MIDWIVES IN MONTANA: HISTORICALLY INFORMED POLITICAL ACTIVISM

by

Jennifer Janna Hill

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Dr. Mary Murphy

Approved for the Department of Liberal Studies

Dr. David Cherry

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Dr. Ronald W. Larsen
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States contiguous to Montana legalized direct-entry midwifery only in the 21st century, while the Montana legislature exempted lay midwives from the Medical Practice Act during the 1989 legislative session and approved a licensing protocol for Certified Professional Midwives in 1991. *Midwives in Montana* examines the historical context of the legalization of midwifery in Montana and identifies significant individuals, groups, and events in the confrontation over home birth in the state. Based on oral histories of legislative participants and drawn from primary and secondary source materials held by individuals and institutions throughout the state, this research compiles scattered documentary evidence to present the history of Montana midwives from territorial days through the legislative events of 1989 and 1991. The efforts of midwifery supporters in the Montana legislature prevailed over organized and well-funded opposition from individual physicians, medical organizations, and hospitals, and resulted in statutory changes that enabled the licensing of homebirth midwives. With a strong rural representation, the 1989 legislative body supported the availability of midwifery care for constituents unable to access urban medical centers. The lobbying strategy employed by midwifery advocates embodied a sophisticated understanding of the conflict between midwives and institutionalized medicine and utilized beliefs about gender and Montana identity to enable legislative success. Additionally, the individuals most closely involved in the lobbying process remained committed to a clearly defined agenda. As a result of their efforts, Montana became the ninth state in the nation to legalize and license homebirth midwives and remains a national leader in homebirth midwifery care.
INTRODUCTION

Each day in the United States, approximately 11,000 women give birth.\textsuperscript{1} Parturient women represent a multitude of ethnic backgrounds, languages, and religions, but most share a common delivery experience. They birth their babies in American hospitals from Atlanta, Georgia to Billings, Montana, and despite geographic and cultural differences, the obstetric procedures they experience remain similar. The course of their labors and deliveries are marked by interventions – induction of labor, fetal monitoring, anesthesia, and episiotomy. Most are reassured that they have access to cutting edge technology, highly trained healthcare personnel, and the latest in obstetric research.

Contemporary American birth practices are consistent across a tremendous expanse of geography, transcend class and ethnic divides, and connect rural and urban women. Unfortunately, most current birth interventions in the U.S. are damaging to women and infants and cause preventable death, injury, and long-term physical, psychic, and emotional harm. Amnesty International rates current American maternal health care as systemically abusive of women and blatantly racist in its treatment of minority women and babies:

“[Women] in the USA have a greater lifetime risk of dying of pregnancy-related complications than women in 40 other countries. For example, the likelihood of a woman dying in childbirth in the USA is five times greater than in Greece, four times greater than in Germany, and three times greater than in Spain . . . More than a third of all women who give birth in the USA – 1.7 million women each year – experience some type of complication that has an adverse effect on their health.”\textsuperscript{2}
Parturient American women die needlessly of preventable pregnancy-related complications, at rates much higher than in other countries. When some women with existing untreated conditions, like high blood pressure or diabetes, become pregnant, their health is threatened by lack of support and inability to procure medical treatment and preventive care.

America spends more of its gross domestic product on healthcare than any other nation in the world, and yet produces inferior and racially discriminatory results for women. A significant number of minority women face obstacles to obtaining quality healthcare in a system that disadvantages women in general and women of color in particular. Racial minorities typically find it more difficult to access quality health care. The distribution of health care in a racist society penalizes women of color, with staggering results in mortality statistics.

"Black women are nearly four times more likely to die from pregnancy-related causes than white women. In high-risk pregnancies, the disparities are even greater, with African-American women 5.6 times more likely to die than white women. Among women diagnosed with pregnancy-induced hypertension, African-American and Latina women were 9.9 and 7.9 times more likely to die than white women with the same complications."4

The American system is not only harmful to women; it needlessly puts infants at risk. In a global comparison, the United States has infant mortality rates similar to Hungary and Croatia, and the most recent statistics reported an average of 5.9 American babies dying for every 1,000 live births. Cuba produced better results with 4.76 deaths per 1,000 live births. Countries like Singapore, with a rate of 2.59,

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1 For an expanded ranking of countries by infant death rates, see Appendix H.
Sweden with 2.73, and the Netherlands with 3.69, have implemented delivery practices that support women and infants in the birth process and prevent many unnecessary deaths.\textsuperscript{5}

The World Health Organization studied global C-section and pregnancy outcome rates and determined that the optimal C-section rate was between 5\% and 10\%.\textsuperscript{6} Rates lower than 5\% indicated a loss of life from emergency complications of pregnancy, while rates in excess of 10\% evidenced excessive abdominal surgeries with concomitant recovery time, financial expense, and risk of complications. The C-section rate in the United States rose from 4.5\% in 1965 to 32.9\% in 2009, far surpassing the optimal 10\% rate.\textsuperscript{7,ii} One-third of American infants are now delivered surgically, a rate in excess of statistical or evidence-based recommendations.

Too often, C-sections are performed unnecessarily, as part of routine obstetric practice, despite the impact on mothers and babies. Childbirth Connection, a maternal health advocacy organization formed in 1918, described the effects of the immoderate use of C-sections:

"Short-term harms [from C-section] for mothers include increased risk of unintended surgical cuts, infection, blood clots, emergency hysterectomy, going back into the hospital, a challenging recovery, and death. Babies born by cesarean section are more likely to have breathing problems and to develop several chronic diseases: childhood-onset diabetes, allergies with cold-like symptoms, and asthma in childhood and beyond . . . [Cesarean] mothers are more likely to have ongoing pelvic pain and to have infertility in the future."

\textsuperscript{iii} For an expanded discussion of C-section rates in the United States, see Appendix G.
C-sections involve all of the risks of major abdominal surgery, as well as consequences unique to female reproductive function. The use of the C-section procedure as a life saving measure in a small percentage of pregnancies has been an invaluable resource for women faced with genuine delivery emergencies. But its widespread application to normal deliveries makes the birth process for women and infants inordinately risky.

“The risk of death following C-sections is more than three times as high as for vaginal births. C-sections have been shown to increase a woman’s risk of infection, hysterectomy, and kidney failure, and have been associated with a 52 percent increase in the risk of developing a life threatening blood clot.”

Medical management of birth places too many women and infants in jeopardy, necessitating further procedures to correct harms incurred in inappropriate usage of medical technologies and interventions.

Abundant analysis exists documenting the failures of obstetric care in the United States, from erudite academic texts to accessible volumes available from public libraries. Well-researched and readable publications present the realities of hospital-managed births. Jennifer Block, in *Pushed: The Painful Truth About Childbirth and Modern Maternity Care*, compared the American system of surgical intervention to the European countries Denmark, Sweden, and the Netherlands, which have more favorable maternal and infant outcome rates. She showed that lower C-section rates in European countries resulted from the integration of continuous supportive care for women and the use of obstetric specialists for high-risk births only. Block presented the case for maternity care based on practices that
show statistical evidence of success over time and demonstrated the ways in which American birth practices resulted from economic and legal circumstances that damaged the overall health of mothers and children.

Marsden Wagner, in *Born in the USA: How a Broken Maternity System Must be Fixed to Put Women and Children First*, explained that the American medical system is based, not on science, but on inherited and traditional practice.\textsuperscript{11} Using statistical research he demonstrated that most obstetrical interventions endangered mothers and infants, but remained standard medical procedure despite their proven damages. Wagner, a medical doctor, scientist, and the World Health Organization’s Director of Women’s and Children’s Health, described how the structure of American medicine ignores the true needs of laboring women and newborn babies, pressures physicians to support ineffective birthing practices, and promotes medicine as an unquestioned authority.

The medical community continues to defend standard obstetric practices despite significant paradoxes. According to French physician Michel Odent, electronic fetal monitoring increases C-section rates but has no other statistically testable benefits; healthcare professionals tell women that homebirth is dangerous, but about one-third of Dutch women deliver at home with much lower mortality and C-section rates than the US; and many technological invasions into birth provide no verifiable benefit while exponentially raising medical costs.\textsuperscript{12} A surprising number of individual women and physicians follow mainstream obstetric practice, assuming that the status quo provides a measure of safety.
Comparatively poor obstetric results are not a recent phenomenon, but have become an American tradition, with maternity care in the United States failing to deliver top-tier outcomes for nearly one hundred years. In 1918, data collected by the U.S. Children’s Bureau revealed that sixteen nations had more favorable maternal survival rates than the US, with ten countries achieving lower infant mortality rates. In the past 90 years, American birth practices have incrementally changed but the results have not. The system continues to perpetuate poor outcomes, inequitable distribution of healthcare, and procedures that inhibit healthy pregnancies, deliveries, and infant development. Literature documents the ills of existing birth practices and advocates specific evidence-based recommendations with proven results. Scientifically-based conclusions have been available to medical schools, nurses’ training courses, and hospital administrators, yet harmful medical procedures remain largely in place, and hospitals continue to require birthing mothers to adapt themselves to the medical model. Modern practitioners have documented proven and efficient practices that support women and achieve optimal birth outcomes. Too often, existing obstetric practices remain intact.

Most women deliver in the hospital, and it is a common assumption that the hospital is the safest place for birth, the only reasonable birth location. History proves otherwise. Federal, state and local governments throughout the United States began collecting public health data in the early 1900s, tabulating the results, and publishing their conclusions. In 1915, before the shift to hospital birth, laboring
mothers died in childbirth at a rate of 60 in 10,000. By the late 1930s, when half of American women birthed in the hospital, the death rate for mothers climbed to 63 in 10,000, and urban women who labored disproportionately in hospital settings faced a mortality rate of 74 in 10,000. The shift to hospital birth did not result in safer births but nevertheless became entrenched as medical practitioners sought to establish their professional dominance. As discussed in Chapter 2, the mass movement from home to hospital birth in the United States gained momentum when urban women patronized hospitals as evidence of social class. Hospital birth became an indicator of patriotism and a signifier of American identity. More common in urban areas with accessible hospitals, hospital birth became routine even in rural areas when automobiles made long-distance travel to the hospital affordable and less time consuming.

The history of American childbirth reveals that birth is about patriarchy, not medicine, and philosophical variances in beliefs about reproduction and women’s bodies result in diverging practices before, during, and after delivery. Midwives and physicians voiced fundamentally different beliefs about birth. Anthropologist Robbie Davis-Floyd, a pioneer in birth culture analysis, demonstrated in her groundbreaking book *Birth As An American Rite of Passage*, that 20th century American birth practices socialized new citizens into the dominant cultural structure and introduced a particular way of viewing the world and human experience.
Davis-Floyd framed birth as a liminal point in a woman’s life, a time when identity was reshaped from “woman” to “mother.” The openness to re-visioning personal identity made the practices surrounding birth particularly potent, with pregnant women following a similar developmental progression from conception to post-partum. Davis-Floyd diagrammed three stages of identity change over the course of pregnancy – the initial acceptance of the pregnancy and self-perception as a pregnant woman; the experience of identity change in a number of contexts, including interactions in public, with the medical community, and with other pregnant women; and most particularly during the process of birth itself, when the woman remained sensitive to cultural rituals and imprinting. Women’s openness to new identities invited and/or received attention in the form of ritualized practices, such as pubic shaving and enemas, noticeably present during hospitalization.

Davis-Floyd showed that standard medical practice initiated the mother into a model where the mother’s body became the responsibility of medicine; the woman became the lowest ranking member of a rigid hierarchy with the doctor serving as high priest. The medical model framed the body as a mechanized structure, and a pregnant woman’s body as an unpredictable and somewhat defective machine. This worldview, labeled as “technocratic” by Davis-Floyd, attempted to cast birth, an entirely nature-based and female event, as being about men and machines. American birth rituals that placed women in prone positions and required them to submit to demeaning procedures like pubic shaving and enemas, established the proper order by formalizing misogynistic practices under the guise of doing what
was “best” for mothers and children. American birth practices existed for patriarchal purposes with medical justification. As women questioned how to define “best,” some placed value on maintenance of the social order and participation in traditional rituals, while others chose markedly different birth practices. Midwives and home birth advocates championed a different way of birth, claiming that the mother remained the most important person in the birth of a child and an active participant in the birthing process.

Early feminists interpreted women’s reproductive capacity differently and traced women’s oppression to their fertility. Simone de Beauvoir, in *The Second Sex* in 1952, staked out new ground for women and encouraged the formation of an independent female self as a means to achieve freedom from social constraints.\(^\text{16}\) She conceived of a new consciousness for women, and introduced a formerly unfathomable independence of personhood for women. Her work broke the chain between the capability and the necessity to reproduce. By positing an existing identity for women separable from their reproductive function, de Beauvoir established reproductive theory as a critical component of feminist philosophy.

De Beauvoir’s critique of reproduction disparaged motherhood as a social tool intended to keep women defined as “natural” and less than men. Men had the freedom to assume absolute independence, and an unencumbered female self required a similar lack of constraint. Her longing for and advocacy of female personhood caused her to understand the reproductive act as a choice by women to enter into a social bargain that identified women solely as wombs. Even though de
Beauvoir disconnected the ability to reproduce from the mandate to have children, she could not conceive of a woman having children and escaping the cultural prison of motherhood. The position of mother did not allow a woman to exist as a person but required that she be defined in relation to her domestic responsibilities – she was the wife of her husband and the mother of her children. By equating childbearing with oppression, de Beauvoir set the tone for continued feminist dialogue about reproduction.

Shulamith Firestone, a devotee of de Beauvoir, published *The Dialectic of Sex: The Case for Feminist Revolution* in 1970. Firestone looked to female biology as the cause of the sexual imbalance of power, and perceived women as subservient to their reproductive capability. The female estrous cycle drove the female life span; feminine experience existed only and in accordance with the reproductive frame of reference. Change required the complete and total repudiation of established family structure and reproductive assumptions.

Firestone claimed that any feelings women had for children represented “shared oppression,” and demonized motherhood as a ploy of patriarchy. Freedom for women meant escaping the dictates of the reproductive cycle and transcending the biological determinism that dictated human culture for centuries. Firestone claimed: “The heart of woman’s oppression is her childbearing and childrearing roles.” She advocated a wholesale restructuring of cultural mores, accomplished first by total disavowal on the part of women to participate in oppressive reproductive practices. The existing roles must be abolished, obliterated, and
rendered nonexistent before women could conceive of giving birth and remaining free.

The activism of the feminist movement promoted the separation of women from reproduction and echoed the philosophical underpinnings of de Beauvoir and Firestone. Second-wave feminists fought for access to birth control, the legalization of abortion, equal entry of women to full-time paid employment, and protection from workplace sexual harassment. Feminism focused on doing just as de Beauvoir and Firestone advocated – separating women from the dictate to reproduce, freeing women from male dependency, and legalizing safe and affordable abortion.

The political victories of second-wave feminism brought tremendous gains for women. The independent female life envisioned by de Beauvoir began to materialize in the consciousness of American women. The advent of the birth control pill allowed women to control pregnancy, and freed them to manage a career, a profession, and personal aspirations. The focus on reproductive rights gained women some freedom from the reproductive dictates condemned by de Beauvoir and Firestone, but in the process, reproduction itself became the problem. As a result, some aspects of feminism failed to speak to women who wanted to have children or who saw reproduction as a tool for empowerment instead of oppression.

When Raven Lang published the *Birth Book* in 1972, she understood the position of feminist theorists who claimed repression through reproduction, but did not perceive reproduction itself as the problem. Lang labeled the cultural and medical institutions surrounding childbirth as the onus of oppression, not
motherhood itself, and argued that women could be liberated in childbirth by taking ownership of the event and directing the birth process. Reproduction need not be tainted by its patriarchal history – in fact, its close association with oppression rendered it a powerful tool for personal freedom. Lang encouraged women to self-educate and mutually support each other through pregnancy and birth. The unity of feminine experience achieved through woman-centered birth resulted, according to Lang, in ownership of one’s body, choices, and actions. Women who directed their own birth process outside of the medical establishment underwent a realization of personal power and fulfillment critical for their liberation.

Suzanne Arms, in *Immaculate Deception* in 1975, followed Lang’s line of reasoning, and laid the blame for women’s imprisonment in fear-based childbirth at the feet of patriarchal Judeo-Christian dictates. Arms posited that Christianity inextricably linked sin and pain for women. Women brought sin into the world through the mythical Eve and paid for their participation in original sin by pain in childbirth. This tenet of Christianity – the requirement that women pay with pain – exhibited the religion’s inherent misogyny, and Arms credited the emphasis on pain with creating the mandate that childbirth was, “*inherently* dangerous, risky, painful, and terrifying.” According to Arms, women achieved a redemptive freedom from patriarchy by denouncing culturally constricting and dehumanizing beliefs and rebuking the male god that demanded the suffering of women. Women achieved independence by trusting women, the female body, and the process of birth.
Firestone and de Beauvoir rooted women's oppression in reproduction – childbirth was the problem. For Lang and Arms, a certain kind of childbirth – informed, empowered, and at home – presented the solution. They agreed on one thing – reproduction mattered. Despite, or possibly because of, their feminist motivations, de Beauvoir, Firestone, Lang, and Arms all placed reproductive choices at the center of women's lives in much the same way that patriarchy defined women according to their biology. Reproduction mattered in its presence or in its absence. Women should evade childbirth, or women should embrace a certain kind of childbirth. Depending on perspective, childbirth freed women or imprisoned them in destructive patriarchal patterns.

The thin history of midwifery provided a ready-made narrative that demonstrated the manipulation of birth practices to benefit organized medicine and its erasure of traditional midwifery birth skills. The story of midwifery proffered a plethora of vignettes illustrating the removal of highly proficient women from history, with their contributions colonized by men and their methods labeled as witchcraft. Authors like Barbara Ehrenreich and Deirdre English, in Witches, Midwives, and Nurses: A History of Women Healers in 1973, Richard and Dorothy Wertz in Lying-In: A History of Childbirth in America in 1977, and Judy Barrett Litoff in American Midwives: 1860 to the Present in 1978, told the history of birth practices with a confidence born of overwhelming evidence. These texts presented the work of midwives through the centuries and enumerated their methods and results. Newfound midwifery history detailed traditional knowledge held by midwives, as
well as the calculated removal of female practitioners by medical professionals. The historical record chronicled witch-hunts, drugged and screaming laboring women, babies slow to breathe, revenge episiotomies, and the fiasco of puerperal fever, supplying unending ammunition to demonstrate the dangers of institutionalized obstetrics. The suppression of midwifery provided a case study in the efficacy of women's knowledge and buttressed feminist claims of patriarchal conspiracy.

Second-wave feminism painted reproduction in three ways: childbearing as oppression, childbearing as a means to empowerment, and reproduction as an emblem of the power of patriarchy. The triad of themes composed feminist thought about reproduction, centered feminist theory around reproductive issues, and complicated feminist philosophy by simultaneously embracing contradictory positions.

Feminist theory dismantled and reshuffled these thematic components. Adrienne Rich, in *Of Woman Born: Motherhood as Experience and Institution* in 1976, described the two-pronged nature of motherhood. Women shared the potential to reproduce, even if they chose not to, and that shared potential united women in the inability to conceive, the choice to defer reproduction, or through pregnancy and childbirth. Rich contrasted the shared potential to reproduce with the oppression of institutional motherhood. The traditions surrounding motherhood pitted women against each other, forcing a competition for scarce resources. Women sought the ablest male economic providers, the best opportunities for their children, and elusive and illusory validation as “good” mothers. The competition among women
agonized them to each other and obfuscated their shared barriers. In Rich’s
analysis, reproduction united and encumbered women, bringing them together
while simultaneously dividing them.

Linda Gordon, in *Woman’s Body, Woman’s Right* in 1976, chronicled the
separation of women from the dictates of reproduction.24 Her work heralded the
potential for reproductive freedoms to transform society and its ingrained
hierarchies. An emblem of patriarchal power, childbearing would cease to be
oppressive when women freely chose to reproduce, and she suggested access to
birth control as the practical means to achieve that end.

The year 1978 welcomed two widely divergent perspectives. Nancy
Chodorow, in *The Reproduction of Mothering: Psychoanalysis and the Sociology of
Gender*, claimed that mothers’ socialization of their children created gender
stereotypes.25 Chodorow contended that women perpetuated the repressive system
when they produced daughters who wanted to mother and sons who could not
nurture. Her claim that gender inequalities resulted from too much mothering gave
the impression that if mothers quit caring, the system would right itself. By contrast,
Ina May Gaskin, in *Spiritual Midwifery*, glorified birth as sacramental and invoked
maternal caregiving as a remedy for the ills of humanity. She said that, “the wisdom
and compassion a woman can intuitively experience in childbirth can make her a
source of healing and understanding for other women.”26 Chodorow and Gaskin
echoed the earlier contrast between de Beauvoir/Firestone and Lang/Arms,
reiterating the contradictions inherent in supporting women as a unique sub-group of humanity while attempting to reduce the significance of their separate status.

Feminism supported women because of their gender and argued for the elimination of gender as a discriminatory tool, leaving feminist mothers at a theoretical crossroads. Receiving the blessing of the feminist movement only for the typically masculine, public, non-motherly parts of their experience, women perceived a feminism that failed to support motherhood. Mothers like Dolly Browder, a Montana midwife and feminist, faced an intellectual dilemma, endorsing a social movement that censored their maternal role:

“I think that’s probably the worst thing that the women’s movement did in the beginning, is they did not pay any attention to women who were mothers, and that was most of us. It really was to try and get women in the workplace and be able to change tires, and do these sort of male-dominated things. But they were not supporting women as mothers.”

Women who embraced a jointly feminist and maternal identity struggled to unite divergent philosophies.

