

“REDISCOVERING” MIDWIFERY: HOMEBIRTHERS ... AND STATE INVESTIGATORS

Virginia’s “homebirth renaissance” paralleled the national resurgence of interest in homebirth among middle-class, primarily white women in the 1980s, prompting both CNMs and underground DEMs to offer homebirth services in many urban areas of Virginia. One newspaper article contrasted homebirth CNMs to the granny midwives of years past:

Modern training colors ancient role

Midwives Alice Bailis and Marsha Jackson don’t fit the image of the granny delivering babies in a mountain shack. Their combination of medical training and supportive care make them a popular choice for couples who want to play a more active role in the birth of their children. [Heneghan 1990:33]

Alice Bailis and Marsha Jackson established Birthcare & Women’s Health in 1987 to provide homebirths in northern Virginia and the DC metropolitan area (including areas of Maryland). In 1992, the CNMs also opened a

¹² As of 2003, Virginia is one of only 12 states that require “physician supervision” for CNMs.

freestanding birthcenter in Alexandria, Virginia, due to a brief lapse in the availability of professional liability insurance coverage for homebirths (Birthcare 2003). Other CNM practices in the DC area, such as the Maternity Center in Bethesda, Maryland, phased out homebirth practices during the late 1980s and early 1990s. In contrast, Birthcare was committed to keeping homebirth available for women in the area and were eventually able to resume their homebirth insurance coverage. They also decided to retain their birthcenter. Alice Bailis explained:

I was really certain that we were not going to be [offering birthcenter births] for very long, and we were only going to do it until we found someone who was going to write [homebirth malpractice] insurance for us, and then after that, the [homebirth] work would continue. But I guess the first week that we were open, there was a teenage couple who didn't want to have their baby at his parent's house or her parent's house. They needed a place to have a baby. So I saw there was indeed wisdom in having a birthcenter. And not long after that, there was a homeless woman who needed a home, she didn't have a home to birth in—she was living in a shelter. So she came and birthed at the birthcenter, and then, I mean we gave her a place to birth. [Personal Communication, September 9, 2002]

By 2002, Birthcare had grown to a group of five CNMs who attended 18-25 births a month; approximately 70% in clients' homes and 30% in their birthcenter (Birthcare 2003).

Also during the 1980s, a handful of other CNMs—as well as a few obstetricians and osteopaths—were providing homebirth services in Virginia, particularly in rural areas. Juliana van-Olphen Fehr, a rurally-based CNM who operated a homebirth service from 1984-1997 in northwestern Virginia, recalls one of the first lessons she learned from her clients 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]

In the 1980s and into the early 1990s, most unlicensed midwives also felt safe continuing their homebirth practices—despite Virginia laws that had made their occupation illegal since the 1970s. For example, Sherry Willis, who offered homebirth services in the Blue Ridge Mountains of Northern Virginia, told a reporter that she preferred “the autonomy of her form of midwifery” to that of physician-supervised nurse-midwifery (Strobel 1990:27-28). The reporter continued:

She has never been sued, and, she says, has no fear of legal repercussions. No baby has ever died in her care.

“I'm a community-created midwife,” she says. “I don't advertise. I didn't even have business cards for 10 years. These families have gotten to a point where they are emotionally and physically ready, and willing to accept the realities of nature.” [Strobel 1990:27-28]

Similarly, Carol Cahours, an unlicensed midwife who practiced in Central Virginia during the 1990s, told a reporter, “Everyone knows I'm here”: ironically, the article was entitled “Unlicensed Midwives Can't Practice Legally Under Virginia Statute” (Pegram 1996:B-5).

While many DEMs disregarded the laws that were designed to eliminate their practice, others questioned their legal application. One DEM who had practiced legally in Texas and California, but had switched to offering birthing talks and facilitating childbirth support groups when she moved to the Northern Neck of Virginia, explained to a reporter:

“Present Virginia laws define midwifery as being present at the time of birth and receiving payment for this.

Payment could be anything: a goat, a painting, money, even just a thank-you. A licensed nurse midwife may only facilitate labor and birth under the direct supervision of a physician. Obviously, the definitions of midwifery are a bit unclarified here. What if you suggested that a laboring woman drink a cup of tea or take a walk? What if you took her blood pressure for her at her request? Is this practicing midwifery or medicine?” [Stacey Newby as cited in Norris 1995:74]

During the mid- to late 1990s, the state began to answer these questions by intensifying investigations—and in several cases the criminal prosecution—of underground midwives and those who assisted them. For example, in 1994, Dr. Susan Osbourne had her physician's license put on probation after providing backup services and ordering tests for an unlicensed midwife in Richmond and was ordered to take 50 hours of obstetrical training (Pegram 1996:B-5). For DEMs, however, the results of investigations were often more damaging. Martha Hughes, for example, an unlicensed Certified Professional Midwife who formerly practiced in Virginia, is now a part-time waitress in Rappahannock County (Neuberger 1999b:A-1). Hughes had attended over 200 homebirths in Virginia, but stopped practicing after her arrest in a manslaughter case regarding a baby who died after a homebirth she assisted in 1995. The charges were eventually dropped because the baby's parents maintained that their midwife had done all she could to save their baby and would not cooperate with the prosecution (Glod and White 1999:B01;

Neuberger 1999b:A-1). Hughes' practice, however, remains closed. Following Hughes' early retirement, several former and potential clients were not able to have homebirths because they were unable to find available practitioners to attend them (Neuberger 1999b:A-1).

In several other cases, midwives have been investigated by the state without provocation by a maternal or infant death. For instance, one 80-year-old, fourth-generation, African-American midwife who had practiced for 60 years in Virginia recalled:

“And you know they want to run me up a brick wall ‘cause of delivering babies here in my home. Yes, indeed, and they had the judge to write me a letter ... No more delivering ... I can deliver one per year if it's not any relation to me, and after that no more. Oh yes! The doctors don't like it at all.” [Fraser 1998:156]

Several participants in my study also told me lengthy narratives about being reported to the state by hostile physicians or healthcare officials. One DEM described how she became aware of the illegality of DEM in Virginia and her subsequent investigation by the state:

[After training as a midwife out-of-state,] I came home and I thought, okay, now I'm all ready to start having births, so I called [the] Department of Health and I said, “Okay, I want to know how to get either a permit or a license or whatever it is you are doing now with midwives.” And they laughed, and the woman on the phone said, “We don't do that anymore in this state.” And I'm like, “What are you talking about 'that'? And she said, “If you want to be a real midwife, you go through nursing school, you go through midwifery school, and you become a nurse-midwife, get doctor back up.” She told me, she knew too, she was very clear. And I thought, she doesn't know what she's talking about, because I know there's got to be a way. And Christa, you know, there is no way. But people just gravitate to where they need to be. As time went by I started helping folks around here with births and some long-distance births. I just kept right on going, because the need was there and they certainly had the right, and I was delighted to share the experiences with them. And people started getting investigated. I was aware that there was a move to legally [eliminate] midwives who were not sanctioned by the state, but my first introduction personally was having a cop show up at the back door. Of course, the kids and the dogs and everything were climbing all over him, “Is that a real gun?” I opened the door and he says, “I have a warrant for your arrest.” I said, “Why?” And he says, “For practicing midwifery without a license.” “Well, come on in and let's talk about this.” He said, “I have the right to take you to jail if I think that you may flee before your court date.” I said, “Look at me, sir, I'm here canning and I have all these kids and things, I'm not going anywhere.” He said, “I believe you ma'am.” And he was shaking, he was visibly shaking, his hands were shaking, his paper was shaking, and I could tell he had no desire to be here. Um, I called ... the director of the [local] health department. So I called her and asked for an appointment and she said, “No.” I called her again and asked for an appointment and she said, “Okay.” So, I went and said, “Why did you do this? Why did you choose to report me to the state?” She said, “Because you have continued to sign birth certificates and you know you can't legally, it's illegal, and you've got to stop doing that.” So, it was all over a birth certificate. That was in [the mid-1990s], I've never signed another one. I said, “That's okay, I don't have to sign birth certificates, we can work around that.” So, it cost the lawyer fee and several trips to ... court and then it was dropped. [Personal Interview, unnamed participant, 2002]¹³

Another DEM asked that I not include her full story—for fear that the state may still be investigating her. Recalling her investigation, she was told:

“You will either receive a summons to go to court ... and go through a prosecution trial or you'll receive a letter dismissing your case. When either one of those two things happen, it's closed and until either of those two things happen it's not.” Neither of those have happened and it's been [many years], so it's an open case and they do that. They love to keep them open because then what [they're] waiting for, Christa, is ... if something happens at a birth and that gets brought to the public eye, that's when I will be prosecuted. [Personal Interview, unnamed participant, 2001]

This midwife joked that for identification purposes, “my first name is ‘The’ and my last name is ‘Midwife.’ That keeps me from getting prosecuted” (Personal Interview, unnamed participant, 2001).

¹³ All transcriptions are the author's, with the assistance of Asan Askin, Anna Inazu, Robbie Kaplan, Janet Gallay, and Emily Tumpson on selected interviews and legislative hearings. I identify speakers by name when quoting public discourse (such as legislative hearings or quotes in newspapers), but references to formal interviews I conducted with midwives and midwifery advocates are referenced with pseudonyms or as unnamed participants for their protection. I use the following transcription conventions:

[brackets] indicate text inserted for clarity and/or my questions during a speaker's account

... indicates a pause by the speaker

.... indicates the omission of text by the author

During the late 1990s, many DEMs found themselves more cautious in their practices for fear of prosecution. When I asked one midwife how the investigations of other midwives in the state had affected her, she responded: Ultimately, it has made me unable to fully be present in the [birthing] women's experience many times and it really pisses me off. I find myself sometimes being really conscious of the clock and that is not my way at birth. But sometimes I'd be conscious of something like pushing, a mom has pushed for four to six hours or something like that, even though I'll know in my heart of hearts this baby sounds great [and the Mom is doing fine]. I'm conscious of the fact that if someone could get a hold of this and twist it, I could end up in jail over it. And I hate my thoughts going in those directions when I'm needing to be fully present for a woman at that time. So, I guess the primary way, Christa, is not being able to just be there for her, but being distracted by political, legal snafus. [Personal Interview, unnamed participant, 2002]

Other midwives have simply stopped practicing. One former midwife who now works as an artist cited the tenuous legal position of midwives as a prime reason for her decision to stop practicing: "There were a couple of instances that made me realize things could go a different direction and [people] could cause me a lot of trouble. And my partner wasn't very supportive. He was always giving me grief about 'Why are you doing this?' ... My freedoms could be taken away from me" (Personal Interview, unnamed participant, 2001). And others, like Rosy Farlam, who recently received her national credential as a Certified Professional Midwife, have moved to other states where they will not have to practice illegally.

Still other aspiring midwives have chosen to become legally practicing CNMs, in hopes of avoiding harassment and legal battles. One nursing student confided:

I am scared. I'm scared of the legal ramifications. I'm a single mother, my children need their mother, I don't wanna go to jail. So yeah, the law keeps me from doing what it is in my heart that I want to be doing. I don't want to be in nursing school—I'm learning how to give catheters, I'm learning how to do IVs, and injections, and yeah, I might need that knowledge, but I'd rather be learning about birth. I'd rather be learning about acupuncture points and the more traditional ways of handling [childbirth]. I just went through the mother-baby, the labor division of my RN program and I don't think I learned anything new that I could use in a homebirth practice—it's all how to induce labor and how to counteract the negative affects of the drugs you've given.... I guess that knowledge will be helpful for one thing or another, but this isn't where, if I had a choice, if I had a choice I would not be doing it this way. I'm trying to make the best of it, to keep it in perspective, but if I lived in another state, it would be a very different experience. [Personal Interview, unnamed participant, 2001]

Similarly, a CNM who currently practices in a hospital revealed:

The only reason that I became a nurse-midwife is that I found out that the only way to be a legal midwife in Virginia was to be a nurse-midwife. And I did not want to go to nursing school. I never wanted to be a nurse. I wanted to be a midwife. But I also knew that it was unlikely that I would ever live any place besides Virginia and that I was not willing to operate outside the law. [Personal Interview, unnamed participant, 2001]

Even as legally practicing CNMs, however, Virginia midwives have not been immune to harassment by medical officials and more commonplace state investigations in recent years. For example, the CNM-run birthcenter in Charlottesville closed in the late 1990s because they could no longer secure physician supervision for their practice: "after the Board of Medicine ruled that the supervising physician was too far away, the only birthcenter in Charlottesville was forced to close and a homebirth midwife had to close her practice as well, abruptly leaving an entire community without the access they had come to rely on" (Ellen Hamblet, Presentation to the Board of Medicine, August 3, 2001). Other CNMs have not been able to find jobs practicing midwifery: the Taskforce on the Study of Obstetric Access and Certified Nurse-Midwives (1992:10) indicated that at least one-third of Virginia CNMs were practicing outside of their chosen profession in 1991. Moreover, five of the eight CNMs I interviewed in 2000 and 2001 were working outside of their field.

I have not practiced clinically as a nurse-midwife ... due to the difficulty of getting supervision. I came back [after receiving my CNM certification] and worked as a Labor and Delivery nurse initially at [one] hospital and my plan was to get to know the physicians and so that the nurses would become familiar with me because the one midwife who had gotten privileges there had had a lot of conflict with the nurses through uncertainty about her knowledge base and her roles. So, I thought, if I go in there and work with them and become one of them first, then that would then ease the transition into working there as a nurse-midwife because they would already feel, you know, comfortable with my area of knowledge. [Personal Interview, Megan Jones, April 16, 2002]

Unfortunately, like many other CNMs in the Commonwealth, Megan has still not been able to obtain physician supervision to practice—even within the hospital.