Mary O’Brien, in *The Politics of Reproduction* in 1981, attempted to rejoin feminism and mothering. She explained that historical praxis examined past events through the lens of destruction and ignored the role of women in the family as original producers. According to O’Brien, men experienced alienation in reproduction – the male partner had no control over his sperm after impregnation. Patriarchal cultural institutions sought to reestablish male control over the uniquely female-centric event of childbirth. O’Brien suggested a blurring of the private/public divide within feminist theory and the creation of public discourse about
reproduction. Her call for inclusion of female reproduction as a truly public issue, not only a public discussion about a woman’s issue, fueled further examination of the role of family and motherhood.

O’Brien’s analysis illuminated the recalcitrant nature of reproductive theory, and its difficulty in defining a complex issue with clarity. Reproduction existed in context, lived in the lives of women who grappled with a host of reproductive issues. Women wanted access to birth control, abortion, and reproductive healthcare, as well as quality childcare and maternal leave. Feminism struggled to support women in a full range of reproductive choices.

The Boston Women’s Health Collective, motivated by a desire to inform and empower, published the first edition of Our Bodies, Ourselves in 1984. The text provided information about reproduction without judgment or didacticism and encouraged women to make decisions about their own bodies, free of coercion or shame. The book represented a growing openness to women’s choices for their lives, their sexuality, and their bodies, and reassured women that feminism represented choice. Our Bodies, Ourselves pragmatically bridged the gap between public women’s issues – political activism and voting rights – and private ones, like birth control, reproductive medical care, and sexuality. The authors perceived reproductive issues as ripe for political and cultural change. Reproductive knowledge empowered women to imagine their lives as venues for individual expression instead of laundry lists of reproductive dictates.
Early feminist theorists critiqued patriarchy as flawed and destructive, and the new generation of thinkers applied the patriarchal critique to the bastion of science. The compilation *The Making of the Modern Body: Sexuality and Society in the Nineteenth Century*, edited by Catherine Gallagher and Thomas Laqueur and published in 1987, contained a selection of articles detailing how culture constructed, interpreted, and analyzed the physical body. The authors demonstrated that political ideas about “male” and “female” dictated scientific understandings of the respective genders, and showed how anatomical studies justified social norms.

Londa Schiebinger, in *The Mind Has No Sex? Women in the Origins of Modern Science* in 1989, examined the male bias of science, using as evidence the exclusion of women from employment at scientific institutions. She discussed the marginalization of peripheral groups by science, and the systematic neglect by the scientific profession of certain subjects, issues, and problems, frequently those of importance to women and racial minorities. Inequalities in research and practice affected science by eliminating voices of opposition, ignoring the profession’s misogynistic past, and silencing disagreement about unquestioned scientific assumptions. The bias of science disallowed research that did not fit within the male rubric of the discipline. Like Schiebinger, Thomas Laqueur, in *Making Sex: Body and Gender from the Greeks to Freud* in 1990, examined the disconnection between the assumed “facts” of biological sex and the implications of sex difference. Culture
directed science, determining the problems to be studied and the remedies offered. Patriarchy preferred male issues and interpretations, and science followed suit.

As part of the scientific establishment, physicians framed the discourse about birth policies and protocols in the language of science, with an assumed immunity to political or sexist bias. The clear prejudice of science legitimized the perceptions of feminist natural birth advocates who interpreted standardized delivery procedures as manifestations of patriarchal beliefs about childbirth, reproduction, and the bodies of women. But agreement about the misogyny of medicine fell short of a unified feminist theory of birth.

Feminism grappled with the lack of universals, the intransigence of patriarchal assumptions, and the reality that women, even feminist women, continued to have babies. The absence of universals brought feminism and reproduction to a deeper and more complex relationship, one with fewer absolutes but greater recognition of the importance of context and the continued relevance of reproduction in the lives of women.

**Historiography and Methodology**

Birth, along with death, is one of the few constants throughout human history, and can open a window of comparison and understanding across generations. Childbirth is a uniquely female activity. A study of birthing practices and attendant birth beliefs illumines ideas about gender and technology. A study of midwifery illuminates intractable assumptions about women and demonstrates the
confluence of gender stereotypes and resulting birth practices. Beliefs about the female body and the role of women in society are revealed when medicine, a traditionally male-dominated vocation, challenges midwifery, a profession practiced almost entirely by women.

This study begins from the assumption that home birth is a safe and reasonable practice. The research documenting the effectiveness of midwifery for low-risk births has been performed ad nauseum, as has the indictment of the modern medical obstetric system. Academic and popular literature lament the current state of childbirth in America; evidence abounds supporting the physiologic viability of midwifery practices. In theory, natural birth advocates won the birth battle; in this skirmish they had science on their side. But the practices surrounding childbirth remain entrenched. Physicians in America continue to follow prescribed obstetric practices for which there is no supporting data, and American women accept the mainstream medical model of childbirth, despite abundant scientific and anecdotal evidence demonstrating various harms to themselves and their infants.

This research seeks to excavate assumptions about birth practices by examining a specific place – Montana – at a certain time – 1988 through 1991 – to describe and analyze the confluence and confrontation of mainstream medicine and the practice of homebirth midwifery. Until 1989, midwifery in Montana had a legal status; the law neither codified its practice nor specifically outlawed it. Chapter 3 introduces the Montana practice of midwifery just prior to licensing, as well as the individual women endeavoring to alter bureaucratic policy. The project identifies
the currents that drove the legalization process in the state, and places legislative events in historical context. Most physicians in Montana worked with midwives, recognizing the quality of their work and supporting their efforts. Some doctors, however, found the practice of midwifery appalling, and in 1988 the Montana Board of Medical Examiners filed suit against a Missoula midwife. Midwives across the state organized, and during the 1989 session of the Montana legislature they advocated statutory changes that protected the professional practice of midwifery within the state. Chapters 4 and 5 describe the legislative process and draw conclusions about the political effectiveness of midwives in the legislative and public opinion arenas.

Midwifery’s past illumines its present, and Chapter 1 describes reproductive practices in Montana, investigating prophylactics, abortion, and birthing conditions beginning with the pre-statehood era. Much of the history of midwifery comes from the European and “developed world” bias, and this study will rely on those early sources. Immigrant midwives in the state of Montana had ethnic origins in Europe, and the assumptions confronting Montana midwives grew from the Euro-American tradition. Midwifery opponents marshaled arguments transplanted to western geography from a colonial and nationalistic American tradition. Montana midwives combatted rhetoric initially voiced during the professionalization of obstetrics in the late 1800s and early 1900s.

Montana was among the first ten states in the nation to legalize midwifery, and remains a leader in homebirth practices. The midwives in Montana have
maintained a consistent licensing structure in the twenty-two years since the approval of the 1991 licensing standards, and homebirth rates in Montana consistently top annual state rankings. According to the U.S. Department of Health and Human Services, Montana reported the highest rate of home birth in all fifty states for 2009, shared first place with Oregon in 2010, and ranked second in 2011. But Montana’s neighboring states – North and South Dakota, Wyoming, and Idaho – remained, until recently, among the most resistant areas to home birth, indicating that Montana’s early licensing structure did not represent a regional phenomenon, but instead resulted from characteristics, circumstances, and individuals unique to the state. Idaho, after a protracted legislative battle, instituted a licensing process in 2009; Wyoming vigorously prosecuted midwives in the 1990s but eventually legalized the profession in 2010; and North and South Dakota continue to disallow the practice of homebirth midwifery, despite consistent and vocal homebirth advocacy. For the past twenty years, pregnant women in Idaho, Wyoming, and the Dakotas who sought the assistance of midwives broke the law, while Montana women just across the state boundary line accessed legal and licensed midwifery services. Across America, homebirth midwives are fully licensed and legal in only twenty-eight states. Homebirth advocates are currently active at the legislative level in thirteen states that lack midwifery licensing statutes, with nine states remaining entirely opposed to potential direct-entry midwifery legalization.iii

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iii Appendix L lists states by year of midwifery legalization.
To document the people, practices, and personalities involved in the events in Montana, I relied heavily on oral histories. Most of the key participants in the 1989 session are still living, with memory intact, as the Montana legislative events unfolded only 25 years ago. I assembled legislative records, newspaper articles, private collections, Montana Health Department documents, and statistical compilations to understand the context and consequences of the events. The individuals I queried, both supporters and opponents of midwifery, willingly offered to share recollections, feelings, and perceptions of the midwifery legalization process, for which I am grateful. Many expressed their sense of contributing to something meaningful, something significant in the making of history.

In Montana in 1989, a group of midwives came together to challenge the mainstream medical system. They weathered a court battle and vehement opposition by the medical establishment, represented by hospitals, physicians, and professional healthcare organizations. Montana midwives convinced a majority of state legislators to support home birth. They changed the law and protected the right of women to have their babies in the circumstances of their own choosing. The midwives of Montana altered the face of birth in the state and shifted the power dynamic in the never-ending battle over who orchestrates birth. By establishing a licensing protocol controlled by midwives, they protected the practice of homebirth midwifery from medical management. This is the story of women, men, and families who beat the patriarchal bureaucracy by integrating themselves into its machinery and using the tools at their disposal to legitimize home birth in Montana.


Ibid, p. 81.


Ibid, p. 11.


27 Dolly Browder, interview with Darla Torres, March 4, 2002, Missoula, Montana, OH 378-1, Montana Feminist History Project, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.


Big Push for Midwives, “State Regulation PushChart,” available at www.pushformidwives.org, accessed August 7, 2013. For a listing of states by the date of midwifery legalization, see Appendix L.
Montana contains rich natural resources and beautiful vistas; the grassy plains stretch to the east and mountains in the west feed verdant river drainages. With an average span of 275 miles from north to south and 535 miles east to west, the state occupies more of the earth’s surface than many European countries. The areas of Italy, Belgium, and Switzerland can be simultaneously contained within Montana’s boundaries.¹

Throughout its known history, the state’s abundance enticed a multitude of visitors, animal and human alike. Wildlife found it irresistible; the ungulates for the spring grasses growing from snow-watered soils and the predators – bear, wolves, and mountain lions – for a feast of bison, elk, deer, and mountain sheep. Eagles, hawks, and osprey fished the rivers, creeks, and lakes, while a pantheon of smaller hunters and hunted filled out a diverse and nutritionally dense ecosystem. Watered creek bottoms sheltered chokecherries and currant bushes, fescue and timothy grasses covered the plains, and mountain valleys nurtured camas and balsamroot.

Native Americans inhabited both the western and eastern portions of the area. In recent centuries, Flathead and Shoshone tribes claimed the western and more mountainous territory, while the Blackfeet and Absaroka utilized the eastern plains.² Despite the abundance of the region, the climate presented threats to human habitation. Temperature extremes ranged over a 180 degree span, from -70 to 117 degrees Fahrenheit; varied and violent weather brought hail, wind, rain, snow, and
sleet; an unpredictable growing season made crop cultivation a gamble; and forest and prairie fires joined forces to render Montana a challenging environment.³

Residing along mountain rivers or under cottonwood-shaded prairie streams, Native peoples gathered roots and herbs, hunted for meat, and lived ordinary, everyday lives beneath the canopy of the expansive sky. Songs were sung, meals eaten, conflicts and skirmishes managed, jokes told, and, of course, babies were born. Few records exist detailing birth practices in pre-contact Montana. Native women rarely recorded perceptions or descriptions of birth in written form, unsurprising given their oral traditions, as well as taboos related to the sharing of private women's matters with mixed company or male listeners.

Some rare accounts, like that of Pretty-Shield, a woman born in 1856 in the area that would become Montana Territory, indicated that the Crow defined and utilized birth ceremonies, and that Native tradition regarded childbirth as a routine life event. When Pretty-Shield delivered her first child, the birth attendant, or “wise-one,” prepared a lodge for her. The attendant drove two stakes into the ground inside the lodge, and arranged robes to support Pretty-Shield’s arms while she kneeled. In the final stages of labor, Pretty-Shield grasped the stakes while pushing. Once she delivered the baby, she wrapped it in a skin with buffalo hair to cushion it and a piece of firm rawhide to support its head. Like other women of her tribe, she carried her infant in her arms until the child was about six months old, when she transferred it to a back-cradle.⁴
An active lifestyle, walking and moving during labor, and belief in the normalcy of delivery likely contributed to trouble-free births. Pretty-Shield said, “We Crow women had no trouble when our babies were born.” Women managed the process of birth, and despite its routine nature, it was a female-only event. Men were not allowed at births – the Crow felt the presence of a male might slow the delivery process. Native birth attendants used herbs and roots, particularly in prolonged or difficult labors, and their community prized their knowledge and compensated them, often handsomely, with gifts of horses, blankets, and other valuables. Pretty-Shield’s birth attendant received a horse and robes in payment for her assistance.

Infants slept with their mothers, received skin-to-skin contact, and breastfed on demand for an approximate twenty-four month period. The extended breastfeeding provided Native infants with an ample supply of vitamin D and resulted in lower occurrences of rickets as compared to immigrant infants and children. Native women valued breastfeeding and used herbs to increase their milk supply.

The fur trade, increased economic commerce with points east, and regular contact between Native American women and Euro-American men resulted in bi-cultural marriages, with a variety of individual adaptations to birthing practices. Despite varied personal changes, the belief in birth as manageable and routine remained largely consistent. Emma Magee, born in Montana Territory in 1866 to a Shoshone mother and white father, noted that her mother birthed her babies
without a doctor or nurse, and after resting for just a few days, returned to her normal routine. Magee, as an adult, birthed her baby alone, confident in her knowledge of the birthing process.\(^8\)

Over the centuries, practices changed but birth remained a potent symbolic element in Native philosophy. Katsi Cook, a Mohawk midwife working in Quebec, Ontario, and New York, explained the role of birth in Native religious life as, “a re-enactment of creation. The power of the birth story is that each birth is a re-weaving and re-creation of the world, encoding patterns and knowledge that inform the growth and development of the individual as well as the culture.” Knowledge of birth processes was essential “for the transformation of women and society.”\(^9\) The confidence with which Native women approached childbirth grew from a belief in the mother’s body as creator and sustainer of life.

Despite healthy birthing traditions and confidence in their ability to deliver their babies, Native American women in Montana faced obstacles to their personal, family, and communal health. Mining activity in the state mushroomed in the 1860s, and cattle ranches occupied space formerly populated with buffalo. The U.S. Army set up forts to manage relations with local tribes and squelch resistance. Life stressors affecting Native American mothers – racism, limited economic resources, violence, and less-than-optimal nutrition – put reproduction at risk.\(^1\) As increasing numbers of Euro-American women traveled to Montana Territory, the deteriorating birthing situation for Native women mirrored the realities that new arrivals faced.

\(^{1}\) For a discussion of contemporary Native American birth outcomes, see Appendix D.
Early Montana

With far-reaching railroad expansion and the growth of mining, Montana outgrew its designation as a territory and, in 1889, gained official status as a state. The population of Montana Territory, estimated at just over 20,000 in the 1870 census, grew to nearly 550,000 residents by 1920 – a 275% increase representing a staggering population explosion over a fifty-year timespan. The dramatic rise in the Montana population resulted from new settlement, with immigrants traveling to the state in hopes of capitalizing on increased economic opportunities.

Men, particularly those in economically unstable situations, commonly left their families behind while they headed west in search of gold and land. The wives who remained in the east managed businesses, ran farms, and raised families. They supported the settlement of Montana by assuming additional family responsibilities and providing a place for men to return to if their western wanderings proved too risky. James Fergus, faced with a struggling business and in need of a capital infusion, left his wife Pamela and their four children in Little Falls, Minnesota, to journey west in search of gold. After an unsuccessful venture in Colorado, James eventually settled in Virginia City, Montana, purchasing additional claims and finding financial stability in a rough, new Montana town. In his absence, Pamela took charge of the children and James’s business interests in Little Falls, selling butter, milk, and eggs to support the family. Four years after James’s initial departure, Pamela traveled to Virginia City, Montana, ready to settle into her new home and reunite with her husband.
Settling in Montana posed many challenges, including access to healthcare. Medical services throughout the United States were unregulated and inconsistent during the 19th century and Montana was no different. But early immigrants to Montana, mostly male and unattached, left a critical healthcare service behind.

Wives, sisters, daughters, and extended female kin networks provided home nursing in the context of intact communities. Women, as unofficial healthcare providers, gave the ill and infirm the necessities for recovery – food, cleanliness, warmth, and human companionship. Among the immigrant population, few capable individuals, especially few females, resided in the state to provide the caregiving essential for health. Barbers, dentists, or others of varying education and experience performed emergency procedures when a trained physician could not be located.

White women new to the territory faced childbearing with trepidation. They left female support systems and family members and faced the experience of birthing in the absence of traditional family networks. Laurentze Koch married Peter Koch, a Danish emigrant, in 1874, and moved to Bozeman, Montana, where Peter worked as an attorney and banker. In 1875, Laurentze wrote her mother Annette that she felt “rebellious and ugly” when she realized that she was pregnant, and dreaded the frequent nausea. Unlike many of her contemporaries, Koch had access to a doctor, as well as the services of a midwife. The military post physician, Dr. Whitefoot, administered calomel, a common purgative, to alleviate her frequent stomach discomfort. The midwife, Malinda Rich, attended her in her “sickness” and provided “advice and assistance” as the pregnancy progressed.
Military physicians, like the doctor who attended Laurentze Koch, served as the first medical professionals in the state, accompanying the U.S. Army in its attempts to quell Native American resistance to white incursion. Miners and soldiers did not present a stable enough population base to attract a cohort of trained physicians to Montana, and residents self-doctored or sought out the services of scattered professionals in the area.

Early communities depended on the services of women like Mary Powell Jenkins. Jenkins moved to Montana with her husband in 1888 and settled on a ranch near Toston. Toston and Radersburg residents had access to one doctor in Townsend who served people living in a fifty-square-mile area. The neighbors called Mary Powell Jenkins whenever anyone needed nursing care. This included chronic illness, birth, contagious disease, and death. She went to the homes of neighbors to provide nursing care, staying for days at a time. During births she was called when labor started and she stayed with the mother throughout the delivery process. The father or a neighbor typically contacted the doctor during the final stages of the birth. The doctor oversaw the delivery and then went on to other patients. Jenkins remained with the mother, sometimes for several days, getting the infant and mother fed, bathed, and stabilized. If time allowed, she helped with the other children, made meals, and did what she could to keep the household going. After a death, Jenkins prepared the body before the funeral. She was not trained in nursing, but people in the community depended on her skills and experience.
In addition to traveling around her community and assisting neighbors, Jenkins raised twelve children, helped run the family ranch, served as the clerk of the school district for twenty years, and participated in community events. She did not charge for her services and saw her nursing work as a necessary part of being neighborly.14

Once families settled in the state and communities sprang up, medical infrastructure materialized. The first of these medical entrepreneurs were Catholic nuns, who initially came to the area in 1864 to provide medical services for Native Americans at St. Ignatius. The Sisters supplied general assistance to Native Americans and white immigrants in the area, operating with meager funds and supplies. Mother Caron, head of the Sisters of Charity of Providence, also initiated the establishment of St. Patrick’s Hospital in Missoula during her tenure in western Montana.15

As Montana communities developed, residents acted on the need for health facilities. The call for hospital services and formal medical care resulted in the creation of small hospitals. The Miners Hospital in Helena, founded in 1866, was soon followed by two small Deer Lodge hospitals in 1870, and the Sisters of Charity of Leavenworth completed the St. James Hospital in Butte in 1881.16 Despite the growing number of medical facilities, rural residents outside the reach of urban hospitals struggled to access medical care. Skilled community members, even those with limited knowledge, were pressed into service in emergency cases and long
convalescences. Women moving into the state assisted friends and neighbors with caregiving duties.

Dedicated individuals devoted time and energy caring for and traveling to meet the needs of their neighbors. Nonetheless, as kind and generous as far-flung neighbors were, their availability varied, and those in need because of illness or injury frequently went unattended. The spread of infectious diseases highlighted the absence of official healthcare infrastructure, and in 1901 the Montana State Board of Health was created to assist in containing tuberculosis, smallpox, diphtheria and typhoid. As urban populations grew and infectious diseases spread, city and county municipalities hired health officials to systematize and regulate sanitation and public health in these growing settlements. State and municipal governments funded public health efforts, but hospitals in Montana remained largely private institutions.

Hospital administrators found it difficult to locate skilled nurses to staff hospitals, and founded nursing schools early in the state's history. From 1894 to 1927, nineteen nursing schools opened in Montana, spread from Great Falls to Bozeman and Missoula to Miles City. Nurses worked in hospitals, with country doctors, and in homes as private duty nurses. Catherine Flynn graduated from St. Patrick Hospital School of Nursing in Missoula in 1911 and explained that the home nurse garnered respect and good treatment, but “her work was very hard and tedious. She had 24-hour care of the patient in addition to maintaining relations with the family and hired help.” Elizabeth Rae, a nurse and midwife trained in
Scotland, operated her maternity home in Livingston in the 1890s, offering midwifery services and caring for premature babies that required specialized attention. Her neighbors called her Aunty Rae, and she proved to be an essential caregiver in the community, where people remembered her warming infants on the open door of her stove. Competent birth attendants practiced in a number of Montana communities prior to 1900, including Fort Benton, Helena, Toston, Townsend, Radersburg, and Malta.

Despite growing access to hospital care, women in rural areas continued to birth almost exclusively at home. Sophie Guthrie, born in 1882 and pregnant at the turn of the century, lived 25 miles from Big Timber and successfully delivered seven babies at home. Her mother, who birthed twelve of her own children, came to help Guthrie with her first birth. By the time Guthrie's last baby was due, there was a doctor in the area. Guthrie called him to assist with the delivery but then discovered that she did not like his methods. With the experience of several trouble-free births, she knew, “well and good that he shouldn’t be doing what he was – trying to lift the child when nature was taking care of it slowly and gradually.” Guthrie told her husband to evict the doctor, and then, after laboring through the night, delivered the baby by herself, “just all right.”