Another CNM, who had secured physician supervision to practice as a nurse-midwife, described her fear as the state investigated her birthcenter practice for operating an unlicensed "outpatient maternity hospital":

Somebody came in and investigated us and we were, we had felony charges against us for operating an unlicensed maternity hospital. And nobody ever gave us formal notice that we'd been cleared of those charges, but the Board of Nursing did their piece of the investigation and didn't find anything wrong with us. Ultimately, I think that the Board of Healthcare Facilities, the Department of Healthcare Facilities, I can't remember who it was—but that took a tremendous of energy, just like dealing with the threat of being prosecuted and I mean, we just answered it as if they were out their minds.... We got our lawyer to consult with us that—he was fabulous—and we basically looked at their letter and answered every point that they had and sent them thirteen and a half pounds of paper in a box and never heard from them again. So, they never wrote to us and said, "Fine, girls, everything is okay, go right ahead," pat, pat, pat, but they never, ya know, they never went after us either.... So, we were [accused of] operating an unlicensed hospital, which is a felony, carries a year in jail and a \$2400 fine. And they certainly let us know that, but probably its statute of limitations is over ... so I guess we're not, we'll continue to engage in this illegal activity, but nobody's upset about it anymore. That was scary. [Personal Interview, unnamed participant, 2002]

As these stories bear out, there is a great deal of fear about the potential for state prosecution among all midwives in Virginia. In the late 1990s, this fear became an effective tool for the state to encourage midwives to stop providing homebirths.

As a case in point, during a highly publicized criminal case against a midwife in Virginia, both the state prosecutor and the judge felt it was important not only to put the midwives involved on trial, but also to send a "clear message" to "deter others who are similarly situated" (Author's fieldnotes, May 5, 2000). In 1999, Cynthia Caillagh, a prominent underground DEM who had attended approximately 2,500 homebirths during her career as a midwife in New York and Virginia, and her assistant, Elizabeth Haw, were charged with involuntary manslaughter, practicing midwifery without a license, and practicing medicine without a license after their client, Julia Peters, had died following a homebirth on September 8, 1997. The medical examiner's report cited postpartum hemorrhage as the cause of death, but Caillagh and Haw's attorneys, as well as their supporters, maintained that the cause of Peters' death was open to question. Before the trial, supporters suggested that the lab report documenting Peters' hemoglobin and hematocrit levels—9.8 and 22, respectively—did not support the diagnosis of postpartum hemorrhage (Voices for Healthcare Rights Fund 2000b) and that the delayed issuance of the medical examiner's report—8 months after the date of death—was significant to the defense's case (Neuberger 1999a).¹⁴

Nearly three years after Peter's death, the case ended in a plea bargain on May 5, 2000. The prosecution dropped the manslaughter charge—which would have required a full trial—in part because of the publicity around defense attorney Peter Greenspun's case, involving expert witnesses to testify against the Medical Examiner's report (Krishnamurthy 2000b:A-1) and in part because Daren Peters, Julie Peters' husband, maintained that the midwives "did their job" and refused to cooperate with prosecutors (Hall 1998e; Glod and White 1999:B01). Caillagh pleaded guilty to practicing midwifery without a license, practicing medicine without a license (based on testimony regarding her use of Pitocin and her performance of an internal vaginal exam),¹⁵ and the neglect of an incapacitated adult.¹⁶ Haw pled guilty to practicing midwifery without a license. Both received suspended jail sentences, were

¹⁴ Critics of the prosecution also questioned the impartiality of Chief State Medical Examiner Marcella Fierro, who was married to a Richmond obstetrician (Krishnamurthy 2000a:B-4) and vocally opposed the licensure of DEMs. Fierro reported to lawmakers at a Health, Welfare, and Institutions Subcommittee meeting regarding the licensure of DEMs in 2001, "We do see, each year, a few deaths where there was no physician involved, where the woman, generally it is due to postpartum hemorrhage, where this has not been recognized and the woman has been allowed to bleed for hours and hours and hours and then dies of shock" (Author's Transcription, January 30, 2001). Following a legislator's request for specific statistics regarding maternal deaths as a result of homebirths with midwives, Fierro was unable to substantiate her claims, repeating several times, "We don't have figures for that" (Author's Transcription, January 30, 2001).

¹⁵ During the early 1900s, midwives in Virginia could have their permits revoked for "entering the birth canal" (Fraser 1998:153). A "Midwife Manual" from the Virginia State Department of Health in the mid-1900s, which reviewed safety rules for midwives, read: "Rule Three: She must not pass her fingers or any instrument into the birth canal of the woman, for the purpose of making an examination or for any other purpose" (n.d., as reproduced in Smith and Roberson 2003:155). This set up an historical precedent for internal examinations to constitute the "practice of medicine" in Virginia, which is a crime often prosecuted as a felony.

¹⁶ The final change, the violation of a statute governing care provided to incapacitated persons, is most commonly brought to bear in cases intended to protect patients in mental institutions and nursing homes who are unable to consent to treatment and no authorized person has consented on their behalf (Voices for Healthcare Rights Fund 2000; Commonwealth of Virginia 2000a:§18.2-369). This sets up a disturbing precedent; by Virginia case law, the definition of an "incapacitated person" now includes a pregnant woman in labor, and her husband's consent for treatment has been determined insufficient.

fined \$2,500 and \$500, respectively, and promised to stop delivering babies unless the state law is changed.¹⁷ In a press release following the trial, Caillagh (2000) indicated that the prosecutions' agreement to drop charges against Julie Peters' mother-in-law, Claire Peters,¹⁸ and reduce charges against Beth Haw weighed heavily in her decision to plead guilty to the three misdemeanors.

This case in particular inspired broad media attention, which many midwifery supporters suggested was because the case coincided with the introduction of legislation to decriminalize DEM in Virginia. This publicity was both positive and negative. A prominent five-part series of articles in Fredericksburg's newspaper, *The Free Lance-Star*, drew public attention to Peter's death and the legal controversy surrounding it (Hall 1998a, 1998b, 1998c, 1998d, 1998e). The battery of letters to the editor by supporters of Caillagh and Haw, however, suggested a distinct bias in the reporting and began to refer to the investigation as a "witchhunt," a "bogus investigation," and a "political persecution" of alternative healthcare practitioners in Virginia (Voices for Healthcare Rights Fund 1999; Krishnamurthy 2000a:B-4).¹⁹ In response, Stafford Circuit Judge James Haley Jr., told supporters of Callaigh and Haw: "this prosecution was not a persecution," reiterating the statement twice more for effect (Author's fieldnotes, May 5, 2000). Subsequently, the prosecuting attorney, Eric Oleson, told a reporter that Caillagh's guilty pleas, "prohibit her from being a martyr" (Krishnamurthy 2000b:A-1).

Other reporters cited connections between the investigation and concurrent legislation that midwifery supporters were introducing to the General Assembly in 1999 to legalize the practice of DEM in Virginia:

Now, debate about state regulation of childbirth has been reborn. Two midwives were charged with manslaughter in January in the case of a Stafford County woman who died after her baby was born at home in 1997.

Such rare criminal cases have inspired media onslaughts, but the intense publicity may do little to clear up myths about traditional midwifery. Virginia's 22-year-old ban on the practice probably has compounded the mysteries by forcing practitioners to operate without detection. [Neuberger 1999b:A-1]

A well-known physician who supports midwifery, Dr. Marsden Wagner, the former Director of the Women's and Children's Health Program in the European Office of the World Health Organization, wrote in an editorial for *The Roanoke Times*:

It can be no accident that these midwives have been charged just at the moment the Virginia General Assembly is considering new legislation on midwifery. But health care in Virginia should be determined on the basis of the best scientific evidence and not on the basis of unproven, anecdotal horror stories. [Wagner 1999:A13]

Following the case, Caillagh moved out of state and Haw discontinued her plans to become a midwife. After the trial, supporters continued to rally around Caillagh and Haw, as they shifted their attention towards legislation to decriminalize DEMs throughout the Commonwealth. Reaffirming many homebirthers concern for their midwives, Debbie Goodman wrote for the Voices for Healthcare Rights Fund's "Trial Update":

During the past 2-1/2 years the Stafford County courts and the media have made Julie [Peters] into a naïve victim. The charge of Neglect of an Incapacitated Adult is an insult to Julie, Daren, Cynthia, and to every woman who has ever given birth. The trial in Stafford may be over, but its wounds will be felt for a very long time. All of us who support a family's right to informed decision-making in all areas of our lives need to work together to change the laws in Virginia and stand in defense of one another and our practitioners. Don't let this happen to another midwife or another family again. [Goodman 2000]

SECTION 4

THE IMPETUS FOR POLITICAL ACTION: DECREASING ACCESS TO HOMEBIRTH MIDWIVES

As physicians' became less willing to supervise CNMs and the state stepped up investigations of DEMs and CNMs in the 1990s, midwives practicing outside the hospital became more aware—and more fearful—of their tenuous legal and professional position. Consequently, many closed their homebirth practices. By the end of the

¹⁷ Ironically, this decision came on International Midwives Day, May 5, and on the eve of what Governor James Gilmore had proclaimed Virginia's Midwives Day to recognize "the positive impact that midwives ... have had on improving infant mortality rates and decreasing the incidence of complications and unnecessary medical interventions during childbirth" (Gilmore 2000; Voices for Healthcare Rights Fund 2000a).

¹⁸ Claire Peters was present at Julie Peter's birth and assisted EMTs in their attempts to resuscitate her daughter-in-law in her capacity as an intensive care nurse. She was charged with perjury in connection to her testimony before a Secret Grand Jury, though her case was dropped following Caillagh's guilty pleas.

¹⁹ Contributing to Caillagh and Haw supporters' discontent, the prosecuting attorney, Eric Olson, later thanked the reporter, Jim Hall, in court for his investigative contributions to the prosecution's case (Author's Fieldnotes, May 5, 2000).

1990s, CNMs offered homebirth services only in the areas surrounding Richmond and Northern Virginia.²⁰ In 1998, the VDH estimated that 20-30 underground midwives were practicing throughout the state, though “this number is impossible to verify empirically and . . . may be too high” (JHC 2000a:5). Furthermore, many of these practitioners had also begun to restrict their clients to women they knew personally or through other trusted clients. As a result, women seeking midwives to attend homebirths were unable to find them in many areas.

Rather than going to the hospital and giving up their desire to deliver in their homes, many families looked into other options. Some homebirth proponents chose to have “unassisted” homebirths in the absence of an available midwife, with only their friends and family present. The three women who participated in my study that had had unassisted homebirths described their experiences as “empowering,” “a great experience,” and “priceless.” Others, however, have expressed less comfort around their decision.

If I was pregnant right now, I would have to have an unassisted birth and I would do it and I’m not comfortable with that—not physically. I know my body can give birth, I’m not scared of the birth process; I want the support. I want a midwife that I can talk to if I’m having trouble, just to hold my hand, just to wipe my brow, just to . . . It’s a safer feeling to have a midwife standing by. I would have an unassisted birth if I had to, but it’s not something that I want. I thought about that, if I were pregnant now, I think about that nearly everyday, if I were pregnant now . . . [Personal Interview, Zoë Moondust, April 14, 2002]

Another homebirther, Anna Turner, who had had several homebirths with an underground DEM who had been forced to stop practicing, even considered not having any more children: “I really question whether to have more children, I mean, that’s terrible. I mean what if we have more children? What are we going to do?” (Personal Interview, April 16, 2002).

Other homebirthers sought care from the few CNMs providing care for homebirths. However, as Veronica Nelson, a doula in Northern Virginia,²¹ where several CNMs attend homebirths legally, wrote to a local listserv:

Just getting back this morning from a hugely medically intervened OB/hospital birth - client had wanted to use a home birth midwife after we talked in January (and even still when I got to her home yesterday morning), but you know how that goes.....the CNMs were booked.) [Listsrv message, March 26, 2001]

In sum, many homebirthers in Virginia have been unable to access the practitioners they desire.

SECTION 5 GRASSROOTS ORGANIZING

The decreasing availability of homebirth practitioners in Virginia was the catalyst for many women, as well as a few men, to begin grassroots organizing during the late 1990s to maintain and enhance access to midwives who would attend homebirths in their communities. Notably, many practicing midwives in the Commonwealth remained relatively quiet on the political front during initial organizing efforts. For DEMs, exposing themselves as practicing underground midwives would have risked possible state investigation and legal repercussions. Some CNMs reported feeling pressure from their supervising physicians and Virginia medical groups and also remained largely absent in the political arena. Several CNMs in my study also disclosed that supervising physicians had dissuaded them from supporting DEMs, both individually and through professional groups. As a result, the support of midwifery in Virginia has gained a national reputation as an example of the “Consumer Movement for Midwifery.”²²

²⁰ The increasing urbanization of all CNM practices in Virginia—and particularly for CNMs offering homebirth services—runs counter to the initial state and medical support of midwives to serve rural and medically underserved areas (Commonwealth of Virginia 1991:House Joint Resolution 431; Stern 1999:4). However, the recent migration of obstetricians away from “rural areas [in Virginia] because of heavy workloads and little financial gain” (Davis-Floyd 1992:300) has left a dearth of prenatal care and delivery services by both physicians and CNMs, as the latter must find a local physician willing to supervise their practice (Task Force 1992:8-10).