In the community of Malta, Montana, in the 1890s, two midwives, Mrs. Richey and Mrs. Clanton, helped local parturient women. When labor was imminent, the midwife traveled to the home to assist at the birth and then stayed for up to two weeks, performing necessary housekeeping chores like meal preparation and
cleaning, and receiving a salary of $1 a day. Malta women gained an additional delivery option when Mary Robertorye, a local midwife, moved into town in 1907 and opened her home to maternity patients.\textsuperscript{24} Malta reflected a national trend, with women delivering at home well through the 1920s.\textsuperscript{25}

Even though they initially resisted birthing in the hospital, Montana women did utilize medical services for complications arising from abortion. While successful abortions went unrecorded, abortion-related infections often proved fatal, and thus made it into the public record. Some death certificates recorded abortion as the cause of death while others obliquely listed infection or hemorrhage. Avoiding deaths from self-induced abortions and poor outcomes from unskilled abortion practitioners provided the impetus for larger Montana communities to maintain at least one competent abortionist.\textsuperscript{26}

Dr. Edwin S. Kellogg opened his practice in Helena in 1884. Prosecutors named him in seven abortion-related cases during the course of his career, but failed to obtain any convictions. Abortion remained hidden from public view, without advertisement or publication, as did all matters related to reproductive function. Successful abortion convictions depended on testimony from the patient, but women maintained loyalty to their abortion providers and rarely named names. Faced with imminent death from abortion-related infections, some patients did provide an abortionist's identity to authorities, and those cases generated official charges.\textsuperscript{27}
Dr. Sadie Lindeberg, born near Miles City in 1884, returned to the community to practice medicine in 1909 after graduation from the University of Michigan Medical School. Lindeberg delivered more than 8,000 babies in the Miles City community in the sixty years she practiced there. Though she did not openly advertise the fact that she performed abortions, doctors throughout the state knew about her activities, and physicians from other communities referred patients to her. A Miles City physician said, “We decided Sadie was doing a good job. Let’s let her do it, rather than all these quacks.”

Practitioners performed abortions via a variety of procedures, and prior to the advent of antibiotics the process carried with it a heavy risk of infection and death. Professional abortionists forced the cervix open and packed it with an irritant, causing a miscarriage. The Montana Department of Health began tracking abortions in 1973, but prior to that date the official record is silent about the number of abortions performed in the state. Doctors came to see trained abortionists, usually general practice physicians themselves, as important members of the healthcare community. When Dr. Sid Pratt of Miles City learned about the abortions performed in his community, he initially “got all hot and bothered.” Pratt discovered, though, that the abortionist did a clean job without complications, and he had “a growing up process.” Pratt saw that abortion, “even though it was an illegal sort of thing, fulfilled a social need, that was going to be met by a person who was capable of doing it, or a person who was not.” Abortionists, trained and ill equipped alike, met the need throughout Montana.
The difficulty of locating a professional abortionist, in combination with the scarcity of birth control products and information, made reproduction a minefield for immigrant women. The aforementioned Sophie Guthrie, living in Montana in the early 1900s, knew some birth control methods, and after her marriage used a diaphragm obtained from a pharmacist in Big Timber. The distance to town was an obstacle to continued prophylactic use, as the diaphragm broke and Guthrie could not purchase a replacement before she became pregnant again.30

Those fortunate enough to have access to contraceptives or information about birth control frequently obtained it from other women, particularly mothers or female relatives. Dovie Zehtner married in 1913 and talked with her mother about menstruation and reproduction. Despite the difficulty of obtaining contraceptive information and devices, Zehtner had enough detailed reproductive knowledge, and most certainly the cooperation of her husband, to successfully plan the timing of her pregnancies.31

Availability of contraceptive knowledge and practice differed widely during the late 1800s and early 1900s. The Comstock Law, signed by President Grant on March 3, 1873, forbade the manufacture, advertisement, or sale of contraceptives and abortifacients in the United States, and prohibited the importation of such items from other countries. The statute directed the seizure and destruction of any obscene material.32

Anthony Comstock, born in 1844 in Connecticut, enlisted in the Union Army during the Civil War and held strong religious convictions. He failed to see any
action during the war, and at its conclusion settled in New York. Comstock believed that contraceptive devices, available from pharmacists, doctors, and storekeepers, comprised a central component of the vice trade. He worked for the New York Society for the Suppression of Vice, becoming the chief enforcer of the law that bore his name. The war on vice touted the notion that “natural” contraception – abstinence or the rhythm method – could be implemented by women of character, but that artificial methods like condoms and diaphragms indicated moral decay.

While Comstock Era rhetoric drew a firm line between socially acceptable women and prostitutes, contraceptive and abortifacient use resided in a gray zone in the lives of ordinary Americans. Personal letters, advertisements, and trial transcripts provide evidence that the Comstock Law dampened the availability of contraceptives and reproductive knowledge but in no way eradicated it. States applied the Comstock Law selectively, and enforcement in Montana followed suit. Contraceptives existed but required additional effort to obtain, and the device used indicated social class and moral standing. Women exercised great care in discussing or revealing the products or methods that they employed. Public discourse about contraception and abortifacients gave the impression that devices and products did not exist, while private practice and declining birth rates hinted that women and men put contraceptives to widespread pragmatic use. The social stigma of open discussion about contraception remained, though, even years later. Annie Knipfer married in 1919, and when asked about her contraceptive methods nearly sixty years later, would only say, “Well, we did our own planning, if you get what I
mean.”\textsuperscript{36} Women used douches, spermicides, pessaries, and concoctions of their own invention, some with questionable efficacy.\textsuperscript{37} These methods often failed even when used according to the letter of the instructions and under the best of conditions, rendering the usefulness of turn-of-the-century birth control devices and methods highly suspect.

The silence surrounding all aspects of birth and reproduction made it difficult to track or compute reproductive frequency, context, and details. Fortunately, the state of Montana passed legislation in 1907 that mandated centralized state recording and tabulation of population and mortality statistics. Epidemic diseases and outbreaks of contagious infection prompted the collection and reporting of vital statistics for the purpose of measuring the effects of diseases like diphtheria, tuberculosis, small pox, measles, and whooping cough, in addition to intestinal ailments resulting from tainted food and milk. Counties appointed registrars and drafted forms for the recording of essential statistical information. The first report calculated 5,842 births in the first twelve months of data collection, with the highest number – 595 – born in Silver Bow County, followed by Flathead County with 196, and 192 babies born in Yellowstone County.\textsuperscript{38} Infant and maternal mortality rates, computed for the first time in 1910, showed 6,124 babies born, and 714 infants and 62 women dying in childbirth. Of the cities in the state, Butte had the highest number of births, with 842 reported in the city-proper, followed by Great Falls with 462.\textsuperscript{39} It was much more dangerous to be born than to give birth, as infant deaths far outnumbered maternal fatalities – over 11 infants died for every
one maternal death.\textsuperscript{ii} By taking on the task of collecting data, the state publicized birthing realities within its boundaries, and tacitly acknowledged maternal and infant health as worthy of institutional attention.

\textbf{Homestead and Depression-Era Birth}

Settlers traveled to, through, and from Montana in search of economic opportunity, creating an ever-changing resident population. The Homestead Act of 1862, signed into law by Abraham Lincoln during the Civil War, encouraged permanent communities by offering 160 acres of land to settlers. The language of the 1862 Act allowed for single, widowed, or divorced women to claim homesteads in their own names, and in Montana, women filed nearly one out of every five new homestead claims. The law required homesteaders to live on the land for five years, construct a dwelling, and cultivate a portion of the acreage. For an arid state like Montana, 160 acres fell far short of the area required to support a family. Successful homesteading necessitated additional land and the Enlarged Homesteading Act of 1909, which allotted 320 acres per claim, provided the impetus for a flood of new settlement, particularly in the eastern portion of the state.\textsuperscript{40} With the slaughter of the bison herds complete, the vast prairies stretched for miles, inviting cultivation and prompting the railroads to advertise the benefits of homesteading to potential settlers.

\textsuperscript{ii} Appendix A includes a description of rate computations and data from 1910 through 1920.
Individuals and families responded, staking their claims and establishing homes, tilling fields, and populating towns along the railroad lines. Far removed from the acrid smoke and pollution of urban squalor, homesteaders escaped overcrowding, contaminated water, and continuous exposure to epidemic illnesses, but faced a sequence of circumstances that challenged the limits of physical and emotional reserves. The previous residents of Montana's eastern plains, the Blackfeet and Absaroka, used the area selectively, adapting to seasonal weather patterns, and utilizing their intimate knowledge of the area to find productive and habitable locations. In contrast, newly arrived homesteaders followed a sedentary and extractive practice, attempting to harvest resources from a gridded portion of land, tied to their claims regardless of insects, heat, fire, or drought. The consequences for the most vulnerable of the homesteading population – children and pregnant women – proved tragic.

The homestead boom, from 1900 through 1920, brought an estimated 200,000 new residents to Montana, many of them women of childbearing age. Details of homesteading births, rarely recorded, found audience when, in 1912, Congress approved the creation of a federal department to focus on the needs of the nation's children. Julia Lathrop, a contemporary of Jane Addams at Hull House, headed the new Children's Bureau. Lathrop established a wide-ranging assessment of the existing conditions of women and children, and the Bureau collected data on infant mortality and the causes of infant death. Initial studies indicated a direct correlation between the living conditions of the mother and subsequent infant
fatality. Babies at risk – infants without maternal caregiving, bottle-fed babies, and infants whose mothers lacked the income necessary for a reasonable standard of living – died at higher rates. The evidence showed that poverty caused infant deaths, regardless of the race or class of the parents, an interpretation that generated much animosity to the work of the Children’s Bureau and its continuing studies of infant mortality. Based on the conclusion that maternal well-being determined infant health, the Bureau expanded its jurisdiction to include issues surrounding the welfare of women.

The Children’s Bureau performed analytical surveys throughout the country, and selected a rural Montana homesteading county as the site of one study. Because the information collected from individual women included comments and identifying details, Bureau policy mandated anonymity and did not name individuals or the county. The report, published in 1919, detailed the living conditions, birth environment, and mortality statistics in the entire county. Bureau personnel interviewed mothers of all children born during a five-year period, amassing information from 463 separate births. Results painted a troubled pregnancy portrait, with few mothers receiving prenatal care, and one in four parturient women choosing to leave the state to access medical care and family support systems. Women who remained in Montana and delivered at home faced few options. Among the study participants, 46 birthed with the assistance of their husbands, three women delivered entirely alone, and physicians attended 129 births. The largest group – 181 homesteading women – birthed with the assistance
of friends, neighbors, and midwives. Midwifery evolved in Europe concurrently with medicine, resulting in a developed and institutionalized practice. European midwives, like European farmers, miners, and metal smiths, immigrated to the West, plying their trade while establishing homesteads. Experienced midwives practiced midwifery as a profession in Montana, travelling to the homes of neighboring women, providing skilled assistance, and charging for their services. In communities without a professional midwife, women turned to friends and neighbors with a variety of accumulated skills and experience. Some birth assistants could rely only on their own experiences of childbirth, while others had greater exposure through work as a nurse or years of helping pregnant friends and neighbors.

Annie Knipfer birthed a baby in Montana during the homestead boom. She hailed from Massachusetts and worked as a nurse, caring for infants and assisting doctors at births. Her future husband traveled to Montana to homestead and on a trip home convinced her to relocate. Knipfer took the train to Baker, Montana in 1919, married her husband the next day, and then traveled by wagon the 42 miles to the ranch. In her years there, neighbor women called for help during delivery, and Knipfer assisted in the birth of four babies.

Yet, when Knipfer became pregnant, she chose to deliver her first baby in Baker. The doctor required ranch women to relocate to town well in advance of delivery to rest and build up their strength. As directed, Knipfer arrived in town several weeks before the birth. She delivered a healthy baby, but the doctor used forceps, causing serious injury to Knipfer that required a long recuperation.
Concerned about delivering her second baby in the wintertime with impassable roads, Knipfer traveled to Massachusetts with her daughter to deliver near family. The birth went well, and she returned to Montana five months later.⁴⁴

While Knipfer left the state to deliver her second child, Hazel Dorr married in 1924 and birthed all her babies in Montana. Dorr lacked access to reproductive information and contraception, and bore nine children in the state, the oldest three during her first four-and-a-half years at the family ranch near Eaton.⁴⁵ Rural women like Dorr faced reproductive obstacles because of their poor physical condition. Separated from family, friends, and neighbors by great distances, homesteading women performed physically strenuous work and returned to their responsibilities soon after delivery. The demands of children, crops, gardens, livestock, housekeeping, and food preparation required physical stamina, while isolation and distance disallowed the opportunity to work cooperatively and share responsibilities.

The Montana State Board of Health analyzed birthing conditions by collecting data, but the newly gathered statistics revealed an unfortunate reality. For the years 1911 through 1919, the state of Montana registered the highest maternal death rate across the nation. A total of 7,888 infants and 1,000 women died in childbirth, a total of 8,888 preventable deaths. For this period the infant mortality rate in Montana averaged 86 deaths per 1,000 births; the maternal mortality rate in the state averaged just under 11 deaths per 1,000 births.⁴⁶ The statistics were, as the State Board of Health phrased it, “a distinct shock to our self-complacency.”⁴⁷
Montana’s geographic sister Alberta, Canada, experienced a similar distinction, with the highest infant and maternal mortality rates in Canada in 1921.\textsuperscript{48} Montana’s Canadian counterparts endured similar living conditions, and reported a concomitant death rate for women and children during and immediately after birth. Giving birth on the Montana and Canadian prairies proved to be more dangerous than delivering in the midst of urban crowding, industrialization, and infectious disease.\textsuperscript{49}

High death rates provided a sense of urgency to secure some answers as to cause. After studying the conditions in Montana, the State Board of Health concluded that women suffered from a lack of information, and the Health Department made educational materials available. Homesteading women requested copies in their search for reliable sources of information about childbirth, infant development, and sanitation. On the national level, Congresswoman Jeannette Rankin, after digesting the early findings of the Children’s Bureau and its conclusion that infant and maternal deaths could be reduced, introduced a bill in 1918 to protect maternal and infant health. The bill found few congressional supporters, but the enfranchisement of women in 1921 presented legislators with a new voting bloc. Women’s organizations claimed to be aligned on issues rather than along party lines, and demanded passage of the Sheppard-Towner Act as a primary goal. Fearing punishment from women at the polls, members of Congress supported the measure and passed the Sheppard-Towner Act in 1921 with a generous margin of support.\textsuperscript{50}
The federal government distributed Sheppard-Towner funds to the states; the states used the proceeds to sponsor conferences, disseminate information on maternity care, provide sterile birthing supplies in advance of home deliveries, pay for public health nurses, and educate mothers about sanitation and hygiene. The implementation of the Act involved the training of midwives as part of its public health agenda. The Children’s Bureau determined that at least 45,000 midwives practiced throughout the country and utilized the connections that midwives maintained with birthing women to facilitate the transfer of information.51

Montana received Sheppard-Towner funds, and used them in combination with an allocation of state funds to distribute literature informing mothers about maternal and infant health and to hire public health nurses who served in every county and worked with 17,000 infants and children. In a two-year period, the Board of Health distributed 350,000 items in fulfillment of requests from around the state.52 The funds received from Sheppard-Towner represented a minimal commitment – about $13,700 per year from 1921 to 1929 – but the monies made an impact beyond the actual dollars spent. Prior to the Act, federal, state, and local governments did not address factors surrounding birth. The creation of the Children’s Bureau and the Sheppard-Towner Act marked the entrance of government into the arena of maternal and infant public health.

Sheppard-Towner failed to be renewed in 1929, much to the disappointment of its supporters. Its demise resulted from a combination of political and economic forces. The American Medical Association opposed government-funded healthcare
and labeled the Act a communist ploy, stating that it violated the rights of states. Additionally, the women’s lobby lost influence as the threat of a powerful women’s voting bloc failed to materialize. The failure of the Children’s Bureau to establish lasting ties to moneyed interest groups meant that it lacked the institutional fortitude to withstand the shifting political environment in Washington, D.C.53 Over the eight years of its existence, maternal and infant mortalities declined and supporters declared the Act a success.54 Montana anticipated the death of the Act and took steps to fund and continue effective state programs initiated under Sheppard-Towner. The 1929 Montana state legislature approved the allocation of $18,800 in state funds for the Child Welfare Division of the State Board of Health – 75% of its former budget, but enough to continue essential programs.55

The influences of Julia Lathrop, the Children’s Bureau, and the Sheppard-Towner Act, combined with publicity about high rates of birth-related mortality, brought maternal and infant health to the forefront of public discourse. As the Depression of the 1930s lengthened, economic woes derailed public focus on reproductive issues. In homesteading communities, residents experienced extreme drought and unemployment, and preventive maternity care failed to generate sufficient public support.

Women struggled with choices and decisions about pregnancy, birth, and reproduction with fewer resources at their disposal. Lettie Cook lived on a ranch near Niehart, and delivered three babies in the late 1920s and early 1930s. With access to a doctor, she birthed all three of her children in the hospital, returning
home after the births to care for her chickens, pigs, and garden. She knew about birth control, but found douches to be the only readily available method, saving time and money by obtaining and mixing the ingredients at home. Women trimmed margins and pushed limits to keep families functioning, even foregoing food in their fight to stay afloat. Phyllis Baird delivered five children in the 1930s and 1940s, eventually losing so much weight that the doctor encouraged her to wean her last baby early, as she was “just some hide and bones and a hank of hair.”

Some women decided that having a child in the midst of the Depression was simply not a reasonable option. Eleanor Mast and her husband married in 1930, and struggled to ranch on leased land. As Mast said, “the slums couldn’t have more dire poverty.” She used a variety of available birth control methods like kerosene and cold-water douches, but despite her efforts became pregnant soon after getting married. Mast and her husband were, “just completely horrified,” given their dire financial condition. They sold everything they could, and Mast traveled to Butte to obtain an abortion. Several years later, Mast had two children, and recollected that the decision to have an abortion, “really was worth it because while we didn’t become extremely affluent, we did well, and we were able to do well with our children.” Mast obtained the reproductive services she needed, but other women, faced with the combination of pregnancy and poverty, were not so fortunate. A woman in northern Montana remembered watching her mother die of a hemorrhage from a self-induced abortion. Pregnant for the eighth time and 50 miles from the nearest doctor, her mother made do with her own wit and the resources
she had on hand. Unfortunately, managing without medical care and extended support networks proved fatal, as it did for so many other Montana women.

“Modern” Montana Birth

The beauties of the Montana landscape, the bounty of its natural resources, and the promise of financial success drew people to the state, but its geographic scale and rural population presented a continued obstacle to safe and sustainable reproductive practices. Public health nurses initiated contact with pregnant women, attempting to provide the information and support necessary for healthy pregnancies. The federal government, via passage of the Hill-Burton Act in 1946, buttressed the state public health infrastructure by funding the renovation and construction of hospitals around the state. Montana women, like women across the country, came to see hospitals as beneficial birthing environments. By the 1950s, hospital birth had achieved acceptance and replaced the home as the default delivery venue. Birth officially migrated to the hospital, and women delivered at the hands of doctors and nurses trained in routine obstetric procedures.

Medical professionals dispensed more than routine delivery assistance; they also upheld moral customs and enforced control over the sexual practices of mid-century Montana women. As access to reproductive services expanded, doctors and nurses assumed the role of moral guardians of women’s bodies, deciding when and how patients could obtain birth control and proscribing specific delivery practices. Joan McCracken graduated from nursing school in 1958, and described the doctors
in Billings, Montana, as controlling, opinionated, and domineering, purveyors of
dominant moral assumptions: “If you wanted to get a diaphragm before you got
married, you had to bring your application for a marriage license to the doctor.”

Even providers like Dr. Sadie Lindeberg, who challenged conservative medical
practices by performing abortions, enforced mainstream social norms. Anne Dunbar
married in 1962 and went to Dr. Lindeberg for an abortion. When Dr. Lindeberg
heard that Dunbar was married, she “did not want to perform the abortion.” But
when Dunbar informed Lindeberg that her husband was of African-American
descent, “Well, that changed everything completely.” An increased variety in
contraceptive devices and birthing practices did not result in immediate availability
for Montana women as they struggled to access the care that they wanted,
navigating the preferences of doctors in their search for reproductive services. Mary
Lisa Pryne asked her doctor for contraceptives, but he refused on the grounds that,
“he didn’t prescribe contraceptives to unmarried teenagers.” Six months later, Pryne
marked the year 1969 pregnant at the age of 16. “Modern” reproductive practices
in Montana denied women the authority to make decisions about their own bodies.
Technologies, treatments, and information presented a potential for greater control
over reproduction, but barriers to access hindered Montana women from freely
implementing all available reproductive options.

From the mid-19th to the 20th century, the Montana landscape witnessed the
increasing complexity of the human population, from Native birth practices to
institutionalized western medicine. In the midst of rapid population growth, women
obtained abortions, attempted to control their fertility through available contraception, and delivered babies in all manner of Montana contexts – in homes, in lodges, on the prairies, and en route to new settlements.

With a growth in population, Montana women gained access to additional reproductive services. Immigrants to the state included professional midwives who offered affordable care in maternity hospitals or in the homes of birthing women. The state of Montana offered literature about pregnancy and delivery, sanitation, and the care and feeding of infants. Sheppard-Towner funds supported public health nurses who worked in communities to improve the condition of pregnant women and children. Public resources funded efforts to reduce infant and maternal mortalities. Despite improved availability, reproductive services came to women with a caveat. Along with a commitment of public funds came tacit interference in the reproductive choices of Montana women. To obtain available services, women endured the censure and control of healthcare practitioners, from the criticisms of the county health nurse to the dictums of the doctor. Women gained access to reproductive information and educated birth assistants, but the increased scrutiny by medical professionals over their choices moderated the reproductive gains of Montana women in the early to mid-20th century.