²¹ In *The Doula Book*, Marshall Klaus, John Kennell, and Phyllis Klaus define a doula as “an experienced labor companion who provides the woman and her husband or partner both emotional and physical support throughout the entire labor and delivery, and to some extent, afterward” (2002:4).

²² Many midwives and midwifery advocates in Virginia, as well as nationally and internationally, have adopted the term “consumer” to distinguish women who seek access to midwifery care from midwives themselves (Rothman 1982; Sandelowski 1984; DeVries 1986, 1996; Sullivan and Weitz 1988; Garcia, Kilpatrick and Richards 1990; Oakley and Houd 1990; DeVries, Benoit, van Teijlingen, and Wrede 2001; Mander and Fleming 2002). The “consumer movement” for midwifery in Virginia differs from legislative struggles in many other states where the majority of political organization has been among midwives themselves. See, for example, discussions of recent legislative debates in Florida (Miller 1999) and Minnesota (Lay 2001).

Nevertheless, some midwives have remained politically active, though sometimes with much trepidation, in the two statewide organizations for midwives. The Commonwealth Midwives Alliance (CMA) formed in 1983 to support midwives who sought “full access to legal, autonomous midwifery services, in all setting[s], for the citizens of Virginia” (Hughes and Wood 1999). In 1999, CMA had approximately 20 members, most of whom were practicing DEMs, former DEMs, and aspiring midwives from around the state. In my interviews with members of CMA, many indicated that statewide physical meetings were difficult because practicing midwives were often on call for clients in their local communities. However, CMA has served as a consistent support network for DEMs over the past 20 years.²³

The Virginia Chapter of the American College of Nurse-Midwives (VACNM), formed in 1984, is the primary organizing body for CNMs. In 2000, 85-90% of the then 126 CNMs in Virginia were members of the ACNM (American College of Nurse-Midwives 2000), though participation in the Virginia Chapter was variable depending upon political climate, particular agenda items, and the location of the meetings. Like DEMs, CNMs were often on call for clients, which made attendance at physical gatherings difficult.²⁴ Nonetheless, several active members worked (and continue to work) on legislation to improve and enhance their ability to practice in a variety of settings.

For example, during the late 1980s, Virginia CNMs Alice Bailis and Marsha Jackson, and many of their homebirth and birthcenter clients, “mounted a highly publicized and successful challenge” to insurance companies’ increasing surcharges on physicians who worked with midwives (American College of Nurse-Midwives 2002b:26).²⁵ In particular, one physician-owned malpractice carrier, the National Capital Reciprocal Insurance Company, increased their physician surcharge for working with CNMs by more than 4,000% in one year—from \$300 to \$12,000 per midwife per year (Jenkins 1994:104). The CNMs ultimately won the case; the DC Superintendent of Insurance ruled that no actuarial tables existed in the U.S. that would justify charging extra premiums for “vicarious liability,” the indirect legal responsibility of physicians for midwives, and that all risks associated with midwives were already included in the current price structure for obstetrical liability insurance (Jenkins 1994:104). This case was influential in the development of the Professional Liability Committee within the national ACNM to address the problem of discriminatory physician surcharges on a nationwide level (American College of Nurse-Midwives 2002b:26).

VACNM’s first legislative victory in Virginia occurred in 1991 when the state passed a resolution to study “the potential for the expansion of the practice of nurse midwives” (Commonwealth of Virginia 1991:House Joint Resolution 431). Several CNMs were among those appointed to the Task Force (1992:ii) and the group ultimately recommended that increasing the number of CNMs practicing in the Commonwealth would improve infant and maternal mortality statistics. Further, to generate more practicing CNMs, the Task Force suggested the establishment of a school for nurse-midwives in Virginia (Task Force 1992:25). In 1997, state funding allowed Shenandoah University to expand their nursing program to offer a Master’s Degree and Post-Master’s Certificate in Nurse-Midwifery. One of the original founders of VACNM, Juliana van Olphen Fehr, became the director.

Another victory for VACNM was the passage of legislation in 1997 mandating direct insurance reimbursement (including Medicaid) for CNMs (Commonwealth of Virginia 1997:HB 1360). Jessica Jordan initiated this bill while she was legislative coordinator for VACNM because she and other CNMs were unable to be reimbursed for their services if they were not practicing directly under a physician. During the early 1990s, some CNMs attempted to provide services only to those who could pay out of pocket, but they found that most clients

²³ After 2003, when the law prohibiting DEMs from receiving compensation was struck down, midwives in CMA became the primary public proponents of legislation to license CPMs. However, homebirthers and other midwifery advocates have remained supportive of licensure efforts. Although they are less involved in the specifics of proposed regulations, citizens and consumers continue to lobby for access to midwives and organize educational forums throughout the state.

²⁴ Several CNMs confided that because Virginia midwives practiced in such diverse locations (hospitals, physician practices, public health departments, an air force base, private practices, birthcenters, and homebirth practices), they had very different legislative, legal, educational, and social needs. As a result, some chose to attend national meetings of the ACNM, but opted out of meetings of the Virginia Chapter.

²⁵ In the 1980s, insurance companies began to require physicians to pay surcharges—additional professional liability premium charges—for working with midwives. S. D. Cohn’s (1989) study of professional liability insurance and nurse-midwifery practice, carried out in 14 states and the District of Columbia in 1988, showed that these surcharges ranged from \$94 to \$23,000 per midwife per year and were responsible for the closing of over 14% of affected CNM practices and for fee increases in an additional 26% (American College of Nurse-Midwives 2002b:26). The “insurance crisis” of the 1980s abated in the 1990s; the American College of Obstetricians and Gynecologists (ACOG) Survey of Professional Liability indicated a decrease in physicians who reported an insurance carrier surcharge for employing a nurse-midwife from 60% in 1992 to 32% in 1996 (ACNM 2002b:26). However, malpractice insurance concerns have re-emerged in recent years and the volume of calls regarding physician surcharges to the national ACNM’s office has increased once again (ACNM 2002b:27).

were unable or unwilling to do so. For CNMs who operated homebirth practices, birthcenters, or provided prenatal and gynecologic care privately, legislation which mandated direct insurance reimbursement allowed them to expand their care to include women who paid through private insurance and Medicaid in the late 1990s.

In 1999, VACNM also officially supported efforts to legalize the Certified Professional Midwife (CPM) credential in Virginia, in addition to the ACNM-based certification credential for DEMs, the Certified Midwife (as reported in JCHC 2000a:8-9). This initial support was a notable break from the national ACNM policy, which had opposed the licensure of any midwives who are not certified by their organization. The alliance between DEMs and CNMs in Virginia is likely due to the contemporary legislative restrictions that prohibit *all* midwives from practicing autonomously—without the supervision of a physician. Many CNMs recognize the importance of autonomous midwifery practice, particularly for practitioners who offer out-of-hospital birthcare. Some CNMs hope that establishing licensure for DEMs will lead to the expansion of their own autonomy. Several CNMs also practiced as DEMs in Virginia before becoming nurse-midwives to comply with state regulations; these practitioners remain prominent members of statewide midwifery organizations. In recent years, many of these individual CNMs have maintained their support of legislation to license DEMs, but VACNM has not conferred their official support. When I asked CNMs in my study about this shift, most highlighted Virginia CNMs' tenuous relationship with individual physicians and medical organizations in the state, expressing concerns about reprisal by the physicians who supervise them (and therefore determine whether or not they are able to practice).