Regardless of historical context, the devaluing of female biology denied simple solutions to pregnant Montana women. Native American women faced an attack on their birthing traditions, homestead-era settlement patterns denied immigrant women the support of family and friends, and social stigma surrounding
female sexual activity restricted access to contraception. Habitual disregard for the needs of parturient women imposed costs on Montana women, families, and communities.

2 Ibid.

3 Western Regional Climate Center, Desert Research Institute, 2013, available online at www.wrcc.dri.edu/narratives/MONTANA.htm, accessed July 7, 2013.


5 Ibid, p. 82.


13 Laurentze Koch, letter to Annette Koch, dated February, 1875, Collection 2230, Christian D. Koch Family Papers, Merrill G. Burlingame Special Collections, Montana State University, Bozeman, Montana.
Female healthcare professionals played an extensive role in organizing, staffing, and maintaining medical institutions across Montana and the West. Catholic orders operated throughout the state, with scattered Methodist and Episcopalian organizations also establishing institutions. Nuns and deaconesses hired doctors, raised funds, trained nurses, set rates, and established formal business procedures. The work of Barbra Mann Wall in “Unlikely Entrepreneurs: Nuns, Nursing, and Hospital Development in the West and Midwest, 1865-1915,” Doctor of Philosophy Dissertation, Department of History, Notre Dame, 2000; documented the work of religious orders to provide buildings and institutional structures out of a dual purpose – to stay in business, and to expand their religious mission. Nuns interacted with physicians and communities to establish needed medical services, to determine community healthcare needs, and to further their religious goals. The provision of healthcare had overtones of religious duty, gender norms, and genuine service. Nurses made lifestyle and economic sacrifices to serve their patients, and while they exerted much control and autonomy, they did so within the context of appropriate female behavior. Todd Savitt and Janice Willms in “Sisters’ Hospital: The Sisters of Providence and St. Patrick Hospital, Missoula, Montana, 1873-1890,” Montana: The Magazine of Western History, 53:1 (Spring 2003), pp. 28-43; demonstrated that nuns and female administrators guarded their power base, both within the religious organization and during interactions with physicians and community members, but did so with sensitivity to gender-appropriate language and gender-specific behavior. Couching their concerns in the language of request, spirituality, and assistance, they avoided using directly forceful or confrontational terms whenever possible. Women’s activism in agitating for and providing healthcare melded with their motivations. The traditional combination of home, family, and religion made healthcare a ready platform for the mission of female religious orders, and a cause they could act on with authority.
According to Alma Gretchen McNeely, “From Untrained Nurses Toward Professional Preparation in Montana, 1912-1989,” Dissertation, Doctor of Nursing Science, University of San Diego, 1993; the Columbus Hospital School of Nursing opened in Great Falls in 1894, the Murray Hospital School of Nursing in Butte in 1896, the Montana Deaconess Hospital School of Nursing in Great Falls in 1902, St. John’s Hospital School of Nursing in Helena in 1905, St. James Hospital School of Nursing in Butte in 1906, St. Patrick Hospital School of Nursing in Missoula around 1906, St. Peter’s Hospital School of Nursing in Helena in 1909, the Bozeman Deaconess Hospital School of Nursing in Bozeman in 1911, the Frances Mahon Deaconess Hospital School of Nursing in Glasgow in 1912, St. Vincent’s Hospital School of Nursing in Billings in 1913, the Sidney Deaconess Hospital School of Nursing in Sidney in 1916, the Holy Rosary Hospital School of Nursing in Miles City in 1916, the Kalispell General Hospital School of Nursing in Kalispell in 1916, the Butte Deaconess Hospital School of Nursing in Butte in 1918, the St. Joseph’s Hospital School of Nursing in Lewistown in 1919, Forsyth Deaconess Hospital School of Nursing in Forsyth in 1921, Sacred Heart Hospital School of Nursing in Havre in 1921, St. Ann’s Hospital School of Nursing in Anaconda in 1924, and the Billings Deaconess Hospital School of Nursing in 1927.

Montana Nurses Association, Nursing in Montana (Great Falls, MT: Tribune Printing, 1961), p. 3. Montana nurses organized in 1912, and met in Missoula for their first state convention. Augusta Ariss, an early Montana nurse and historian of the Montana Nurses Association, explained in Historical Sketch of the Montana State Association of Registered Nurses and Related Organizations (Butte, MT: Convention of the Nurse’s Association, 1936), that nurses desired a distinction between trained nurses and untrained women who provided nursing care in homes. Nurses requested licensure and accreditation by state government. The nurses’ convention formed a State Board and pursued licensing, which was accomplished in 1913. Thereafter, all nursing graduates registered with the State of Montana.

According to the Montana Nurses Association, Nursing in Montana (Great Falls, MT: Tribune Printing, 1961); the Nurse Practice Act of 1913 differentiated between Registered Nurses and Licensed Practical Nurses. Women with hands-on nursing experience who lacked the academic requirements to be licensed as registered nurses in 1913 continued to perform nursing duties and received the designation of practical nurses. Practical nurses achieved professional licensing status in 1953 with the formal codification of practical nursing experience and education.


Sophie Guthrie, interview with Kathryn Person White, August, 1976, Columbus, Montana, OH 49-20, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.


Oral history research for the Montana Women’s History Project resulted in the publication of “Using Oral History to Chart the Course of Illegal Abortions in Montana," Frontiers: A Journal of Women Studies, 7:1 (1983), pp. 32-37, by Diane Sands. Sands stated that, “Every major town in Montana had at least one abortionist.” The collection of oral histories, titled the Abortion in Montana Collection and held by the Mike and Maureen Mansfield Library at the University of Montana, provided invaluable insight into the experience of abortion prior to Roe v. Wade.


Malcolm D. Winter, Jr. and Malcolm D. Winter, Sr., Miles City Medical History, 1876-2009 (Self-published in 2010 and available from the Miles City Public Library).

Sid Pratt, interview with Diane Sands, undated, OH 164-5, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.
30 Sophie Guthrie, interview with Kathryn Person White, August, 1976, Columbus, Montana, OH 49-20, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.

31 Dovie Zehtner, interview with Kathy Person White, October 21, 1976, White Sulphur Springs, Montana, OH 49-44, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.


38 Montana State Board of Health, First Biennial Report of the State Registrar of Births and Deaths, 1907 and 1908, Montana Historical Society Research Center, Helena, Montana.

39 Montana State Board of Health, Second Biennial Report of the State Registrar of Births and Deaths, 1909 and 1910, Montana Historical Society Research Center, Helena, Montana. For a description of rate computations and data from 1910 through 1920, see Appendix A.


43 References throughout the chapter to the 1919 report were drawn from the study authored by Viola Isabel Paradise and titled Maternity Care and the Welfare of Young Children in a Homesteading County in Montana (Washington, D.C.: Government Printing Office, 1919).

44 Annie Knipfer, interview with Kathy White, August 25, 1976, OH 49-28, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.

45 Hazel Dorr, interview with Mary Melcher, August 1, 1981, Monarch, Montana, OH 49-24, Women’s Oral History Collective, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.

46 Data compiled by the author from Biennial Reports of the Montana State Board of Health, 1911 through 1919; reports held by the Montana Historical Society Research Center, Helena, Montana.


56 Lettie Cook, interview with Mary Melcher, August 1, 1981, Monarch, Montana, OH 49-57, Montana Women’s Oral History Project, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.

57 Phyllis Baird, interview with Diane Sands, March 17, 1983, OH 164-10, Illegal Abortion Collection, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.

58 Eleanor Mast, interview with Diane Sands, 1981, OH 164-008 and OH 164-009, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.


64 Anne Dunbar, interview with Diane Sands, June 16, 1981, OH 164-1, Abortion in Montana Collection, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.

65 Mary Lisa Pryne, interview with Diane Sands, August, 1981, OH 164-3, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.
The term *midwife* is rooted in Old English – *mid* meaning “with” and *wife* meaning “woman,” coming to us from a period in history when “woman” and “wife” were synonymous. Midwives worked with women during the process of labor and birth and provided care into the postpartum period, assisting mothers to recover and resume normal duties. Midwives practiced since the beginning of human history, and while the nature of their assistance changed over time, elements of contemporary practice reflect timeless components of care. Ancient western narratives like the Bible referenced midwives, and Hippocrates instituted a program of midwifery education around 400 BC.¹ Women birthed in every time and place, yet history told the story of wars and political leaders and kept birth and midwifery invisible, a shadow practice, rife with folklore and old wives’ tales.

The specific ways midwives supported women changed over time, as cultural perceptions of birth evolved and shifted. The birthing rooms in the homes of colonial Americans existed as an entirely female space, the birth a social event shared with other women. Patriarchal practices, while advocating male control over women and children, posited childbirth as beneath the purview of men, base, and degrading. However, by the 1860s in America, male doctors claimed control over childbirth and redefined reproduction as a medical event sanitized and blessed by male presence. Medical training emphasized the use of technologies and surgical birth interventions, and superseded the midwife’s personal knowledge of birth,
developed through the experience of delivering her own children and augmented by attending other births.

The History of Midwifery

The earliest known European midwives appeared in the historical record in the 1400s; public records documented bureaucratic details of medieval midwifery practices. Pregnancy did not necessitate the services of a physician and doctors received no obstetrical training. Women practiced midwifery as a female vocation, wholly unrelated to the growing profession of medicine. European schools for midwives existed as early as the 13th century, with concomitant regulations and texts.2

France became the center of midwifery training and education, and instituted schooling and apprenticeship programs designed to improve the knowledge and standard of care provided by midwives. European countries licensed midwives by the 1700s and regulated their education and training.3 Midwifery schools existed across the European continent, and European colonists settling in America emigrated from a cultural milieu where midwifery was an established profession.

Midwives in early America – self-taught, trained in European midwifery schools, or apprenticed to a more seasoned midwife – functioned at the center of community life. Martha Ballard worked as a midwife in Maine and recorded a diary from 1785 to 1812.4 Her story exemplified the wide-ranging activities aggregated under the title of midwife. Ballard tended and collected herbs, attended the sick and
dying, prepared the dead for burial, observed autopsies, and testified in court. Her
tasks placed her in intimate contact with birth, death, and sexuality; she participated
in the joys and sorrows – quotidian and extraordinary – of the community. Ballard
knew her neighbors and they certainly knew her, as they depended on her
accumulated knowledge and empathic spirit.

Attending women through repeated pregnancies brought the local midwife
into regular and continuing contact with the details of neighbors’ lives. In Colonial
America, women birthed their first child in their early twenties and continued with
pregnancies fifteen to twenty months apart. A woman could expect ten to fourteen
pregnancies in the course of her reproductive life. Mothers nursed infants for one to
two years, and when combined with serial pregnancies, could experience two
decades of uninterrupted nursing and pregnancy. Colonial women knew the energy
demands of such constant caregiving, and the period of a woman’s confinement
after delivery represented an essential practice to ensure recovery to full health.

The midwife provided reassurance and support during the stages of labor
and dispensed herbal remedies and suggestions for easing labor discomfort, but did
not perform medical interventions such as bloodletting and purging. Personal
experience of childbirth was the prime prerequisite for work as a midwife. Colonial
communities recognized a midwife as a professional caregiver after she birthed her
own children and demonstrated her skill in assisting other women.

The female world circled around shared birthing; girls, from childhood
through adolescence and young adulthood, attended the labors of aunts, sisters,
mothers, friends, and neighbors. Exposure to birth provided a level of familiarity with parturition, its normal progression, and its unfortunate exceptions. A young woman in labor with her first child could remember scores of birth experiences, presentations, and outcomes, and recall the circumstances and details of a multitude of delivery dramas. Colonial women knew firsthand the hazards of childbirth, as well as its normal and reasonable outcomes. Women of all ages retained and shared a wealth of birthing knowledge. The problems associated with childbirth generated worry and concern and colonial women acknowledged the risks of childbirth, as well as other dependably regular life hazards – accidents, illnesses, disease, and weather. Despite everyday dangers, colonial America provided a comparatively healthy birthing environment by sheltering parturient women from the sanitation issues and attendant diseases that accompanied urban crowding. Infant death occurred with some frequency, as did maternal mortality, but healthy outcomes for both mother and child were the norm.

The experience and expertise of individual midwives varied. Midwifery manuals and reference works existed for those midwives wanting to supplement their practical knowledge, but colonial-era midwives rarely sought out advanced knowledge. They perceived the birth process as routine – not an anomaly to be analyzed. Midwives provided succor and companionship to laboring women as they experienced an ordinary and recurring life event.

Midwives bore the main responsibility for birth, but colonial women called for a doctor when unexpected problems arose. Patriarchal subordination of women
resulted in the devaluing of the birth process, placing it off-limits to men, and reserving it as a strictly female activity. But as physicians utilized tools and technologies like anesthesia, cervical dilators, and uterine sounds – all in common usage in the mid-1800s – they argued for the expansion of birth boundaries to include a formal role for men in delivery. Male doctors visited the women’s world of birth, carrying with them an armory of procedures, some helpful and others of questionable benefit. Based on standards of appropriate male/female contact, doctors performed physical examinations under full or partial cover, and their resultant blind groping put pressure on the bladder and bowels. The emptying of bladder and bowels via catheter and enema, a previously unnecessary procedure, became routine. Doctors bled laboring women, and administered ergot to strengthen contractions. Laboring women fell victim to blistering and purging, common remedies in the 19th century, especially during lengthy labors when other treatments failed to deliver results. Medical doctors instituted an interventionist approach to childbirth, preferring action over observation.

Few schools or training facilities existed for midwives in early America, and the technological gap between physicians and midwives expanded as physicians experimented with widespread use of labor anesthesia. Despite the known dangers associated with the use of anesthesia in labor – hemorrhage, lengthening of labor and reduction of the strength of contractions, as well as newborn breathing difficulties – many physicians felt that its calming benefits outweighed the risks.
Forceps, another questionable technological advance, provided assistance in difficult deliveries, despite the potential for great damage to the mother if misused.

As birth technologies evolved, scientific thinking about the female body adapted to justify evolving treatments. Scientific advances provided a more fact-based understanding of the uterus – it did not wander around, nor did it have a separate chamber for each gender as 17th and 18th century scientific pronouncements claimed. Medicine demystified female reproductive organs and came to analyze the labor process as an occurrence separable from the woman and manageable by the physician. The uterus maintained an identifiable shape, could be measured throughout the course of pregnancy, and behaved according to a pattern in the midst of labor. Science freed the uterus from the female body, and the physician, formerly handicapped by his sex, began to claim authority over women's reproductive processes based on male prerogative and scientific training.

The ability of doctors to implement technological advances contributed to mothers' willingness to invite them into the birthing room. But doctors did not have carte blanche with laboring women. Laboring mothers, surrounded by family and friends and attended by a midwife, maintained the prerogative of summoning the physician. Ensconced in the home and capable of controlling the birthing environment, women monitored the activities and procedures performed. With the laboring mother's female friends and relatives present as an experienced and authoritative audience, the physician adapted his treatment to gain the acquiescence and approval of those in attendance. Birthing mothers sought
medical assistance from doctors while maintaining control of the birth. Laboring women and their female companions remained the decisive force in treatment decisions and birthing practices.

When birth complications occurred, birthing mothers wanted options, and medical doctors provided a list of possible interventions. The combination of tools like forceps and anesthesia, along with the ability of physicians to claim intellectual superiority about uterine processes, provided the opening for a permanent and expanding role for physicians in the birthing room. The breaching of the female birth sphere by male doctors facilitated subsequent medical control of the birthing process.\(^\text{12}\)

Changing perceptions of birth developed concurrently with new procedures. The late 1800s heard the oft-voiced physician belief that childbirth was a “dangerous” undertaking and that laboring women benefitted from the saving intervention of doctors.\(^\text{13}\) As ideas about birth evolved, the perception of childbirth as a risky yet routine event was replaced by the notion that birth was unknown and unpredictable, as it appeared to male physicians observing the labor and delivery process. Childbirth, a lengthy series of physiological events involving unobservable internal activity, put doctors in the position of waiting on Mother Nature, and the imprimatur for independent male action and intervention disallowed a cooperative approach. When complications presented, evolving standards of obstetric practice favored the course of action that allowed the highest level of physician control,
diminishing reliance upon communication with or cooperation on behalf of the laboring woman.

Birth interventions gained acceptance and delivery migrated from the communal to private space. The attendance of male physicians and their desire for quiet and controlled birthing environments reduced the number of friends and relatives in attendance and changed the delivery from a social and recreational event to a medical and procedural one. As the number of attendants decreased, the authority of the physician increased and the birth space, formerly viewed as unworthy of the attention of the doctor, became inhabited by male physicians directing the course of action.

The professionalization of medicine – the American Medical Association formed in 1847 – was followed by the creation of obstetrics as a distinct specialization. The *American Journal of Obstetrics and Diseases of Women and Children* began publication in 1868, with the American Gynecological Association forming in 1876 and the American Association of Obstetrics and Gynecologists in 1888. Obstetricians capitalized on rhetoric advertising the moral imperative to rescue women from their faulty feminine biology. Obstetrics applied ready-made misogynistic dogma to the birth process, elevating the physician to religious intermediary. Charles Meigs, a prominent American obstetrician, declaimed in his introductory lecture in the Jefferson Medical College on October 9, 1854, that his was an attempt to:

“... explain the laws of all animated nature, so, there can be none more ennobling, none more elevating to the soul than the sciences we
pursue in order to obtain the knowledge of those principles, out of which we deduce our power to act as physicians and surgeons among mankind."\textsuperscript{17}

Obstetric practice wore the mantle of a virtuous pursuit, noble in its sacrifice to help humanity escape the unpredictability of the female body.

Women in need of medical attention chose from a diverse array of practitioners, as the late 1800s provided fertile ground for a diversity of medical specialists from herbalists to homeopaths to phrenologists. Homeopathic doctors treated illness with substances that produced a result similar to the disease, while allopaths administered drugs or compounds intended to reverse the effects of the illness. The reality of widely divergent styles of practice among doctors worked against a unified professional image. Allopathic practitioners lacked systematized education, licensing, and procedures, producing inconsistent methods and divergent results.

Cognizant of the poor image their profession garnered, doctors organized and mobilized to reform the system of medical education in America. Abraham Flexner, an educational consultant, conducted a full examination of the medical educational system, and concluded, in his influential 1910 report, that the supply of doctors should be drastically limited and educational standards significantly improved.\textsuperscript{18} Obstetrical training received a particularly harsh assessment. Flexner noted that doctors lacked training in delivery, with physicians attending their first birth after receiving their license. Few were skilled in directing labor and ensuring a safe delivery.
Following Flexner's report, the medical profession worked to improve both the training and reputation of obstetrics professionals by standardizing procedures and utilizing teaching hospitals to ensure that licensed doctors observed births and gained familiarity with the use of instruments. Poor women, unable to afford medical care, became hospital training tools, delivering in operating theatres ringed with audiences of medical students.\textsuperscript{19}

As organized medicine made efforts to improve its image and the quality of its practice, hospital birthing posed new dangers. Puerperal fever afflicted women in the maternity wards of hospitals in unprecedented fashion, causing as many as 75 percent of maternal deaths.\textsuperscript{20} Childbed fever reached epidemic proportions in some hospitals, claiming the lives of otherwise healthy mothers. Two doctors, Ignaz Semmelweis in Europe and Oliver Wendell Holmes in the United States, independently came to the same conclusion – examining physicians transmitted childbed fever on their hands from the birth canal of one woman to the next. Despite these findings, doctors unswervingly adhered to the “worthy profession” rhetoric and refused to believe that a physician could carry bacteria between patients. Even when studies showed that aseptic procedures prevented puerperal fever, the profession of medicine resisted the idea that the unwashed hands of doctors could spread death.\textsuperscript{i} Puerperal fever, common into the 1930s and 1940s, continued to kill needlessly until the widespread use of penicillin and other antibiotics finally reduced its effects.\textsuperscript{21} Despite the efforts of many health professionals to encourage

\textsuperscript{i} The incidence of puerperal fever in Montana is discussed in Appendix C.
simple preventative hand washing, only the availability of pharmacological
treatments reduced the impact of childbed fever.

Even as allopathic physicians made great efforts to enhance the training and
licensing of obstetricians, they faced lingering defiance. Midwives provided lower
cost care with comparable results, and women continued to request their services.
Medical organizations described “the midwife problem” and strategized how to
reduce competition by eliminating midwifery practice entirely. Many midwives in
the late 19th and early 20th centuries were immigrants who trained in their country
of origin and worked within their own particular ethnic working-class communities,
making them additionally vulnerable to racial and classist broadsides.

Physicians wanted a battle, and drew the lines between doctors and
midwives. Doctors attacked midwives for their lack of knowledge and their
adherence to out-of-date, old-country traditions. In 1917, Philadelphia physician
William R. Nicholson gave voice to common anti-midwife themes, describing
immigrants as “ignorant in every sense of the word, . . . do not speak English, . . .
have but little money, . . . are prolific breeders, and . . . come here with definite and
fixed ideas in favor of the midwife rather than the doctor.” A Mississippi
bureaucrat decried midwives as “filthy,” “ignorant,” and “not far removed from the
jungles of Africa.” Organized medicine painted midwifery as the choice of crude
illiterates, in contrast to physicians, who were cultured and cosmopolitan birth
practitioners. Those who wanted to assimilate to American culture saw that in
America, American physicians delivered American babies in American hospitals. The choice to employ a physician was becoming a badge of civic pride.

The combination of racial, gender, and classist themes provided a powerful propaganda tool in a country with residents anxious to belong, and the option to choose a conclusively American birth proved irresistible. Even as immigrant midwives assimilated and a generation of American-born women entered the midwifery ranks, the familiar racist, sexist, and classist tropes continued to prove powerful. Midwives attended half of all births in 1900, but the next several decades saw a dramatic change. By 1930, 85% of laboring women chose to use the services of a physician. Accounting for race and economic level revealed the shift to be even more dramatic, with many of the remaining midwifery-assisted births occurring in marginalized communities. Midwives practiced disproportionately among racial minorities and economically disadvantaged communities. Medicine ignored the practice of granny midwives in the South, Latina midwives in California, and Native American midwives on reservations since they did not represent a desirable market. Ironically, midwives serving these neglected pockets of the American population proved an invaluable source of knowledge in the resurgence of midwifery in the 1970s.

Doctors effectively made the case for physician-assisted birth, and midwives lacked the organizational tools and professional will to compete. Few midwifery schools existed in the United States, and since by the early 20th century midwives typically served particular ethnic groups, they lacked any widespread organizational
structure, or even a common language. Midwives shared common elements of practice, but arrived at that knowledge from a variety of sources in a number of languages – they did not share a terminology, philosophy, or form of professional organization. While midwives relied on the income generated by their efforts, service to their friends and neighbors remained a primary motivation, and they lacked the unifying group identity necessary to combat rising public opinion and medical rhetoric deployed against them. Distance, absence of shared philosophy, language barriers, and scarcity of economic resources conspired to hinder midwives from corresponding and cooperating. For medical organizations in the 1930s, midwives presented an easy target – diffuse, unorganized, and marginalized.

Physicians demonstrated business acumen in attempting to remove midwives from practice, and their efforts proved effective. Medical doctors became the primary caregivers for childbirth, and laboring women called a doctor if one was available. But resistance remained to the notion of giving birth in the hospital. Hospitals were centers of death and disease, and as institutions that cared for the dying they seemed an unlikely place for birthing. Doctors came to the houses of the wealthy, while poor women went to the hospital for free or low-cost medical care, “paying” for medical attention by giving up control over their bodies. Doctors and teaching hospitals gained patients, but earned the image of lower-class institutions in exchange.

Hospitals gained an unlikely ally with the burgeoning availability of the automobile. Access to transportation meant that women could travel to the
hospital in the early stages of labor, going to the doctor at a centralized location and ensuring availability of medical attention. Urban women made the switch to hospital birth initially, with rural women eventually following.

Changes in the culture of care also eased the acceptance of hospital birth. Physical proximity to female friends and family diminished with a more mobile population. The community surrounding women during the birth and the post-partum period and the relatives who helped in running the household and feeding the family were separated by long distances. Far removed from lifelong friends and family, a birthing woman could not count on willing assistants to step in and allow her the time to deliver and recover at home. Instead, the specter of managing the birth responsibilities on her own and returning to work immediately after the birth loomed large in the minds of pregnant women. Hospital birth looked attractive; the hospital took care of the clean up, nurses assisted with the new baby, and the mother temporarily escaped her domestic role.\textsuperscript{29} Institutional care replaced home-based family care, providing a desired benefit to parturient women.

Physicians found that hospital birth simplified their routines – with centrally located obstetric patients the doctor attended to other duties while a woman labored, managing two or more simultaneously birthing patients. Able to provide consistent care to all of their patients while women labored in the hospital, physicians advised hospital delivery from a public health perspective, demonstrating results in improved physician accessibility. In an effort to tackle lingering issues of class, private hospitals catered to wealthy women by offering
elite birthing environments. Private nurses, well-appointed rooms, and access to the latest anesthesia marked the upper-class birthing suite as distinctly different from hospitals serving poor and disadvantaged women.

The support of physicians, middle-class patients, and wealthy women cemented the transition from home birth to hospital delivery. In 1900, fewer than 5 in 100 babies were born in the hospital, but by the 1920s, hospital birth was the choice of thirty to fifty percent of women in urban America. The trend accelerated into the 1950s, when hospital birth became the widespread norm. By 1960 an entire generation entered the world through the hospital portal. Lacking continued contact with home birth, women of childbearing age relegated out-of-hospital delivery to the historic dustbin, unaware of the rapid transition to an unknown and untried practice of birth. The substitution of medical birth in a hospital ward for social birth in the company of friends and family was complete.

**Institutional Birth**

Ensconced in hospital ward beds and absent the benefits of movement, the presence of caring friends, and the familiarity of the home environment, women’s birthing pain intensified. Laboring women demanded a remedy, and the medical profession responded. Twilight Sleep, the anesthesia innovation developed in Germany and introduced to the United States in the 1910s, followed common delivery use of ether and chloroform. The laboring mother received morphine at the commencement of labor, then scopolamine – an amnesiac that removed all memory
of the birth – with a final dose of ether or chloroform as the baby’s head entered the birth canal. Women had to be restrained, sometimes with strait jackets, during scopolamine births because they threw their bodies around and did damage to themselves. Due to the amnesiac effects of the drug, however, women remembered nothing of the violent experience, and valued the alleviation of pain. The cocktail of drugs, adjusted by individual doctors to their specifications, provided a blank birthing slate. The mother arrived at the hospital pregnant, came to her senses remarkably deflated, and met her baby when the nurses brought it from the nursery.

Twilight Sleep removed women entirely from the delivery process. The birthing mother had no memory of the birth experience, no recollection of her baby’s response, and no sense of participation in the process of delivery. The immediate drug effects required recuperation time for both mother and child, and the long-term results of a birth carried out entirely by pharmaceutical drugs and hospital professionals impacted the development of modern birthing practices. Scopolamine usage encouraged continued pharmaceutical intervention in the birthing process, separated women from the experience of their bodies during birth, and legitimized mandatory hospitalization.

The cluster of physician-only procedures – anesthesia, forceps, episiotomy, and C-section, introduced and marketed as fringe benefits of hospital birth – became integrated as normal birth routines to the extent that mainstream physicians implemented the procedures without questioning or debating their efficacy.
Medical schools taught birth interventions as standard practice, leaving newly minted physicians without any background in birth absent medical technologies or techniques. After decades of established hospital births at the hands of physicians, women struggled to conceive of birth by any other means. The social movements of the 1960s and 1970s opened the door to question the status quo, and medical institutions, with their heavy-handed restrictions and formulaic protocols, were ripe for rebellion.

The Challenge to Medical Bureaucracy

Emboldened by personal preference, safety concerns, and cultural change, individual women challenged the dominant medical model, only to find themselves classified as “hostile patients.” Doctors administered the Twilight Sleep drug combination to women through the early 1970s, even over patient objections. Physicians cut episiotomies while mothers begged them not to, and women who contradicted or questioned medical procedures found themselves discounted, patronized, or ignored.34

In this context, alternate birthing theories, promulgated by doctors like Grantly Dick-Read and Fernand Lamaze, gained credence. Dick-Read, an English physician, challenged the medicalized model of birth in print, first publishing his findings in the United States in 1944.35 Dick-Read researched the factors that amplified labor pain and concluded that when the laboring mother received support throughout the entire labor process, the birth proceeded unrestricted. He
demonstrated that supported delivery resulted in safer and more comfortable birth experiences without negative emotional interference, but he found little acceptance among mainstream practitioners since his methods adapted poorly to the institutional birthing model. Hospital procedures dictated harsh light, lack of privacy, unnatural and uncomfortable birthing positions, and disallowed the presence of caring friends or family. The very conditions necessary for a supported and empowered birth were anathema to institutionalized policies.

Fernand Lamaze popularized his theories in *Painless Childbirth: The Lamaze Method*, published in 1956. Lamaze educated both parents about birth procedures and helped them manage technocratic interventions. He encouraged medication-free birth, and included the husband as a birth participant. Implementation of his methods helped a mother avoid “losing control” during a birth by teaching her to focus on managing the process. The woman directed the delivery and relied on her birth preparation to maintain composure during labor. Lamaze’s methods proved more adaptable to American birth practices. A calm and quiet mother made the labor easier for medical professionals to manage. As a result, hospitals allowed adherents of the Lamaze method to attempt non-medicated birth, and lifted restrictions requiring women’s arms to be strapped down during labor.

The experience of hospital birth awakened resistance among birthing women. Victoria Cain, pregnant in 1970, received scopolamine as part of a routine delivery. The doctor induced labor, prescribed Demerol, and delivered her baby with forceps. During her second pregnancy, she discovered the theories of Fernand
Lamaze. Concerned that the hospital would ignore her request to birth without medication, she labored on her own until the last stages of labor and went to the hospital just before she delivered the baby. Stories like Cain's played out across the United States, as women searched for ways to direct the circumstances and procedures surrounding childbirth.

Midwives who witnessed the growing demand for natural birth described it as a trend sparked by women's negative experiences with institutionalized birthing and supported by midwives from other countries who shared their accumulated knowledge. In Cain's early practice in southern Montana in the late 1970s and early 1980s, she worked with women who requested assistance, but assured her they would birth independently if necessary. Cain remembered a client saying, "Well, I'm doing it [delivering at home] anyway, so you want to come help or do you want me to do it on my own?" Jeanine Walker, in California in the early 1970s, saw the international connections of women as fuel for the growth of midwifery. She met with African midwives who were receiving contraceptive training in California, as well as British midwives employed in California hospitals, and noted the desire of the African and English midwives to transmit their knowledge to novice American practitioners. Dolly Browder, living in Missoula in the late 1970s, thought it made sense to birth her babies at home without medical personnel. She saw birth as a natural event and she trained as a midwife to help friends and neighbors in Missoula birth at home as well. She said that home births during the early 1980s had remarkably low C-section rates: "I think a lot of it was that I wasn't taking care of
people. They were really their own healthcare provider.” Kathee Dunham, also a midwife in Missoula, reflected that, “When I was first starting midwifery … people that wanted homebirths were really passionate about birthing at home and they truly, truly believed that homebirth was where they wanted to be.” Midwifery clients expressed a commitment to home birth and a motivation to control their own birthing environment, despite obstacles or challenges.

Armed with sparse but growing information about home birth, increasing numbers of women challenged hospital protocols, met with friends and neighbors to devise alternate delivery options, and birthed their babies at home on their own. Raven Lang was one of growing cohort who joined with other women to share resources about birth, to help each other birth at home, and to accumulate knowledge about their own bodies. Lang published the Birth Book in 1972, describing her experiences as a lay midwife and encouraging women to take control of their own births. Activities like Lang’s to organize, educate, and advocate for change in birth practices brought a politically activist element to the fledgling resurgence in lay midwifery.

The activities of women birthing outside of the hospital did not go unnoticed. Kate Bowland, by her own admission, “never intended to be an outlaw,” but cut her activist teeth during the civil rights movement and saw no difference between fighting racist laws and resisting unjust birth practices. Bowland knew Lang from art school, and attended a home birth when visiting Lang in California. Entranced with the birth process and the movement to return control of birth to women,
Bowland stayed and worked with a growing number of midwives at Lang’s Birth Center in Santa Cruz. In the 1974 raid that marked the beginning of the natural birth movement, police arrested three women – Kate Bowland, Jeanine Walker, and Linda Bennett – in an attempt to shut the Birth Center down and keep midwives from practicing. The Supreme Court of California eventually heard the case and publicity surrounding the arrests energized recent converts to the home birth cause. Women refused to stay quiet about their experiences, and books like Immaculate Deception, written by Suzanne Arms and published in 1975, profiled the arrests in California and fueled a politically activist home birth community.

For Jeanine Walker, one of the midwives arrested in California, birth activism grew out of her personal experience. Walker’s husband Frank, a final year medical student during her first pregnancy, planned to be present during the birth, but hospital policy and medical professionals forbade it. As her labor progressed, Walker experienced the “cascade of interventions” and saw how birth was “pathologized.” Eventually, armed guards arrived and unsuccessfully attempted to remove her husband from the delivery room in the culmination of an unexpectedly confrontational birth.

The experience radicalized the Walkers. When they moved to Santa Cruz, California, for Frank to train as an emergency room doctor, Jeanine met local midwives, attended births as an assistant, and trained as an apprentice with Kate Bowland. Walker found herself in the midst of a midwifery movement that was
gaining momentum, attracting supporters, and becoming outspoken, as women voiced their opposition to rigid hospital birth procedures.

While Walker’s legal case moved through the California court system, her husband received an offer from Community Hospital in Missoula, Montana, to oversee their emergency room, and they decided to relocate. Jeanine Walker’s vision for the future of midwifery included actively recruiting and mentoring apprentice midwives, so when she met Dolly Browder in Missoula and discovered a shared interest in home birth, it was only natural for the two women to work together, with Browder training as Walker’s apprentice.

From the midwives of Colonial America to the growing homebirth community of Missoula, the historical trajectory of midwifery followed a seemingly disconnected and fragmented path. Lacking bureaucratic oversight or professional organization, midwives practiced from diverse ethnic heritages and across a spectrum of geographic contexts. Nearly eliminated by the 1950s, practicing midwives rediscovered their past, benefitted from the knowledge of midwives around the world, and initiated vocal and organized resistance to institutionalized birthing procedures.
Midwives, like librarians, have a tradition of quiet resistance to tyranny. As the story goes, the Hebrew midwives in Egypt mendaciously told the Pharaoh that they were not able to kill the male babies as they were ordered, because Hebrew women were “lively, and are delivered ere the midwives come unto them,” Exodus 1:15-21. Judith Pence Rooks documents Hippocratic midwifery training in *Midwifery & Childbirth in America* (Philadelphia: Temple University Press, 1997).


Ibid.


Ibid.


20 Ibid.


in the state of Wisconsin, Borst followed the evolution of midwifery, general practice physicians, and obstetric specialists and showed that class was a distinct criterion that pregnant women used to select a birth attendant. The use of medical doctors indicated higher social standing and reflected the mother’s intention to consciously imbue her choice of birth attendant with a marker of upward mobility.


25 Ibid.


33 According to Judy Barrett Litoff in *American Midwives: 1860 to the Present* (Westport, CT: Greenwood Press, 1978), p. 71; doctors performed cesarean sections in the 1930s in emergency situations only, with a national C-section rate of 2.9%. Current C-section rates in the U.S. exceed 30%, and while international organizations like Amnesty International and the World Health Organization continue to advocate a reduction in the number of C-sections in the United States, the rate shows no signs of significant change. See Appendix G for additional data on U.S. C-section rates from 1930 to 2007.


38 Ibid.


44 Over the course of several years, Bowland and Walker’s case traversed the California court system, concluding with a decision by the California Supreme Court that California state law prohibited the practice of lay midwifery. Jeanine Walker, phone interview with Jennifer Hill, January 20, 2013, personal collection of the author.


Midwives practiced in Montana with multiple motivations, from neighborliness to the need for a self-supporting profession. Aino Hamalainen graduated from midwifery school in Helsinki, Finland, in 1906, and immigrated to the United States, working in New York area hospitals. She relocated to Butte, Montana, in 1913, where she supported herself with the income from her midwifery practice. Attracted by the large Finnish population in Red Lodge, Montana, she moved to Carbon County in 1916, and married Otto Puutio in 1919. Continuing to assist birthing women in the Red Lodge community, Aino Hamalainen Puutio worked as a midwife through the Depression, struggling to keep her clients nourished enough to deliver healthy babies. Puutio practiced as a professional; she met with pregnant women to determine approximate due date, informed them about proper nutrition, and encouraged sufficient rest. She kept her supplies – towels, forceps, scalpel, thermometers, linen cord, and wooden stethoscope – sanitized and packed in a straw bag, ready for emergency calls. She charged $14 for her services, which included prenatal consultation, assistance at the delivery, and post-partum care extending ten or more days after the birth. She worked as a professional midwife with education, training, and European accreditation. In contrast, midwife Annie Knipfer, of Baker, Montana, helped to deliver babies during the same time period, but did not consider it a vocation. She did what she could to help her neighbors, and while Knipfer had some nursing training, she lacked specific instruction in birthing details, did not have access to any midwifery texts, and,
because of her work on the family ranch, did not depend on income from her midwifery services. While Puutio established a regimen of care for pregnant women who hired her, Knipfer responded to the calls for birth assistance from neighbor women with few healthcare options. Both Puutio and Knipfer provided midwifery services, but the counsel and skill they brought to birth differed greatly.

The state of Montana did not provide licensure or regulation of early midwives, and no known government records exist to document how many midwives provided services to Montana women prior to 1954. That year, the State Board of Health began tabulating the number of babies born outside of the hospital with the assistance of midwives, and reported 442 out-of-hospital, non-physician births from 1954 through 1958. Midwifery-attended births represented a small percentage of total Montana births, accounting for less than 1% of births statewide until the 1980s, and increasing to nearly 4% by 2009.

As practicing midwives aged and hospital birth became increasingly popular, demand for homebirth services decreased and young women did not seek out older midwives to apprentice with. With the passing of Puutio’s generation – she died in 1947 – the accumulated expertise of Montana midwives was lost, and later generations of midwives looked to other sources for midwifery training. Living in southwest Montana in the 1970s, Victoria Cain did not know any midwives, and when she wanted to pursue midwifery as a profession, she turned to obstetric textbooks and resources outside the state. Cain, fueled by disappointment with her

\footnote{Appendix E lists the available data for out-of-hospital births in Montana for the years 1954 to 2009.}
own birthing experiences, found a mentor in Ina May Gaskin. Gaskin published *Spiritual Midwifery* in 1978 and promoted a return to woman-centered homebirth practices for the residents of The Farm, an independent, back-to-the-land commune in Tennessee. Her book became the unofficial handbook of activist midwives promoting the resurgence of home birth. She stated that women could, through their intuition and empathy, help other women in ways that men could not; she opened a space for women to be simultaneously feminist and feminine. Promoting a unique blend of woman-as-mother and woman-as-powerful, Gaskin popularized home birth on the national level.

With a pro-woman stance, Gaskin found acceptance among feminist birth advocates, blending ecstatic birth-worship with factual scientific information. Her ability to successfully address the importance of birth, her commitment to birth as the province of women, and her clearly communicated scientific, physiological, and anatomical information made her an able advocate for a new version of midwifery, one fully in command of medical terminology and capable of presenting impressive statistical evidence on the success of midwifery methods in reducing C-sections and technological interventions, and improving overall health for women and infants.

Based on the information she gleaned from Gaskin’s book, Cain birthed her third baby at home with a midwife, and knew that she had found her calling. She traveled to Santa Cruz, California, the site of early homebirth midwifery controversy, to shadow a midwife and gain practical experience, and returned to Montana in 1978 ready to assist at births. Cain lived in Red Lodge, and her practice grew, as
clients looking for alternatives to standard medical procedures sought her out. Clear about her limitations and lack of experience, she encountered pregnant women who were “determined to break out of [the] medical system. They felt that there was no other way out unless they became like pioneers, or explorers, or, ‘We’re going to try this, against all odds, we’re going to do this.’”

Isolated midwives like Cain began to access an expanded body of knowledge that supplied scientific evidence to support unmedicated home birth. Robert Bradley, a physician with an agricultural background, based his findings on the behavior of animals. He observed the birth process in a variety of mammalian species and discovered that females chose protected, dark, and secluded locations to deliver. Movement or disruption affected the labor adversely and complicated the birth process. He postulated that as mammals, female humans birthed according to inherited evolutionary predispositions, and advocated that the physician be assisting but not directing, even putting the husband in the catching position. His ideas became known as the Bradley Method and achieved success with smooth and uncomplicated deliveries. At a time when many were pushing for the husband’s presence in the delivery room, Bradley provided a task and role for the father. The Bradley Method marginalized the physician by placing the woman and her partner at the center of the action. Bradley added information and ammunition to the argument for safe and quiet birth environments.

Frederick Leboyer, a French physician, popularized gentle birth as a means to eliminate infant birth trauma. Countering the assumption that a healthy baby
cried at birth, he asked that the needs and experiences of the infant be considered. Challenging the practice of ignoring or even celebrating the cries of a screaming infant, he said that the feelings of newborns mattered and their reactions should be noted. In *Birth Without Violence*, published in 1975, he used visual images to convey the ways that babies communicated fear, pleasure, and comfort, and suggested that parents and physicians refashion their interpretation of infant expression to learn from and adapt to infants.7

Michel Odent built on Leboyer’s ideas and used his experience as an obstetrician to inform his study of birth.8 Odent’s work with midwives at a French clinic convinced him of the primal nature of birth and he, too, advocated quiet, seclusion, and darkness. Odent suggested that the mother’s sense of where and how she would birth provided critical cues necessary for directing the birth. Advocating for female midwives to attend birthing women, he saw the improved outcomes when experienced midwives assisted at births, and he continued to involve them as part of his birth research. His first book, *Birth Reborn*, published in 1984, was a manifesto for birth reform, and Odent continued publishing, speaking, and traveling internationally to inform and educate audiences about his research results, even headlining a conference for midwives in Missoula, Montana, in 1988.9

Missoula, Montana

The social activism of the 1960s infiltrated Missoula, a university town surrounded by mountains and set along the Clark Fork River. The availability of the
Pill made sexual activity less costly for college women, and newly energized second-wave feminists, sensing the connection between intellectual empowerment and sexual knowledge, provided information about reproduction, birth control, and sexuality on college campuses. Diane Sands, a student and activist in Missoula at the University of Montana during the 1960s and 1970s, published the Birth Control Handbook and distributed it to students. University administrators banned the book and confiscated the copies, inadvertently increasing student demand for the publication. The University eventually allowed the Handbook to be distributed with the disclaimer that it did not represent the views of the institution. Sands advocated reproductive education as a way to empower and educate: “The Birth Control Handbook wasn’t just about telling people about certain birth control techniques. It basically said, ‘You are a human being who’s entitled to know something about your own body.’” Reproductive issues like birth control and childbirth provided a rallying point for Missoula women.

Feminist political activism sought an outlet in the Missoula community, a way to empower women and provide reproductive information. Organizers formed the Women’s Center, with a mission to agitate for political, institutional, and cultural changes. Local feminists volunteered their time and organized classes, workshops, and training sessions on a variety of women’s issues. The organization addressed violence against women and received a grant to train police departments around the state in handling incidents of rape.
Living in Missoula and caring for her young daughter at home, Dolly Browder wanted contact with other women and volunteered at the Women’s Center in 1977. At the Women’s Center she met Michele Neal, a mother who shared an interest in home birth. Fresh from a small midwifery school in Arizona where she worked at a self-directed prenatal clinic, Neal moved to Missoula with her nine-month-old daughter and began to seek out sources to develop her midwifery skills. Both Neal and Browder delivered their own children at home and desired additional training to help other women seeking a similar experience. They began observing home births and studying medical texts and midwifery manuals.