Despite these important coalitions among Virginia midwives and the notable professional advances for CNMs during the past 15 years, many childbearing women were still unable to find homebirth midwives in the 1990s. In response, many homebirthers began to form their own grassroots organizations to respond to the increasing investigations and prosecutions of midwives and the resultant decrease in the availability of midwives to attend homebirths. In the shadow of several widely publicized investigations, groups began mobilizing throughout the state to support midwives.

Peninsula Families for Natural Birth and Health Care (PenFam) was founded in the Virginia Beach area in 1996 by “five moms wishing to create a support network for clients of our local direct-entry midwife as well as provide information for the general public about natural birth and health care” (Greene 1999:1). PenFam eventually dissolved and two organizations emerged in the Virginia Beach area, each pursuing one of PenFam's stated goals. Families for Natural Living (FNL), remains active as an educational organization for informed healthcare decisions. Voices for Healthcare Rights Fund (Voices) began officially in 1998 and focused primarily on generating financial and organizational support for the defense of local midwife Caillagh and her assistant, Haw. Voices' broader goals as an organization were to provide defense funds for other alternative practitioners and defend individual healthcare freedom (Voices for Healthcare Rights Fund 1999). At a meeting with other organizations supporting midwifery in Virginia, Voices maintained: “Our organization does not want to see the diversity of the organizations in the state of [Virginia] relating to midwifery, undermine our ability to defend our rights or to defend our practitioners” (Righter 1999:1).

Shortly after the formation of PenFam in Virginia Beach, Steve Cochran independently organized Virginia Birthing Freedom (VBF) in southwestern Virginia. In 1997, VBF, represented by Crystal Consalvi, brought the issue of increased public interest in DEM to the attention of the General Assembly and introduced the Certified Professional Midwife (CPM) credential for the first time in Virginia during the public commentary period of the state study, “Improving Access to Perinatal Care in Rural and Under Served Areas” (Commonwealth of Virginia, Perinatal/Early Childhood Subcommittee of the Maternal and Child Health Council 1998). This prompted the introduction of a resolution for the Joint Commission on Health Care (JCHC) to initiate a Midwifery Study in 1998, to examine “the advisability of legalizing direct-entry midwifery,” with assistance from the Department of Health Professions and the Department of Health (Commonwealth of Virginia 1999c:HJ 646).²⁶ Following the JCHC's recommendation to introduce legislation legalizing the practice of direct-entry midwifery by individuals who meet the requirements of the North American Registry of Midwives for certification as a Certified Professional Midwife,²⁷ VBF drafted bills license DEMs for the following three years: in 2000 (Commonwealth of Virginia

²⁶ In 1999, midwifery proponents also worked with lobbyist Bill Kincaid, House Delegate Jo Ann Davis and Senator W. Roscoe Reynolds to introduce identical bills to the House of Delegates and Senate Rules Committee, which would have registered and permitted lay midwives under the regulations set forth prior to 1977 (Commonwealth of Virginia 1999a:HB 2686, 1999b:SB 1266). These bills were briefly reviewed, but no action was taken in the House and the Senate struck the bill from the docket.

²⁷ In the final report to the Governor and General Assembly of Virginia by the JCHC, they wrote:

A more subjective observation is that the current state law provides a disincentive for persons receiving direct entry midwifery services to seek medical attention when such attention is warranted. It should be noted that the practice of direct entry midwifery is currently illegal, but the receipt of such services is not. Nevertheless, the current illegal status of direct entry midwifery could delay persons from seeking medical attention for a mother and her baby when necessary, when the

2000a:House Bill 1470, 2000b:Senate Bill 657),²⁸ 2001 (Commonwealth of Virginia 2001:HB 1582),²⁹ and 2002 (Commonwealth of Virginia 2002d:HB 889, 2002b:HB 890, 2002c:HB 891, 2002e:HJ 134).³⁰ Facing strong opposition from the Virginia Chapter of the American College of Obstetricians and Gynecologists (VA-ACOG),³¹ the Medical Society of Virginia, the VDH, the Department of Health Professions, and the State Chief Medical Examiner, each of these subsequent bills were rejected in committee (before reaching the floor of the full House or Senate). While the JCHC had recommended that a bill to legalize the CPM be introduced, it became a disadvantage that no seal of approval was given to a particular piece of legislation (Heyser 2000:B2).

Additionally, there was also a great deal of disagreement among advocates around what form this legislation should take. Despite the JCHC recommendation to legalize the CPM, many midwifery advocates worried about DEMs losing their autonomy. In 1999, VBF initially drafted legislation to decriminalize DEM and allow the

desirable public policy goal would be to have such services sought as quickly as possible. A further subjective observation is that parents who chose direct entry midwifery services appear to be highly motivated to do so, and it is unclear that the desire to seek such services is influenced significantly, if at all, by the legal status of direct entry midwifery.

It should be further noted that the public policy decision against the practice of direct entry midwifery during the 1976 session of the General Assembly was clouded by the General Assembly's decision to grandfather existing practitioners. There is one direct entry midwife still legally and actively practicing today as she has been since 1972, with the full imprimatur [sic] of the state. Therefore it is difficult to cogently argue that the public policy position of the state is that direct entry midwifery is patently unsafe. If this were the case, then there would have been no justification for the grandfathering provisions included in 1976. [JCHC 2000a:21]

²⁸ In 2000, midwifery proponents worked with Delegate Phillip A. Hamilton and Senator Nick Rerras to introduce identical bills to the House and Senate, which would have licensed DEMs under the Board of Health, with advice from a new Advisory Council on Midwifery (which would have been established with this bill) under regulations promulgated by the Board of Health Professions. This bill would have also required DEMs to have a "written protocol with an actively practicing physician who has hospital privileges and is experienced in providing labor and delivery care" and offer a written consent form to "any pregnant woman seeking midwifery care" (Commonwealth of Virginia 2000a:HB 1470, 2000b:SB 657). The Health, Welfare, and Institutions (HWI) Subcommittee rejected HB 1470 outright (7-Yeas, 14-Nays, 1-Not Voting) and the Committee on Education and Health voted unanimously (15-Yeas, 0-Nays) to carry the identical SB 657 over to the 2001 session.