In 1978, Jeanine Walker moved to Missoula with her husband Frank, leaving her pending California legal case behind and starting fresh in Montana. Undaunted by her arrest in California, Walker started practicing midwifery in Big Sky Country. Demand for home birth midwifery was high, and she was busy. Walker and Browder discovered a shared interest in home birth and Walker asked Browder to apprentice as a midwife to assist with the steady requests for birthing assistance.¹²

Midwives like Browder, Neal, and Walker placed particular emphasis on delivering babies outside of the hospital, and pursued direct-entry midwifery. The American College of Nurse-Midwives, established in 1955, licensed nurses with specialized training in obstetrics, prenatal, and delivery care. Certified Nurse Midwives, or CNMs, worked within medical institutions to deliver healthcare to birthing women and their infants.¹³ Lay, or direct-entry midwives, served pregnant
women independently, bypassing medical bureaucracy and delivering infants outside of the hospital in the homes of pregnant women.

Walker, Browder, and Neal organized introductory training sessions on direct-entry midwifery, and Kate Bowland, Walker's mentor in Santa Cruz, traveled to Missoula to teach sessions. A group of local women, including Browder and Neal, gathered regularly to discuss birth topics and share resources about midwifery. The combination of Browder's interest in midwifery, Neal's midwifery training in Arizona, and Walker's connections to the Santa Cruz birth movement fueled a camaraderie and confidence within the Missoula homebirth community.

By 1980, Browder's midwifery activity had expanded to a full-time vocation, and she, along with Neal, began training new apprentice midwives. Montana midwives shared a philosophy with midwives nation-wide, believing that healthy pregnancies started with healthy mothers, that maternal health and well-being held essential value.14 The natural birth movement in the 1970s and 1980s codified and promulgated its philosophical birthing methods and its woman-centric approach. The tenet that women experienced pregnancy and birth as normal life processes led the direct-entry midwifery movement to prioritize a certain method to enhance and encourage maternal well-being. Midwives provided “individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support,” while utilizing technological interventions selectively, believing that the female body provided the best information and adaptation to successfully birth babies.15
The practice of lay midwives like Neal and Browder differed markedly from standard obstetric care. Midwives met with pregnant women, just as obstetricians did, to determine probable due date, and to collect and record data about the mother's weight, overall health, and size of fetus. But the midwife considered all parts of the woman's life – her nutrition, her relationships, her concerns, and her mental health – as relevant to her inquiry and deserving of her time and energies. The midwifery practices in Missoula monitored the progress of the pregnancy and health of the fetus, ordered blood and lab tests, analyzed urine samples, and observed and discussed with the mother matters related to her health, happiness, and well-being. Homebirth midwives visited the home where the birth would take place, interacted with the mother’s family, and spent time with the pregnant woman to address questions. During labor, the midwife monitored the fetal heart rate and encouraged the mother to walk and move in ways that decreased discomfort and encouraged the progress of labor. Midwives did not administer anesthetic or perform episiotomies, but used massage, relaxation, and water therapy to assist the mother. After the birth of the baby, the midwife monitored the delivery of the placenta, and assisted in getting both mother and infant comfortable. In the weeks following the birth, the midwife visited several times, helping the mother to establish breastfeeding and bond with the baby. The intimate nature of midwifery care provided support for the woman as a whole person, recognized the interrelated nature of the physical and emotional components of birth, and respected the importance of the mother as director of the birth process.
Midwifery care reduced C-section rates and birth injuries, but required a lifestyle and living standard far removed from what an obstetrician could expect. Because midwifery care relied on a trusting relationship between midwife and client, the midwife had to be present during delivery. As a client approached her due date, the midwife could not go on a three-day backcountry hiking trip or float the Blackfoot River. In contrast to a physician who checked in on a laboring woman on occasion, the midwife stayed, putting in long and laborious hours during the birth process. The midwife went to the home of the birthing mother, and while this increased the comfort and ease of the mother, the midwife had to adjust to napping on a strange couch, being out of her comfort zone, and adapting to the environment instead of controlling it. While a physician managed multiple births simultaneously and charged a higher fee for their time, midwives provided more time and received less compensation. Midwifery proved a difficult profession with constant demands on time and attention, and midwives struggled to balance the needs of clients with personal satisfaction.

Montana midwives practiced with differing personal styles, and their clientele represented a diversity of ethnic backgrounds and socio-economic levels. Pat Schwaiger began her practice along the Montana/Wyoming border in 1986, driving miles in her cowboy boots to assist “hippies and Rastafarians and Buddhists and fundamentalist Christians.” She worked with women in all manner of birthing locations, from trailer houses to palatial homes. The Wyoming State Board of Medical Examiners filed suit against Schwaiger in 1991, and she quit practicing
midwifery in Wyoming, asking Wyoming clients to travel to her office in Billings, Montana. In 2010, Wyoming Governor Dave Freudenthal asked Schwaiger to chair the newly created midwifery licensing board in the state, a position she still holds.

Ollie Hamilton had her first baby on Okinawa in 1969 while her husband served in the U.S. Army. Military policy dictated birth practices, and military doctors refused to allow her to choose whether or not she would utilize pain medication during the delivery. She found an off-base physician who let her direct her own birth. When she returned to the states and moved to Colorado, acquaintances asked her to talk about her birth experience. They encouraged her to collect information and educate herself, so she attended conferences and sought natural birth resources. Eventually settling in Great Falls, Montana, she assisted at the births of other Jehovah’s Witness church members, and contracted to provide birthing services for Hutterite women, members of an Anabaptist sect with agricultural colonies in northern Montana. Hamilton worked full-time as a midwife in the Hutterite colonies with a starting salary in 1987 of $36,000.18

In the late 1980s when a hospital birth cost around $3,500, the typical midwifery charge of $300 to $700 per birth offered a significant cost savings.19 Additionally, some midwives offered to take payments or trade for their services. Victoria Cain felt that God called her to her work; she did not want lack of money to keep clients from seeking midwifery care. She established payment plans with birthing women and worked to make her charges affordable.20
Schwaiger, Hamilton, and Cain practiced midwifery independently, without the benefit of cooperation or contact with other midwives. Browder, Neal, and their apprentices worked as a loose community, consulting and conversing about midwifery practices, resources, and methodologies. While isolated midwives limited their practices to more narrowly defined reproductive issues, Missoula midwives had the benefit of support and mutual encouragement, and whether by inclination, cooperative efforts, or political persuasion, espoused legislative action and feminist activism more openly.

Montana midwives constructed philosophies of practice from a fusion of convictions about women, the female body, and birth practices. Midwifery used birth to bring women into an appreciative and healthy relationship with their physical capabilities. Birth could be a deep and transformative event with lifelong impacts, or a passing moment in a woman’s life when she felt respected and in control. Regardless of its lasting effect, midwifery-assisted birth brought the potential for a woman to inhabit her body in positive ways. In a misogynistic culture, that was a radical act. While Montana midwives differed in religious convictions, educational backgrounds, and political loyalties, they shared a commitment to birthing women and a confidence in the power of midwifery.

Respect

The midwives interviewed for this project willingly embraced a widely divergent clientele and found commonality with women through pregnancy, birth,
and the post-partum period, despite the challenge of working with individuals who advocated beliefs they found personally distasteful. Midwives held strong opinions about women and the role of birth, and clearly and forcefully supported those opinions. But in the midst of personal certitude, they expressed a desire to assist women of all political persuasions, preferences, and practices. As Stacey Haugland, a Bozeman midwife active in politically liberal social causes explained,

“I will work with women who believe that it is their obligation to produce as many children as God wants, or their husband wants. I’ve worked with people who don’t believe that they are allowed to touch their own bodies because it belongs to their husband.”

Haugland’s commitment echoed the comments of midwives who believed in the power of midwifery to encourage and empower women regardless of religious persuasion or political bias. Midwives allowed disagreement and encouraged birthing women from a position of equality, avoiding heavy-handed persuasion that might derail and violate the trust inherent in the midwife/client relationship.

Montana midwives commanded a birthing expertise far in excess of the understandings held by individual clients but they restrained attempts to dictate specific methods for birthing by respecting individual women as the ultimate authorities over their own bodies and reproductive functions. Evidence-based science informed midwifery decisions but did not remove the client from the decision-making process. Optimal healthcare depended on the mother’s involvement and interaction as an active advocate for herself and her pregnancy. In her practice, Haugland provided information to women and trusted that they would use it in the best way possible. “If we come back to respecting women, we know that
women want their babies to be healthy.” Midwives encouraged clients to integrate, personalize, and apply information to their own lives and circumstances, and achieved successful outcomes by providing accurate and up-to-date information in a context free of domination or coercion. Research provided data and information that necessitated contextualization, and the client interpreted and applied the information to her uniquely individuated life experiences. Healthy births depended, not on particular procedures, but on the mother as an irreplaceable participatory conduit to maternal and infant well-being.

**Empathy**

Modern midwives saw themselves as critical reproductive healthcare providers. While the obstetric profession valued technical acumen, the midwives in this project valued empathic abilities, counting the ability to connect with their clients among their most important skills, and expressing doubt that any practitioner could effectively support laboring women without it. Sandhano Danison, a Missoula midwife who apprenticed with Browder, described what she saw as the source of the lack of understanding between male obstetricians and female patients: “I’ve always found it really odd that the majority of OBs are male, and they don’t have a vagina, so I don’t know that they can totally relate to what that means, and they haven’t grown a baby in their body.” Danison expressed the belief that the shared experience of womanhood and a common reproductive pattern allowed midwives to relate to and support women on a deeper level; the absence of
connection within mainstream medicine left them puzzled. Gauging effective reproductive care by the quality of the relational connection, midwives interpreted a lack of client understanding of birthing as substandard treatment. Schwaiger explained that, “the majority of obstetricians are male, and I think it’s like any other experience in life, you can probably understand your clients’ feelings and situations and plans and dreams better if you’ve done it yourself.”

Midwives depended on their female identity to establish connection and empathy with clients, and found the mother’s femininity important, worthwhile, and unique. The commonality of biology and womanhood provided the impetus to investigate and frame the reproductive experience from a uniquely female-centric approach. “Midwives, most of us are female, most of us are moms, and so we do get it, and we’re going to put a lot more attention on that aspect of care.”

Midwives incorporated the mother’s relationship with existing children into the birth equation, and gave emotional aspects of birth credence as components of successful birth outcomes. They respected the mother’s physicality and recognized her sexual activity, counseling her as she transitioned through pregnancy, delivery, and the post partum period. In contrast to hospital episiotomies, frequently sutured with male sexual pleasure in mind, midwives rarely performed episiotomies, knowing that the natural tearing and healing process of the perineum resulted in intact sexual sensation for the woman. Expressing an appreciation for female reproduction, midwives spoke of the beauty of birth, joy in seeing a woman laboring successfully, and pleasure in the power and function of the female body.
Montana midwives perceived women in relationship to families and communities. Mothers were affected by and responded to friends, coworkers, partners, religious institutions, and neighbors. Women existed within a connecting schema, and midwives refused to remove them from their context, believing that care based on isolated facts and symptoms provided little service to the mother. Kathee Dunham, a farmer and Missoula midwife, saw women as “important parts of families, we’re important in the web of life.” Women mattered as individuals and as members of communities. Michele Neal supported,

“...individualist equality for all - women, men, babies and children. I personally promote social change in birth and parenting by instilling confidence in the family. Everyone is involved with planning of pregnancy, birth, and parenting roles. I encourage creativity - men can be the stay-at-home-dads if that is what the family needs.”

From the perspective of the midwives in this study, care that ignored the relational components of women's lives fell short, failing to address the psychological and physiological aspects central to the birth process.

From a host of contradictions, shared values, and theoretical conundrums, midwives formed composite pictures of birth in ways that allowed for flexibility and fortitude, questioning and confidence. In the midst of patriarchal norms and through their individual lenses, Montana midwives constructed practices that valued women and birth, provided personalized care to parturient women, and affirmed the power of the female body.
Michele Neal, Dolly Browder, Pat Schwaiger, Victoria Cain, and Ollie Hamilton represented the variety within the resurgence of Montana midwifery. They also shared a commitment to serve the birthing needs of women with respect, empathy, and sensitivity. Cain, Schwaiger, and Hamilton practiced midwifery geographically separated from other midwives; Browder and Neal enjoyed contact with local midwives and apprentices. They all became, after the legal changes effective in 1991, the grandmother midwives of Montana, the first fully licensed and newly legal practitioners of an ancient yet evolving profession.
1 Arlene Harris, daughter of Aino Hamalainen Puutio, wrote a description of her mother's work, “An Early-Day Montana Midwife,” which is held by the Carbon County Historical Society in Red Lodge, Montana. Harris also authored an article in Borrowed Times, published September 1, 1974, titled “Midwife Aino.”


3 Data drawn from Biennial Reports published by the Montana State Board of Health and the State of Montana Vital Statistics Reports provide information about the number of out-of-hospital births from 1954 to 2009 and the calculations of midwifery-attended births are based on this data. Appendix E provides a complete listing of the available information.


8 Over the course of his career, Odent published widely, including Birth Reborn (New York: Pantheon Books, 1984); Primal Health: A Blueprint for Our Survival (London: Century Hutchinson Publishing, 1986); and Birth and Breastfeeding: Rediscovering the Needs of Women in Pregnancy and Childbirth (East Sussex: Clairview Books, 2003). For a more complete listing of his work, see the Bibliography.


11 Dolly Browder, interview with Darla Torres, March 4, 2002, Missoula, Montana, OH 378-1, Montana Feminist History Project, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.


16 Ibid.


22 Ibid.


25 Ibid.

Sarah Cobb’s pregnancy proceeded normally, without problems, complications, or worries. Trained as a nurse, she lived out of town, and traveled to Missoula, Montana, for her prenatal work. She was due in May, 1988, and planned to labor at a friend’s home in town to be near the midwife and the hospital.\(^1\) Local midwife Dolly Browder assisted Sarah during her labor, and, as the labor lengthened, she became concerned. Browder “just didn’t feel comfortable staying there, and [thought] that we needed to go in. She [Cobb] agreed. We all packed up and went, came in to the hospital.”\(^2\)

Hospital staff admitted Cobb and monitored her contractions. Browder stayed at the hospital, providing the labor history to nurses and watching over Cobb’s condition. Browder, a long-time Missoula resident, knew many of the area doctors, but had never met the physician on call, R. D. Marks. Marks, a Montana native, hailed from Clancy, but was new to Missoula.\(^3\)

Marks examined Cobb, and she labored for a while at the hospital, but Marks eventually performed a C-section, and delivered a healthy baby. Despite the positive outcome, Marks was furious: “This was dumped in my lap . . . How could this happen? How could somebody do this? Put this person at risk? Such risk and then just hand it to me and say, ‘It’s yours.’ I was just offended that anybody would do that.”\(^4\) Convinced that Browder was violating the law and practicing medicine without a license, Marks determined to act.
Missoula midwives typically received a neutral to friendly reception when they transferred a laboring woman to the hospital. Across Montana, midwives operated in a grey zone. State law neither disallowed the practice of midwifery nor licensed it. While the state did not directly sanction their profession, it did not prohibit it either, and midwives worked openly throughout the state and maintained regular contact with other members of the medical community. Midwifery and institutionalized medicine shared a long history of confrontation, with individual physicians attempting to silence midwives. Browder knew well the story of Jeanine Walker’s California arrest and that conflict with authorities could turn serious.

Marks called Browder the next day, and told her that he planned to contact the police, that he:

“...was going to get rid of all the midwives, and I just was shocked. I had no idea what he was talking about. So I tried to tell him, ‘Listen. I really think that you’re going in the wrong direction.’ I’d be glad to, to go with him to legislature. Let them decide what needs to be done here. He just said, ‘No. No. You’ll be hearing from the Police Department.’ Then he hung up.”

Marks felt he had an ethical responsibility to protect the public health and contacted the authorities, pressing them to follow up and pursue prosecution. County Attorney Dusty Deschamps directed his staff to research the legality of lay midwifery, and when they could not find a clear violation, Deschamps refused to pursue the matter. Marks, puzzled that such a clear danger did not receive a quick and decisive response, searched for other enforcement agencies that might have
jurisdiction. After conversations with physicians, attorneys, and government officials, he contacted the Montana Board of Medical Examiners in Helena. The Board of Medical Examiners, under the aegis of the Department of Labor and Industry, set standards for physician accreditation and monitored licensing of physicians, emergency medical technicians, and other healthcare providers. In 1988, Patricia Englund served as attorney for the Board of Medical Examiners. Marks contacted Englund, explained the situation in Missoula, and relayed his concerns. England did not need convincing, nor was she hesitant to act. As Marks said, she “took it and ran with it.”

Local midwives were not fully aware of Marks’s attempts to locate an enforcement agency, but saw his threat to Browder as reason enough to organize and push for legislative change. Starting in the late 1970s, Missoula midwives communicated regularly and met to discuss pregnancy and birth-related topics, but in 1988 they formalized their organization, calling themselves the Montana Midwifery Association. They informed midwives around the state about the events in Missoula, began fundraising for a legislative presence in the 1989 session, and made arrangements to hire a lobbyist and assess legislative openness to licensing lay midwives.

Months of silence followed Browder’s initial contact with Marks in May of 1988. Browder continued her regular practice, meeting with women, providing prenatal care, and attending births. Demand for homebirth services in Missoula
steadily increased, and Browder worked to train additional midwives to assist with growing numbers of homebirth clients.

On November 16, 1988, six months after Mark’s initial threat, the Board of Medical Examiners filed a complaint against Browder with the Missoula County court. The complaint stated that Browder had,

“... engaged in the practice of lay midwifery, including but not limited to taking medical histories, performing pelvic examinations, providing prenatal care, such as reading and interpreting urine and blood tests, rupturing membranes (the amniotic sac containing the unborn baby), performing episiotomies, prescribing and administering injections, and delivering, and attempting the home delivery of, babies, and charging fees for her services up to $800 per delivery. Such conduct constitutes the practice of medicine without a license, and endangers the public health and safety in the State of Montana. Unless the acts, conduct and practice of midwifery of Mrs. Browder, as alleged above, are enjoined by the court, her continued unlicensed practice will expose the public of this state to great risk of serious or irreparable injury.”

Browder received a copy of the complaint, and the Board informed her that she had two options – give up her midwifery practice or face trial. Browder recalled her previous experience with conflict and official intimidation. In 1972, she worked as a teacher during the school year and looked for seasonal employment during the summer. She inquired about a job fighting fires, but the Forest Service refused to hire women as part of their all-male firefighting crews. Browder made arrangements with the Forest Service office and formed an all-female crew, naming it the Red Star Crew and working during the summers of 1972 and 1973. When a male supervisor attempted to shut the crew down, Browder and a female co-worker filed suit. A federal judge decided the case in their favor, and within a year of the
verdict, the Forest Service employed women on crews throughout Montana.\textsuperscript{12}

Assessing her options in 1988, Browder considered her choice. Midwifery had become a lifestyle and a calling for her, and she felt loath to relinquish it. Believing that midwifery was worth fighting for and recognizing that a court battle might be unavoidable, Browder chose to go to court.\textsuperscript{13}

The court scheduled three trial dates, one in November and two more in January. Patricia Englund, attorney for the Board of Medical Examiners, asked Valerie Knudsen, a Missoula obstetrician, to testify as an expert witness. Knudsen moved to Missoula in 1986 and had a busy obstetric practice. With experience dealing with lay midwives in Oregon before moving to Montana, she felt well-versed in midwifery issues, and concerned about the care midwives provided: “I really thought they were totally inadequate, because they didn’t know what they were doing . . . they were very uneducated.”\textsuperscript{14} Knudsen signed on to be the key witness in the Board’s case against Browder, and explained her willingness to testify:

“I think I was the newest dumbest person . . . so they could ask me to do it . . . I know that none of my partners – I don’t know if they were asked, but they wanted nothing to do with all that publicity, that’s for sure. And yet I was, you know, woman of the 70s, very feminist, came from a very strong pro-women program in Oregon . . . and we felt the same way in Oregon that these lay midwives were causing lots of accidents and problems at home.”\textsuperscript{15}

Given her convictions about midwifery, Knudsen proved a willing participant in testimony preparation and case strategy.

Browder’s trial began November 30, 1988, with a packed courtroom and national press in attendance. The case brought by the Board of Medical Examiners
centered around Browder’s competence to practice midwifery. Newspaper reports statewide followed case testimony, reporting that, “Dr. Valerie Knudsen told District Judge John Henson that while Browder is a ‘great coach’ for women going through labor, much of her care for pregnant women is inadequate.” The initial day of testimony involved discussion of Browder’s practice methods and review of Browder’s client case histories, “with Browder defending her work and Knudsen criticizing it.”

The case revolved around two issues – Browder’s competence to manage labor, and the legitimacy of midwifery as a profession separate from medicine. Two attorneys whose births Browder had attended represented her pro bono, and a long line of supporters testified to her skill. Over the course of her practice, Browder had developed a working relationship with local doctors, and they testified on her behalf. Former clients took the stand to describe the quality of care Browder provided and explain the nature of the services she provided.

State and local newspapers included coverage of the case, and the Missoulian reported that, “dozens of witnesses have shared their perceptions of Browder’s competence and practice. Women who’ve had her assistance at their babies’ births praised Browder for her knowledge of childbirth and her emotional and spiritual support.” But Englund said Browder represented a danger to public health, citing “the potential harm of Ms. Browder’s practice” as “incalculable.” Knudsen’s attacks and the testimony of additional doctors were, in Browder’s words, “vociferous,” and Browder,
“. . . felt really intimidated for the first time . . . So here I am, I’m being opposed by this woman lawyer and a woman OB, who’s sitting on the opposite of my bench. I mean, what kind of prophetic information is that to tell young women? You know, who, what are we battling here?”

As the community of Missoula debated the pros and cons of home birth, the local paper aired opinions on the issue, and supporters from around the country expressed their concerns. Browder felt intense pressure, fearing that the court battle would affect the future of Montana midwifery. During the trial, Browder contemplated the outcome:

“There’s this big picture of Justice, you know, the woman and the scales . . . I really saw those scales and wondered whether it was going to tip in our favor or not. It was just this mystery about what was going to happen with midwifery. I just was so curious, but yet just so exhausted.”

Observers struggled to predict the outcome, since little legal precedent existed. After three full days of testimony, Judge John Henson reviewed court testimony and, on January 19, 1989, issued his Opinion and Order. Henson ruled that Browder was indeed practicing medicine when she:

“. . . monitors the course and progress of the birth directing it to its conclusion. During the delivery, Defendant necessarily engages in diagnosis of the normality or conditions of the birth as it progresses. Defendant conducts a medical procedure by delivering babies. During the deliveries she consistently and continuously takes actions which constitute the practice of medicine.”

While Judge Henson did not disparage the practice of midwifery or fine Browder, he did conclude that she would not be allowed to continue practicing. As Browder’s attorney, John Whiston, explained, “Ultimately, the law was the problem. I think we
convinced Judge Henson that Dolly was competent and no risk to patients but he concluded that this was a question for the legislature.\textsuperscript{21}

With the Montana Midwifery Association mobilized and ready to head to Helena, its members recognized that all midwives in the state would soon face similar legal action if they failed to make legislative headway. Prepared to put her full energies into the legislative session, Browder first dealt with the reality of twenty pregnant clients due in the next three months. If Browder saw clients, she would be subject to jail time.\textsuperscript{22} But Judge Henson’s Order named only Browder, so other midwives chose to continue practicing, at least until the Montana Board of Medical Examiners initiated proceedings against them.\textsuperscript{23} After discussing the risks, local Missoula midwives took on part of Browder’s client load while the remaining mothers opted for a hospital birth. The interim situation left midwives and clients in limbo – Browder could not practice at all; other Missoula midwives attended births while attempting to stay away from controversy and public attention; and midwives throughout the state wondered if they would be next to be served with legal papers.

In the midst of the controversy, midwives faced an uphill battle in their quest for legitimacy, and the strength of the midwives’ organization would be tested in the months to come.

1989 Legislative Session

People paid attention to Mona Jamison. Intense, with short brown curly hair, passionate energy, and a New York accent, Jamison exuded tenacity as she marched
the corridors of the Capitol. She had grown up on Long Island and graduated from the University of Wisconsin. When her husband attended the University of Montana law school, she fell in love with the state and, after she completed her law degree at the University of Utah, they decided to move back to Montana and settled in Helena in 1976.

Jamison began her career working as an attorney in the Montana Department of Health and Environmental Sciences, and after six years transferred to the Governor’s office. She concluded her employment for the state of Montana as chief counsel to Governor Ted Schwinden, ready to open her own firm and apply her experience in state government to legislative lobbying. She started a private law practice in 1986 with initial lobbying experience during the legislative Special Session that year. Over the course of her lengthy lobbying career, Jamison garnered recognition for her work ethic, thorough organizational strategy, and grasp of legislative issues, but during the 1989 session she was new to the lobbying scene and in the process of crafting her reputation.24

The Montana Midwifery Association contracted with a lobbyist well in advance of the legislative session, but when he withdrew shortly before the 1989 session began, he gave Jamison’s name to Browder, hoping that Jamison would be able to fill in on short notice. When Browder called Jamison and asked her to step in as the lobbyist for the Montana Midwifery Association, Jamison agreed.

Midwives desired legislative action to protect their ability to practice. Legislative rules required that procedural protocol be followed to request
professional licensing and the deadlines for filing had long since passed. Jamison concluded that lay midwives should seek an exemption from the Medical Practice Act on the basis that the practice of midwifery did not qualify as a medical event. If successful, an exemption would alleviate any confusion about the nature of midwifery and assert that the Montana Board of Medical Examiners had no jurisdiction to regulate and control the practice of direct-entry midwives.25

As legislators prepared for the 1989 session, the issue of rural access to healthcare garnered public attention. Medical liability rates continued to climb, and physicians wrestled with the choice to discontinue certain high-cost services. With obstetric liability costs soaring, a number of general practice physicians across the state terminated obstetrical services. An estimated 66% of Montana counties lacked obstetric services; of 123 physicians in Montana who delivered babies in 1988, 49 planned to eliminate delivery services.26 Concerns over medical access prompted some residents to suggest midwifery as a solution. As Mrs. Walter Vannoy wrote, “In the small towns where my daughters live they don’t even have a doctor, let alone one that delivers babies. Many of the doctors have stopped because of malpractice insurance. They have come to depend on midwifery.”27

Jamison, too, saw the medical crisis as a ready-made argument for the protection of practicing Montana midwives. A bill to exempt midwives from the Medical Practice Act might pass if it could generate strong support from rural senators and representatives. Sensing an opening for legislative success and
convinced that midwives deserved legislative representation, Jamison plunged into an intensive self-education on the theory and practice of midwifery.

Jamison’s education began immediately. She read books on midwifery, talked at length with Montana midwives about the history and details of the profession, and reviewed opposition materials:

“As I got educated I became a 100% proponent. But at first the concept of a homebirth was shocking to me, so in educating myself it actually helped me understand what the reception would be by people who were opposed . . . So I didn’t need convincing at all, but I needed education, and the education turned me into 100%.”

Jamison soon took up the cause of midwifery for personal as well as professional reasons:

“I always supported women’s reproductive rights, so even though growing up on Long Island, New York, I would not have been even exposed to the concept of a home birth, as I got educated by Dolly, then my view started to shift. I’m sure I started off thinking, ‘It’s a medical event.’ You never even contemplate not having a birth in a hospital. But as I began to learn and get educated about it, then it made all the sense in the world. So it fit into my fundamental political beliefs at the time, and as I got more and more educated, I probably became a bit of a zealot – I hate to even use that word, but I’m being honest about it. It’s like, I took no prisoners, period.”

Jamison’s discovery of and commitment to midwifery energized preparation for the legislative session. With a limited window of time to prepare, midwifery supporters focused on drafting the legislation they hoped to pass.

In consultation with Browder and with reference to arguments from the opposition, Jamison crafted the language exempting direct-entry midwives from the Medical Practice Act. The Legislative Council reviewed it, as was required of all proposed legislation, and the initial text stated:
“Parents have a right to give birth where and with whom they choose. This chapter does not prohibit or require a license with respect to...the practice of direct-entry midwifery. For the purpose of this section, the practice of direct-entry midwifery means the advising, attending, or assisting of a woman during pregnancy, labor, or the postpartum period.”

The brief bill, only a paragraph in length, attempted to effect a far-reaching conclusion by defining midwifery as a non-medical service and firmly placing practicing midwives outside the jurisdiction of the Montana Board of Medical Examiners.¹

As part of her ongoing self-education, Jamison encountered standard critiques of the profession. Midwifery opponents claimed it was a marginal and unsafe practice, that midwives disregarded the life and safety of mothers and infants, and that the profession lacked a strong and proven track record. Jamison concluded that the bill’s sponsor needed to convey a certain image, to have a reputation that countered preconceived notions about midwifery. She searched for a sponsor who “appear[ed] to be establishment, traditional Montanan.”³ A mainstream, well-respected, and widely known legislative advocate could enhance the overall reputation of the bill and give midwifery supporters credibility.

Jamison contemplated sponsors for the bill, knowing that her choice would be critical. While legislators commonly sponsored bills for a variety of constituents, they did so without a high level of personal commitment. Jamison anticipated opposition from the medical establishment and wanted a strong personal supporter of the bill, someone who would work diligently for its passage. She approached

¹ See Appendix K for a complete listing of HB 458 text and amendments.
Representative Ray Peck to sponsor the bill. Peck, a Democratic representative from Havre, had strong ties to education, worked as a school psychologist, and supported socially liberal and fiscally conservative causes. First elected to serve in the 1983 legislative session, he quickly developed a reputation for fairness - peers respected him and lobbyists feared him. Politics was his second career, and by the 1989 session he was 62 years old with an established track record. He intentionally cultivated the skills and reputation necessary to legislate effectively and did not lend his name to dubious causes or questionable ventures. On the heels of Jamison’s initial request, Peck researched midwifery and became convinced of its safety. He believed women should make choices about their own reproduction, and framed midwifery care as an individual choice that the legislature could and should support.

After agreeing to sponsor the bill, Peck committed to working within the Montana House and Senate to secure its passage. Jamison and Peck, both determined fighters, jointly provided the intensity and drive to maneuver the legislation through stiff opposition. Their shared enthusiasm and camaraderie added an element of fun – they enjoyed each other and shared a no-holds-barred work ethic. Confident in their considerable skills and optimistic that their efforts could achieve passage of the Midwifery Bill, they also recognized the strength of the opposition and the considerable risk of failure.
The Lobbying Process

Jamison, Peck, Browder, and midwifery supporters began the intensive process of hand-to-hand legislative work. Initial conversations introduced legislators to the practice of midwifery, informed them about its history, presented data demonstrating the safety record of midwifery-assisted home birth, and answered legislator questions. Browder and Jamison conducted one-on-one conversations with individual House and Senate members, a strategy they felt necessary to sufficiently inform legislators and combat opposition attacks. They provided the opportunity for legislators to discuss and contemplate birth practices and medical assumptions. The process of in-depth examination transformed sympathetic legislators from tacit bill supporters to passionate home-birth midwifery advocates.

Knowing that supportive legislators would have to withstand emotional opposition arguments, Jamison’s and Browder’s investment in relationships with legislators returned dividends over the course of the session. Browder became the face of the midwifery bill as she went legislator-to-legislator, talking about the services she provided to birthing women, and relating the events of her Missoula court case. The reasoned and logical presentation of her own background as well as her experiences as a midwife in Missoula provided legislators with an identifiable representative of the midwifery profession and personified the intentions of midwifery supporters. With each legislator, Browder repeated, “the whole story over again, whole story all over again. ‘Do you know that pregnancy is not an illness?
Don’t you know that women can give birth on their own? And don’t you know we don’t need episiotomies?” The personal contact proved wearying but productive, as Browder and Jamison built strong support among informed legislators. Legislative conversations early in the process provided a push at the personal level and motivated legislators to follow and support the efforts of the Montana Midwifery Association.

While the legislative team established contacts in Helena, the grassroots supporters of midwifery worked to generate constituent support. The Association produced a regular newsletter, *Montana Midwifery News*, that contained detailed information about the lobbying process, kept supporters up-to-date on legislative details, and provided specifics about donating money, contacting legislators, and attending hearings. The newsletter coached constituents through the letter-writing process, demonstrating how to address pertinent issues in the most direct and effective way possible, and listed legislator addresses, phone numbers, and suggestions about when and how to call. The Montana Midwifery Association organized a phone tree based on legislative districts throughout the state. The contact person for each area of the state, when notified, could quickly contact the constituents of particular senators, representatives, and committee members and ask them to send letters and make phone calls to their senator or representative. With a single phone call, Jamison could mobilize telephone contact and letters from constituents to specific legislators. Jamison would contact Browder and say, “OK, today’s the day. Everyone’s got to call five people on the committee.” Voter
response to targeted legislators produced a two-pronged force—legislators met and spoke with Browder and Jamison on a personal and recurring level, and the state-wide organization of homebirth supporters encouraged legislators from a constituent level, reminding senators and representatives that midwifery mattered to voters.

Browder and Jamison conferred about ways to frame the arguments and reemphasize the most important parts of their message. In a pre-email era, their communication relied on phone calls and in-person conversations. Browder and Jamison talked on the phone every night, crafting strategy as they conferred with legislators and adjusted their emphasis to focus on areas of concern. For Jamison, “It was one-on-one, always one-on-one. I remember I worked the life out of this bill . . . it was one-on-one educating.”

**The House of Representatives**

Representative Peck introduced HB 458 on January 26, 1989, and the bill was referred to the House Human Services and Aging Committee for hearing. As the hearing date approached, the Montana Midwifery Association contacted supporters to attend, while Browder and Jamison strategized about who would testify. Supporters traveled to Helena, and Browder remembered that driving the Montana roads "became an adventure as February began with record cold temperatures and winds. The wind chill temperature outside one legislative hearing was -70 degrees
F. We traveled with sleeping bags in our cars to avoid freezing in case of car trouble.”

At 3 p.m. on February 6, 1989, Stella Jean Hansen, committee chair and Missoula Democrat, called the House Committee on Human Services and Aging to order. Midwifery supporters, along with infants and children, filled the committee room, with the crowd numbering over 100. Representative Ray Peck introduced the bill and explained its intent, and then Jamison addressed the committee. She talked about the importance of the bill in protecting personal freedoms, she emphasized parental choice in choosing a birth attendant and location of birth, and she explained the Montana tradition of midwifery, referencing its continued practice for rural Montana residents. According to Jamison, midwifery provided solutions to existing problems in the provision of medical care and presented an opportunity for legislators to support freedom of choice for Montana parents.

Browder followed Jamison and explained her training as a midwife, the events of the Missoula court case, and her desire to continue serving the reproductive needs of Montana women. Health professionals, two attorneys, and home birthing parents all spoke to the significance of midwifery care, its safety, and the role of midwives in the provision of healthcare to Montanans. Committee members heard an organized explanation of the arguments for the legalization of midwifery and connected the faces of ordinary Montanans to the legitimacy of direct-entry midwifery.
At the conclusion of proponent testimony, bill opponents took their turn, and testified to a legion of concerns about maternal and infant health, increased mortality, and unsafe midwifery practices. Barb Booher, the lobbyist representing the Montana Nurses Association; Jerry Loendorf, the lobbyist for the Montana Medical Association; R. D. Marks, the physician who initiated the complaint against Browder in Missoula; Patricia Englund, the attorney for the Montana Board of Medical Examiners who prosecuted the case against Browder in Missoula; and three additional doctors spoke about the significant dangers of midwifery, expressing a deep concern for the well-being of Montana women and infants.

Bill opponents described childbirth as a delicate process in which potentially life-threatening problems occurred with regularity. Witnesses detailed the training necessary for obstetric certification and explained the public health benefits of rigorous medical education. Marks expressed his amazement that the proposed legislation would allow lay midwives to deliver babies without any state oversight, while requiring proof of “training, certification, and licensure examinations for surveyors, boiler operators, beauticians, guides and outfitters, and truck drivers.” He characterized obstetrical practice as “complicated, technical, and risky” and, in an impassioned statement, asked legislators to vote with fact and not emotion. Opponents of HB 458 grounded their arguments in...
the premise that the presence of a certified physician and availability of modern technology differentiated safe delivery from public health emergencies.

At the conclusion of testimony, committee members addressed questions to witnesses, asking for more detail about midwifery practices, the factors indicating a high-risk birth, and the availability of medical malpractice insurance for midwives. The committee adjourned without voting on the bill, and midwifery supporters left the hearing with a clear understanding of opposition arguments. Medicine claimed the territory of birth as its domain. Jamison needed to provide openings for legislators to question the authority of physicians without implying a wholesale dismissal of the contributions of modern medicine.

Rural Access

In discussions with representatives and senators during the initial part of the session, Jamison discovered that, while physicians found homebirth appalling, many legislators did not consider it at all shocking:

“A lot of the legislators had first-hand knowledge about home deliveries, regardless of what we call it . . . What surprised me was the number of legislators who were born by home birth, whose children were born by home birth, or whose mothers were midwives, even though they may not have been in name, and this basically was rural legislators.”

Rural legislators had personal experience with and exposure to the home-birth process and providers; they knew the local women who assisted with deliveries. Placed in a context of community, rural residents perceived homebirth as a necessary accommodation to the vast spaces and scarce resources of sparsely
populated areas. In the minds of rural residents, the ability of Montana women to manage birth outside of the hospital demonstrated resourcefulness and tenacity. Newly aware of the consistent practice of home birth in Montana history, Jamison chose to emphasize the protection of midwifery as a right of Montanans, a part of Montana identity since the territorial period, and worked behind the scenes to prepare a historical reference for inclusion in the bill text.

Statistical data verified the anecdotal evidence of continued homebirth practice. Starting in 1954, the Montana State Board of Health and the Vital Statistics Bureau collected information about birth location and attendant. The data demonstrated that most births occurred in a hospital setting, but homebirth midwifery care remained a quantifiable birth option, with a steady increase in the number of Montana homebirths during the natural birth movement of the mid- to late 1970s.

A review of legislators’ rural connections showed that 70 of the 150 legislative members represented clearly identifiable urban population centers such as Butte, Bozeman, Billings, Missoula, Kalispell, Great Falls, and Helena. Eighty legislators claimed more rural populations as their base. Nineteen of those voting against HB 458 represented urban areas, while 13 hailed from areas more closely associated with rural issues. Based on the 70/80 split between urban and rural voting bases, rural legislators should have accounted for 53% of the opposing votes, but, in fact, only 41% of the legislators voting against HB 458 represented a rural

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ii See Appendix E for a listing of out-of-hospital births in Montana for the years 1954 through 2009.
population, indicating stronger support for the bill among rural vs. urban legislators. A disproportionate share, 59%, of the legislators opposed to the bill hailed from urban Montana communities, validating the statements of 1989 legislative observers and participants that rural voters and legislators strongly supported HB 458.46

Anecdotal and legislator-based analysis indicated the importance of rural issues for the 51st legislative session, but the census data reflected a diminishing rural Montana population long before the 1990 census. The U.S. Census, conducted every ten years, recorded state population distributions that categorized Montana residents by urban and rural designations. With the “urban” criteria facing continual revisions, the Census Bureau consistently defined “rural” as any area within the boundaries of the United States that did not meet the urban population density requirements. Starting in 1910, incorporated communities with a population of at least 2,500 met the definitional requirement of “urban.” As suburban areas grew, the Bureau attempted to capture patterns of growing urbanization by adding the additional requirement of 50,000 residents for an unincorporated area to be classified as urban, effective in 1950.47 The highest percentage of rural residents in Montana, defined according to the Census Bureau standard, occurred during the homestead boom of the 1920s, when a wave of settlers inhabited the rural portions of the state. Still, Montana remained rural, at least by census definitions, until 1960,
and Montanans continued to value their rural identity, despite U.S. Census Bureau classification, long after that date.iii

On February 10, 1989, the Committee on Human Services and Aging took up action on HB 458, with Representative Thomas Lee making a motion to move the bill. Discussion followed and legislators chose to amend HB 458 by inserting:

“Whereas, the practice of direct-entry midwifery has been practiced in the state of Montana since territorial days; and whereas, it is the intent of the legislature to allow direct-entry midwives to continue serving Montana parents without fear of criminal prosecution.”48

Amendments, worked out by committee members in concert with Jamison, specified an immediate effective date, which was of particular importance to Browder who wanted to return to work as soon as possible. Additionally, committee changes to the bill addressed opponents’ concerns that, with exemption from the Medical Practice Act, midwives would operate without any oversight whatsoever. New language provided for a temporary exemption but required that midwives return during a future legislative session with a licensing package in hand. The Committee voted to pass the bill as amended, on a vote of 12 in favor and 3 opposed.

Ironically, the legal action by the Board of Medical Examiners against Browder provided the rationale for an immediate midwifery exemption. If midwives had not been facing probable legal prosecution, legislators could have directed midwives to compile a licensing schema and seek approval at some point in the future. Midwifery supporters pointed to the threat of further legal action against

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iii Appendix F lists data on Montana’s rural population from the U.S. Census records from 1900 to 1990.
practicing midwives as legitimate grounds for immediate legislative protection. Because an exemption from the Medical Practice Act did not define midwifery too closely, the 1989 battle drew broad support from the entire range of homebirth advocates and protected the widespread practice of midwifery before attempting to regulate and license individual midwives.

Committee amendments improved the bill by focusing attention on the issues necessary for successful passage – midwifery as part of Montana’s heritage, the ability of midwives to continue practicing without the threat of criminal prosecution, and eventual statewide licensing. The stitching together of solutions for both bill supporters and opponents exemplified the legislative process at its best, finding a compromise that resulted in clarification and moderation of more extreme positions.

But approval by the committee did not diminish opposition efforts. Instead, early momentum on the bill resulted in increased energy on the part of the mainstream medical establishment to derail the efforts of midwifery supporters. Just three days after amending and moving HB 458, the same House Committee on Human Services and Aging heard testimony on HB 579, a bill introduced in direct response to lay midwifery efforts. HB 579 altered the definition of medicine to include all matters related to the management of pregnancy, labor, and delivery, effectively rendering midwifery illegal and negating the progress of HB 458. Proponents of HB 579 included Valerie Knudsen, the expert witness from Browder’s
trial in Missoula, Patricia Englund, and lobbyists for the Montana Medical Association and the Montana Nurses' Association.

Bill proponents focused on the dangers of home birth and stated that women who wanted to work as midwives should go to nursing school and be certified as nurse-midwives. In response to statements about the dangers of home birth, Jamison highlighted the continuing deaths of both infants and mothers in Montana hospitals, and reminded the committee that state statistics showed midwifery-assisted homebirth to be just as safe as hospital birth. She explained that birthing at home provided a safe option, not a homebirth mandate. The potential approval of HB 579, in contrast, would force anyone wishing to deliver at home to birth without trained assistance, removing a legitimate choice from Montana voters. After emotional debate, the committee voted the bill down, and midwifery supporters refocused their attention on securing passage of HB 458.