²⁹ In 2001, midwifery proponents, with Hamilton as Chief Patron, reintroduced a revised version of the identical bills from 2000 in the House of Delegates, which would have regulated and licensed midwives under the Board of Health, again with the advice of an Advisory Council on Midwifery that would have been established through the bill. This bill would not have required a written protocol with a physician, like the 2000 bill, but rather a "written protocol for medical emergencies" (Commonwealth of Virginia 2001:HB 1582). HB 1582 would also have required DEMs to obtain a written informed consent form from all clients. The HWI Subcommittee defeated the bill (8-Yeas, 12-Nays, 2-Not Voting).

³⁰ In 2002, midwifery supporters strategized with supportive Delegates and lobbyists to introduce three bills and one study resolution with Hamilton as Chief Patron. Their strategy was to show flexibility around requirements, allowing the state to choose which option was most viable within the existing healthcare system and ultimately pass only one. The first bill, HB 889, would have promulgated the licensure of CPMs through the Board of Medicine and created an Advisory Council on Midwifery. It also required midwives to disclose information about training, experience, malpractice or liability insurance coverage, and procedures to file complaints. Notably, this bill also stated explicitly, "Licensed midwives are not required to have any agreement or assessment of the potential client by another health care professional" (Commonwealth of Virginia 2002d:HB 889)—unlike formerly licensed lay midwives and CNMs who must be supervised by a physician in Virginia. The HWI committee defeated HB 889 (10-Yeas, 12-Nays). The second bill, HB 890 would have allowed DEMs to practice under the regulation of the Board of Health. No other restrictions or regulations were included in the bill. The HWI committee also defeated HB 890 (10-Yeas, 12-Nays). The third bill, HB 891 would have exempted persons who had obtained a CPM credential from any licensure or regulation in Virginia. The HWI committee also defeated this bill (3-Yeas, 19-Nays). Additionally, midwifery proponents introduced a study resolution in 2002, which would have put the onus of recommending "the appropriate degree of regulation" for DEMs on the Board of Health Professions (Commonwealth of Virginia 2002e:HJ 134). The study resolution passed through the HWI Subcommittee (16-Yeas, 5-Nays), was adopted by the House of Delegates (86-Yeas, 11-Nays), but ultimately rejected by the Senate Rules Committee (3-Yeas, 5-Nays, 2-Abstentions).

³¹ During the JCHC hearings to study DEM, representatives of the VA-ACOG reiterated the national American College of Obstetricians and Gynecologist's statement of policy on homebirth, which was drafted in 1979:

Labor and delivery, while a physiologic process, clearly presents potential hazards to mother and fetus before and after birth. These hazards require standards of safety which are provided in the hospital setting and cannot be matched in the home situation.

We support those actions that improve the experience of the family while continuing to provide the mother and her infant with accepted standards of safety available only in hospitals which conform to the standards as outlined by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. [as cited in JCHC 2000a:9]

registration prior to the 1977 law governing the practice of DEMs in Virginia. After they were advised against this strategy by supportive lawmakers, they ultimately introduced the bills above to license the CPM (Hamblet 1999).³²

Even during these lobbying efforts, however, midwifery advocates continued to disagree internally—sometimes even on the floor of the General Assembly. Some homebirthers believed that consumers should have the right to choose any midwife they desired, regardless of state licensure or regulation. Some suggested that rather than focus on the licensure of DEMs, grassroots advocates should adopt a political platform to make the choice to engage in homebirth with a midwife a religious freedom, drawing on the Virginia Statute for Religious Freedom, which was drafted by Thomas Jefferson in 1779 and passed into legislation by James Madison in 1786 (Commonwealth of Virginia 2002a:§57-1). One midwifery advocate explained: “It is my belief that the parents are given true autonomy by God Himself to determine what is a proper [birthing] environment” (Listserv message, Dana Smith, March 18, 2000). Participants in my study reported compelling individual lobbying efforts in this regard, but the issue of religious freedom has remained largely undiscussed on the floor of the General Assembly.

VBF eventually grew to include over 400 midwifery supporters on a statewide listserv by 2000. A VBF fundraising letter described their purpose as follows:

VBF began in 1997 as a grassroots organization of citizens who sensed a compelling need to expand the available options for giving birth in Virginia... VBF's primary, but not exclusive, goal is to convince the Virginia General Assembly to mandate licensure for the Certified Professional Midwife (CPM). We face stiff opposition from the medical lobby, which insists in its writings and at public hearings that home birth is unsafe for any woman at any time. They have power, money and access, but we have something far more valuable: facts, and families (Listserv Message, VBF, December 16, 2000).

With the heightened legislative and media attention on midwifery in Virginia, particularly as a result of the JCHC hearings studying midwifery,³³ as well as the highly politicized investigations of several midwives, women seeking homebirths throughout the state began to organize local midwifery support groups to meet the specific needs of their local communities. In 1999, Harrisonburg Advocates for the Midwifery Model of Care (HAMMOC) formed to “share information, offer support, and affirm the rights of women and families to make informed choices throughout the childbearing cycle” (Rhodes, Shaver, Cunningham, and Copeland 1999). HAMMOC held local gatherings of midwives’ clients and supported several CNMs in their area (Email to author, Melanie Copeland, June 29, 2003). Richmond Families for Birthing Alternatives (RFBA), which began as a support group for clients of local homebirth CNM Nancy Giglio in 1983 (Email to author, Lesin Dippold, May 2, 2003), had approximately 120 members by 1999 (Meade and Dippold 1999), many of whom became active in the legal support of local aspiring midwife, Beth Haw, after her investigation with Caillagh in 1999. Also in 1999, the Fredericksburg Area Consumers of Homebirth and Midwifery Care emerged to maintain “midwifery care and home birth as a local option for childbirth” and were also active in raising money to support Caillagh and Haw during their investigation and court hearings, which were held in Stafford County, near Fredericksburg (Smith and Smith 1999). Freeda Cathcart founded Mothers United for Midwifery (MUM) in the Roanoke Area in response to disagreements about legislation with VBF during 1999. In 2001, mothers and midwives in Winchester organized Midwifery Options for Mothers (MOM) primarily as an educational organization and for the support of local CNMs and DEMs in northwestern Virginia. During 2002 and 2003, MOM held midwifery classes and meetings of midwifery supporters to encourage “autonomous (self-governing) midwifery in Virginia” (Midwifery Options for Mothers 2003).

³² Ironically, legislation to strike down the 1977 statute was ultimately what passed in the General Assembly in 2003.

³³ In 1999, the JCHC Midwifery Subcommittee held three public hearings to gauge public support for legislation regarding DEMs generating a sizeable response from midwifery proponents. Of the 63 individuals speaking at the meetings in Dublin (at New River Valley Community College), Fairfax (at George Mason University), and Newport News (at Christopher Newport University), 61 spoke in favor of legalizing DEM—these included mothers and fathers whose births had been attended by midwives, Virginia’s only legally-practicing DEM, several CNMs, and representatives of grassroots organizations supporting midwifery (JCHC 2000a:8). Similarly, the Committee received 23 written public comments from individuals and organizations, 22 of which supported the legalization of midwifery. Despite a plea for physician participation in this process “to get reasonable legislation ... on direct-entry midwives” in a publication by the Virginia Obstetrical and Gynecological Society and the VA-ACOG (Gerheart 1999:2), only two representatives from these groups spoke at public hearings and only one representative from the Medical Society of Virginia sent a letter opposing legislation (Murray 1999a:10, 1999b:5). In total, the JCHC received comments from 192 citizens, 183 of whom explicitly supported the licensure of CPMs (JCHC 2000b:1-2): “Following the public comments period, the Joint Commission also received a petition signed by 124 citizens requesting ‘the General Assembly to decriminalize the practice of home-based midwifery. This includes legalizing the Certified Professional Midwife’” (JCHC 2000b:3).

Of these community-based pro-midwifery organizations, only Virginia Friends of Midwives (VFOM, formerly VBF)³⁴ and DEMs in CMA remained active around legislation for midwives. FNL, HAMMOC, RFBA, and MOM have also continued to organize educational forums and new organizations continue to emerge throughout the state.³⁵ Similar to many of the nascent national organizations of midwives during the 1970s and 1980s (Schlinger 1992:7), groups supporting midwives in Virginia have often become associated with one personality and, in turn, have drawn in those with personal connections to that individual or those who held similar beliefs, but alienated other midwifery supporters. In one organizing effort to promote a “unity of purpose” among Virginia midwifery groups, the Virginia Midwifery Coalition (VMC), met at rotating locations around the state for several months in 1999. In an email invitation to join the discussion, organizer Brynne Potter wrote:

What we are severely lacking are communication and trust between the various groups in Virginia who seem to have the same goals. That common goal as I see it is to promote greater access to direct entry midwifery ... We are also in agreement that an arching coalition/council would be a multi-faceted benefit to each groups’ existing agenda because of the obvious networking that would come out of communicating better. We each in varying degree[s] understand that we all need each other to reach our goals ... I think this is a labor, and we are in transition. If we are going to deliver safely, we need to join hands and learn to trust each other. [Listserv message, February 9, 1999]

VMC has since dissolved, though the forum for bringing local pro-midwifery organizations into conversation continues on several statewide listservs that support midwifery [to join VFOM’s listserv, go to www.vfom.org and click on “Get Involved”].

SECTION 6 LEGISLATIVE CHANGES 2003-2005

In 2003, VFOM and CMA—with Brynne Potter, Leslie Payne, and Trinlie Wood as their legislative committee—were instrumental in the passage of a law that struck down the 1977 law that had effectively criminalized non-nurse midwifery in Virginia for 26 years (Commonwealth of Virginia 2003a:HB 1961). HB 1961 removed the 1977 definition of the lay midwife and the regulation thereof and further, exempted “individuals who are not registered as nurses” from registration and permit requirements. This bill passed unanimously in the Senate Rules Committee (37-Yeas, 0-Nays), and was adopted in the House of Delegates (84-Yeas, 14-Nays). The purpose of this bill was to pave the way for the DHP to recognize the CPM as an emerging profession. The changes also meant that DEMs could no longer be charged with the misdemeanor of “practicing midwifery without a license,” though there remained a vulnerability for the state to prosecute DEMs for “practicing medicine without a license” or “practicing nurse-midwifery without a license”—both felony changes. Thus, midwives and homebirthers continued to fight for the legalization and licensure of CPMs.

In 2003, legislators tabled a bill that would have followed up decriminalization by promulgating the licensure of CPMs through the Board of Medicine (Commonwealth of Virginia 2003b:HB 1960). Legislators also rejected a study resolution in 2003, which would have required the Board of Health Professions to recommend the appropriate regulation of DEMs (Commonwealth of Virginia 2003c:House Joint Resolution 605). In 2004,³⁶ legislators tabled a bill to remove midwifery from the definition of the practice of medicine and other healing arts (Commonwealth of Virginia 2004a:HB 1354), as well as a study resolution similar to the one introduced in 2003 (Commonwealth of Virginia 2004c:HJR 127). An important minor victory in 2004 though, was that HB 581 (Commonwealth of Virginia 2004b)—which was similar to other bills aimed at licensing CPMs in prior years—passed the HWI Subcommittee (17-Yeas, 5-Nays) and the full House (91-Yeas, 9-Nays). Although it was ultimately defeated in the

³⁴ In 2002, VBF became Virginia Friends of Midwives (VFOM) reflecting a change in leadership to a Board of Directors, including founding members Tammi McKinley, Ellen Hamblet, Sara Krivanec, Bonnie Matheson, and Leslie Payne, in response to “the need for a more inclusive identity as the movement to improve access to midwives has grown [and] to reflect a new commitment to working with likeminded groups of other consumers and midwives” (Virginia Friends of Midwives 2003).

³⁵ Although not a “grassroots organization” per se, Childbirthsolutions.com is a notable childbirth education resource, which was developed in Virginia by Bonnie Buchanan Matheson in 1999. Childbirth Solutions aims “to inform women worldwide about all of their options so that they may make informed choices for the most empowering birth experience that is possible,” and remains a vibrant source of information for childbearing women (Childbirth Solutions 2003).

³⁶ In 2004, lobbyist Becky Rice, RN joined CMA’s legislative team.

Senate Subcommittee on Education and Health (10-Nays, 5-Yeas), this victory led the way to successful legislation in 2005.³⁷

Finally, in 2005, Virginia finally passed a law to license CPMs in the Commonwealth!! The CPM licensure law established an Advisory Board to develop regulations for CPMs under the Board of Medicine, consisting of “three Certified Professional Midwives, one doctor of medicine or osteopathy or certified nurse midwife who is licensed to practice in the Commonwealth and who has experience in out-of-hospital birth settings, and one citizen who has used out-of-hospital midwifery services” (Commonwealth of Virginia 2005). Importantly, the bill ensured independent practice for CPMs and did not require mothers to be assessed by another healthcare professional in order to seek midwifery care. Thus, the “physician supervision” requirement, which has prevented out-of-hospital practice for many nurse-midwives in Virginia, will not affect CPMs under this law. Despite the efforts of some legislators to require malpractice insurance for CPMs—a financial constraint for independent practitioners that is not required for independently practicing physicians or other medical personnel in Virginia—the law passed without this stipulation. Rather, licensed midwives are required to *disclose* malpractice or liability insurance coverage to clients—along with other background information, including their training and experience, their written protocol for medical emergencies, and the procedures to file complaints with the Board of Medicine. One drawback of the bill is that it prohibited the possession and administration of controlled substances, including oxygen. Most midwives and citizens agreed, however, that this was acceptable in order to pass the CPM licensure bill and could be dealt with through future legislation. More information on the law may be obtained at the Virginia General Assembly’s Legislative Information System at <http://leg1.state.va.us/cgi-bin/legp504.exe?ses=051&typ=bil&val=sb1259>.

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