Reaching the full House for debate on February 18, 1989, the bill generated emotional testimony. Representative Mary Ellen Connelly, a Democrat from Kalispell, opposed the bill and, during House debate, expressed her concern that “we’re going back to the dark ages and it really scares me.” But Representative Vivian Brooke, Missoula Democrat, responded that, “We think we’re all the great protectors. I really think you ought to relax about it. Childbirth isn’t an illness and we should not treat it as such.” Despite strongly opposing positions, the House of Representatives passed HB 458, with 75 representatives voting in favor and 23 opposing.49
Elated at their early success, midwifery supporters evaluated their position. With a majority of bills meeting their demise part way through the legislative process, Jamison and Peck knew that securing House passage represented only a necessary first step. Successful legislative approval required stamina and consistent effort to stay on message and build momentum.

**The Senate**

HB 458 was transmitted to the Senate and referred to the Public Health, Welfare & Safety Committee. Bill opponents and supporters prepared for the scheduled hearing on March 13, 1989 with renewed vigor. The rhetoric intensified, and representatives of the medical establishment resorted to, as Jamison called it, "bullying by the boys." Bill opponents even threatened Jamison personally:

"The opposition was vicious, and I hadn't been around that long to have established a reputation, so I'm sure things that had been said to me then would never have been said to me even three or four sessions later, trying to scare me, but they didn't know my personality, so threats were just an invitation to fight harder, and that's exactly – exactly – what I did."

Facing continued opposition from the Montana Medical Association, the Montana Nurses’ Association, the Montana Hospital Association, and individual hospitals and physicians, Jamison, Browder, Peck, and midwifery supporters persisted in their barrage of relentless lobbying. In preparation for the Senate hearing, Jamison and Browder met with individual senators, while midwifery supporters inundated senators with letters, phone calls, and personal appeals.
In the same way that Browder’s court case in Missoula provided the impetus for a full-out push for legislative change, the intense opposition to the Midwifery Bill energized the legislative battle. Jamison focused her energies on extensive preparation for the Senate hearing and midwifery supporters mobilized to show their support for the bill by encouraging as many supporters as possible to attend the Senate hearing.

On March 13, 1989, bill opponents and supporters filled the hearing room to capacity. Almost 90% of the attendees supported the bill, with opponents representing an authoritative yet minority presence. Peck began proponent committee testimony on HB 458 by describing changes to the bill since its introduction in January and emphasizing the amendments to the bill to address opposition concerns. The bill, as passed by the House of Representatives, directed lay midwives to propose licensing standards to the legislature while permitting their current practice until that time. Peck reiterated that the bill promoted parents’ rights to choose where and with whom to have a baby; the bill championed choice without sacrificing safety.

Anticipating a crowd of supporters and opponents wishing to testify, committee chairman Senator Tom Hager notified witnesses that testimony time would be limited to 45 minutes for each side. In response to opposition statements on the medical dangers of midwifery, bill supporters weighted their testimony with medical professionals, including four physicians, along with statements from attorneys, a public health nurse, and a certified nurse-midwife. Twenty-five
witnesses testified in support of HB 458, and eleven additional witnesses, due to the lack of time, presented written statements for the committee’s review. The list of degrees and credentials marshaled by supporters presented midwifery as a legitimate and accepted choice. Testimony in favor of the bill laid an implicit claim to midwifery as a centrist and reasonable birthing method that provided a multitude of additional benefits like reduced cost and accessibility for rural women.

Bill opponents took the floor with Jerry Loendorf, representing the Montana Medical Association, and Patricia Englund, attorney from the Board of Medical Examiners, expressing concerns about the absence of licensing requirements and the role of the state in protecting its citizens from dangerous activities. They reiterated opponent contentions that all babies should be delivered in the hospital with access to the latest technology. Jim Ahrens, president of the Montana Hospital Association, raised the issue of hospital liability. He explained that since hospitals controlled more assets than midwives, lawsuits resulting from midwife negligence would target hospitals. Ahrens described a hypothetical situation where a negligent midwife caused a delivery emergency, transferred the birthing mother to the hospital, and left the medical community exposed to lawsuit.

At the conclusion of opponent testimony, Senator Robert Pipinich, a Democrat from Missoula, explained that many of his constituents lacked access to an obstetrician and asked Loendorf what the solution was for an area like the one he represented. Loendorf responded that if midwives were the only ones who were available to assist in underserved areas, they should be licensed. Pipinich then
queried back and asked if midwives were required to meet certain standards would the Montana Medical Association support their licensing. Loendorf agreed that if they met “a certain criteria of training he could probably support it.”

Representative Peck, as sponsor, presented a closing statement. He revisited the data in favor of lay midwifery, referencing the position of the Montana Department of Health and Environmental Sciences that midwifery posed no additional risk of infant mortality or low birth weight. He said that legal protection of midwifery would help to alleviate the scarcity of obstetrical services throughout the state and reminded legislators that the dangers of midwifery remained fictional, without any basis in fact. His remarks closed the lengthy testimony on HB 458 and the committee adjourned.

When the Senate Committee on Public Health, Welfare and Safety took up action on HB 458 on March 17, 1989, Senator Pipinich showed a folder containing 370 letters that he had received in support of the bill, and Senator Tom Hager said he received 140 phone calls in the last two days urging his support of HB 458. The grassroots midwifery lobbying effort had delivered. Committee members discussed the bill, and Senators offered and approved three separate amendments. The first amendment required each midwife to file an affidavit showing that she met the interim requirement to practice – completion of emergency childbirth training from a state-approved program – until a future legislative session approved licensing requirements.
The fact that midwives did not and could not obtain liability insurance rankled doctors who allocated potential profits to insurance expenditures. As Marks explained, “If I make a mistake, somebody can come after me for all this and then they can go to the midwife and she has no obligation, she can’t be sued, she has nothing. As soon as I am handed this, I have all the liability.” A second amendment addressed concerns of institutional medical providers who anticipated caring for laboring women transferred from midwifery care, protecting doctors from liability in the event that a lawsuit was filed. Removing the risk of physician and hospital liability addressed physician concerns about liability and represented a compromise position. Midwives could practice without doctors and hospitals bearing additional liability costs.

During the March 17 committee debate, Senators also amended HB 458 to restrict midwives from using any drugs. Jamison concurred with all of the amendments, feeling that they alleviated some concerns of the opposition while still allowing for passage of the bill. The committee voted in favor of the bill as amended and the bill emerged from committee intact and with support going into full Senate debate.

Midwifery advocates counted potential supporters and worked to cement a favorable vote from every undecided senator. During floor debate, Senator Pipinich again displayed his stack of letters in support of the bill, stating that his rural constituents “overwhelmingly” supported HB 458. Arguments covered the dangers of home birth, as well as the risk of home birth parents attempting to
deliver without any assistance at all, if the bill failed to gain approval. Senator Paul Rapp-Svrcek, Democrat from Thompson Falls, reminded Senators that their vote was “not about the choices between home birth and hospital birth. The question is, do we want these people to have their babies at home with the knowledgeable assistance of a lay midwife, or without it?”

At the conclusion of floor debate, Representative Peck, as bill sponsor, made the official closing statement in the Senate chambers. Peck spoke about the legislature’s role in removing obstacles to individual reproductive decisions, and heralded HB 458 as evidence of successful legislative process. His statement brought the intense efforts of bill opponents and supporters to a close, and at the conclusion of his remarks, the Senate voted on the bill. In the final tally, HB 458 passed the Senate on March 27, 1989, with 41 Senators voting in favor and 9 opposed.

With its Senate form slightly different from the approved House version, the bill was sent to back to the House, where the Representatives voted in favor of it as amended before transmitting it to the Governor for his signature. Governor Stan Stephens signed HB 458 on April 11, 1989, with the midwifery exemption effective immediately.

During a whirlwind session, the cause of midwifery in Montana transitioned from a marginal practice questioned by the court to a fully legitimized profession sanctioned by the state. Over the course of 76 days, from January 26 to April 11, Montana midwives obtained an exemption from the Medical Practice Act, drew overwhelming popular and legislative support for their efforts, and preserved a
practice they deeply believed in. By 1990, only ten other states – Washington, Alaska, Arizona, New Mexico, Texas, Arkansas, Louisiana, South Carolina, New Hampshire, and Rhode Island – legally sanctioned the practice of direct-entry midwifery. Montana joined a select few states where lay midwives practiced protected from legal prosecution.

2 Dolly Browder, interview with Darla Torres, March 4, 2002, Missoula, Montana, OH 378-1, Montana Feminist History Project, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.

3 Family connections existed between several individuals involved in the midwifery debates in the Montana legislature. Sarah Cobb, whose delivery generated Marks’s complaint to the Board of Medical Examiners, was related to John Cobb, Republican Representative from Augusta, and R. D. Marks was related to Robert Marks, Republican from Clancy. Dolly Browder, interview with Darla Torres, March 4, 2002, Missoula, Montana, OH 378-1, Montana Feminist History Project, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana; R. D. Marks, interview with Jennifer Hill, October 13, 2012, Ennis, Montana, personal collection of the author; Sarah Cobb, phone interview with Jennifer Hill, January 23, 2013, personal collection of the author.


5 Dolly Browder, interview with Darla Torres, March 4, 2002, Missoula, Montana, OH 378-1, Montana Feminist History Project, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.

6 Ibid.


8 Ibid.


The Montana legislature operated on a 90-day alternate-year odd-numbered cycle. The previous session ran from January through April of 1987, and the 51st session of the Montana Legislature was scheduled to commence in January of 1989. Interim legislative committees met in the hiatus between sessions, and over the course of Montana history, the governor called special sessions to address particular topics like tax reform or educational policy. Because of the short session duration, meager salary, and alternate year cycle, state legislators had careers and employment supplemental to their involvement in state government.

11 Board of Medical Examiners for the State of Montana, Plaintiff, vs. Dolly Browder, Defendant, Opinion and Order, Cause No. 70005, Montana Fourth Judicial District, Missoula County, January 19, 1989.


13 Dolly Browder, interview with Darla Torres, March 4, 2002, Missoula, Montana, OH 378-1, Montana Feminist History Project, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.


15 Ibid.


17 “Midwife’s Fate Rests in Henson’s Hands,” Missoulian, January 6, 1989.

18 Dolly Browder, interview with Darla Torres, March 4, 2002, Missoula, Montana, OH 378-1, Montana Feminist History Project, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.
Ibid.

Board of Medical Examiners for the State of Montana, Plaintiff, vs. Dolly Browder, Defendant, Opinion and Order, Cause No. 70005. Montana Fourth Judicial District, Missoula County, January 19, 1989.


Dolly Browder, interview with Darla Torres, March 4, 2002, Missoula, Montana, OH 378-1, Montana Feminist History Project, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.


“Impact of the Obstetrical Liability Crisis in Montana,” Exhibit 458-1, Bill Testimony HB 458, Collection No. LR51, Box 7, Folder 7, Montana Historical Society Archives, Helena, Montana.


Ibid.


Raymond L. Peck Obituary, Great Falls Tribune, June 1, 2011.

34 Dolly Browder, interview with Darla Torres, March 4, 2002, Missoula, Montana, OH 378-1, Montana Feminist History Project, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.


37 Ibid.


39 Ibid.

40 One hundred and nineteen hearing attendees signed the visitor register, with 104 stating their support for HB 458 and twelve opposed. Visitor Register, Committee on Human Services and Aging, Montana House of Representatives, 51st Legislature, Collection No. LR51, Box 7, Folder 7, Montana Historical Society Research Center, Helena, Montana.

41 Minutes, Committee on Human Services and Aging, February 6, 1989, Montana House of Representatives, 51st Legislature, Collection No. LR51, Box 7, Folder 7, Montana Historical Society Research Center, Helena, Montana.

42 Testimony, Committee on Human Services and Aging, February 6, 1989, Exhibit 4, Montana House of Representatives, 51st Legislature, Collection No. LR51, Box 7, Folder 7, Montana Historical Society Research Center, Helena, Montana.


Information used to calculate rural vs. urban legislator representation was drawn from the Copper Book, “Lawmakers of Montana, Legislative Session of 1989,” 328.33M76L, Montana Historical Society Research Center, Helena, Montana.

Mike Halligan, Senate sponsor of HB 458 during the 1989 session, explained that the bill passed because so many rural people depended on the services of midwives, and rural legislators saw the Midwifery Bill as a necessary measure to provide healthcare to rural areas. Legislators from urban areas tended to be less supportive because they maintained more extensive ties to the medical community. Montana legislative districts are reapportioned after each federal census. During the 1989 session, agricultural interests dominated the legislature, but upon reapportionment in 1990, rural legislators decreased by 1/3. According to Halligan, if the Midwifery Bill had been introduced just five years later, it would not have passed because the urban/rural balance of the legislature changed so dramatically. Mike Halligan, phone interview with Jennifer Hill, December 10, 2012, personal collection of the author.


HB 458, Second Reading, February 15, 1989, 51st Legislature, Collection No. LR51, Box 12, Folders 12-21, Montana Historical Society Archives, Helena, Montana. For a detailed calendar of HB 458 activity, as well as bill text and amendments, see Appendices J and K.


53 The statistical records of the state of Montana provide context to assess the actual dangers associated with birth. In 1988, a total of 3,233 women died in Montana; only one of those deaths was during childbirth. By comparison, in 1988 one woman died of venomous plant poisoning, one from accidental mechanical suffocation, and one from excessive heat. In 1989, not a single woman died in childbirth. Montana Health and Environmental Sciences, Montana Vital Statistics, 1988 and 1989, Vital Statistics Bureau, Helena, Montana.


55 Ibid.


57 During legislative testimony, Jamison stated that there was no known case of a client suing a midwife for malpractice in Montana. The low-to-nonexistent rate of midwifery liability suits across the nation were anecdotally linked to a variety of causes, from the relationship of trust between the midwife and client to the standard midwifery practice of recognizing and discussing birth complications and the possibility of fatalities. Minutes, Committee on Public Health, Welfare and Safety March 17, 1989, Montana Senate, 51st Legislature, Collection No. LR51, Box 19, Folder 12, Montana Historical Society Archives, Helena, Montana.


Ibid.

LICENSING IN THE LEGISLATURE

Commitments made to the 1989 legislature required the Montana Midwifery Association to draft and present a licensing bill during the 1991 session. With the prospect of returning to the legislature, midwives prepared to reenter a fundamentally altered debate. In 1989, midwives dialogued with legislators about whether midwifery should be legal in Montana; in 1991 the discussion centered instead on the most effective means to license newly-legal lay midwives. Midwives’ interactions with legislators changed, and the relationship between and among midwifery supporters changed also. The push for legalization during the 1989 session brought midwives, midwifery supporters, and homebirth families from across the state together, uniting them against the interventions of institutionalized medicine. With the passage of the midwifery exemption, midwives began the process of constructing their own licensing structure – a difficult task with the potential to open conflicts between midwives about control, educational credentials, and bureaucratic oversight. The legislative process of 1989 transformed Montana midwifery from a marginalized and unregulated avocation to a legal profession, along with attendant regulations, legalities, and paperwork. Direct-entry midwifery in Montana achieved mainstream status – an uncomfortable place for many midwives who valued their outsider identity.

The psychological shift in perspective required adjustment, the nature of the issues changed, and the amount of work required for successful passage increased. The Montana Midwifery Association took the initiative in suggesting licensing
standards, in part to protect against ongoing attempts by organized medicine to control the licensing process. In other states, medical direction of midwifery licensing created harsh standards that rendered the process impossible to navigate.\textsuperscript{1} To avoid a similar situation in Montana, midwives took on the task of researching, outlining, and communicating the necessary standards to ensure competency among midwifery licensees and to maintain control of midwifery licensing.

After investigating licensing statutes across the country, Missoula midwives and lobbyist Mona Jamison wrote the initial draft of the licensing language. The Montana Midwifery Association formed a steering committee, filled volunteer positions, and began the process of fundraising anew.\textsuperscript{2} Midwives throughout the state supported the licensing process, but Missoula midwives carried the onus of the licensing workload. They contacted freshman legislators, provided background on the issue, and organized fundraisers to generate community support and increase awareness of ongoing efforts.\textsuperscript{3}

Montana state law stipulated that certain procedural requirements be met for any group requesting licensure. The Montana Midwifery Association first sought approval by the Legislative Audit Committee, traveling to Helena on October 1, 1990, to testify. The committee recommended that lay midwives proceed with licensing protocols with the stipulation that the Montana Midwifery Association meet with the Montana Medical Association and other midwifery opponents to reach compromise language on the proposed licensing bill prior to the 1991 session,
and introduce legislation that represented general consensus among all stakeholders.  

Navigating the legislative licensing process involved monitoring deadlines, meeting statutory filing requirements, communicating with state employees in Helena, and generating support from legislators throughout Montana. Licensing required fortitude and finances – determination to remain patient through a maze of details, and fundraising capabilities to pay for the necessary specialized personnel to ensure approval. With her years of experience working in state government, Jamison knew the process, and navigated the requirements so efficiently that the direct-entry midwifery licensing bill was first in line to meet pre-session requirements for introduction in the 1991 legislative session. With their filing and bureaucratic requirements completed, midwives readied themselves for the battle over bill details.

The Montana Medical Association, while continuing to oppose midwifery, recognized the wisdom of providing input on proposed licensing language. Van Kirke Nelson, a physician from Kalispell, past-president of the Montana Medical Association, and chair of the OB/GYN committee in Montana, represented the medical profession in negotiating the language. Browder, Jamison, and Nelson planned to meet to work out licensing details.

The proposed licensing structure included a midwifery board made up of three midwives, one physician, and a member from the general public; an educational exemption for currently practicing midwives; a competency test for
certification; and a path to licensure for apprentice midwives.\(^6\) Jamison, Browder, and Nelson met to fill in the details of permitted midwifery procedures. For Browder, negotiations proved difficult.

“He [Nelson] would never acknowledge that I was in the room. He would only talk to Mona Jamison, our lobbyist. [When] I stayed out of the room, it went much better. Mona was able to talk with him. I just sat out in the hall, had my request. If there was a question, she’d come out and talk to me. It was absurd. But that’s how we wrote the legislation.”\(^7\)

The level of agreement necessary for the drafting of regulations meant that Nelson, Jamison, and Browder reviewed all of the procedures a midwife might perform – like delivering twins or a breech presentation – and determined which should be permissible and which disallowed. They established the number of births adequate to accumulate the base standard of experience and agreed on the educational requirements sufficient to ensure a standard of care acceptable to all parties.

Medical professionals sought to increase the educational requirements necessary for licensure, while midwives opposed excessive regulation and additional barriers to licensing. Both sides struggled to find common ground, but eventually Jamison, Nelson, and Browder worked out a licensing process and Nelson grudgingly agreed to support a licensing bill that contained the negotiated standards, procedures, and stages of licensure.\(^8\)

At the commencement of the 1991 session, the Montana Midwifery Association prepared for the first hearing on the bill. Jamison opened the testimony: “The question before you today is midwifery with regulation, or midwifery without
Based on their success during the 1989 session, midwives in the 1991 session worked from a strong bargaining position. Potential legislative failure did not threaten the legality of midwifery. In the event that licensing legislation failed to pass, midwives could continue working under the temporary licensing system established as an interim measure during the 1989 session, practicing with few restrictions and limited educational and experience requirements.

Senator Paul Rapp-Svrcek, Democrat from Thompson Falls, sponsored the midwifery-licensing bill, and spoke in its favor during Senate hearing testimony. Despite cooperative efforts between the Montana Medical Association and the Montana Midwifery Association in drafting the bill, physicians and hospitals continued to oppose legal and licensed midwifery practice. Nelson testified during hearing testimony that he “[did] not believe in home birth or in midwifery,” and suggested that the licensing bill be amended to restrict midwives from assisting in deliveries more than 50 miles from a hospital. Rapp-Svrcek responded that such an amendment “would defeat my whole purpose in offering this bill” as many of his constituents lived more than 50 miles from a hospital and lacked access to a physician.

With their accumulated experience from the 1989 legislative session and their ongoing relationships with supportive legislators, homebirth advocates effectively quelled the unfriendly amendments. As the midwifery-licensing bill continued its legislative journey, naturopathic physicians in Montana simultaneously sought licensing with a process similar to the proposed midwifery
board structure. Midwifery and naturopathic supporters decided to combine both licensing schemes within the proposed Alternative Health Care Board, which would operate under the auspices of the Department of Labor and Industry. Midwives and naturopathic physicians suggested that the Board be supported by licensing fees to promulgate changes in professional rules and institute disciplinary actions on licensees in violation of state statute.

The midwifery-licensing bill gained momentum with the addition of naturopathic physicians and their supporters, and bill proponents jointly lobbied legislators as the bill progressed through the legislative calendar. Midwifery supporters focused on continuing previously successful lobbying tactics. Browder traveled to Helena “in the middle of February, trying to get over there in storms and caravans of cars, because we had to try and pack the courtrooms and the places over there in Helena when they were having meetings.”11 Their lobbying paid off, and the Senate and House passed the midwifery licensing law. Governor Stan Stephens signed the bill, and midwifery supporters concluded final legislative details by May 5, 1991.

Midwives able to demonstrate provision of care for 75 births – from prenatal through the birth and follow-up – gained eligibility to take the National Midwifery Exam offered through the Midwives Alliance of North America. Seven Montana midwives – Leslie Fellers, Ollie Hamilton, Victoria Cain, Patricia Schwaiger, Dolly Browder, Michele Neal, and Pat Murphy – documented sufficient practical experience, and in the fall of 1991 they gathered in Helena to sit for the exam. All
seven women passed and Montana officially grandmothered them in as the first fully licensed midwives in the state.

The first seven licensed Montana midwives trained midwife apprentices and guided them through the approval process, calling them for middle-of-the-night calls and sharing the unpredictability of scheduling, as well as the willingness to revise planned activities whenever a client initiated labor. New apprentice midwives faced a challenging licensing regime. The standards called for a rigorous education, including coursework in anatomy and physiology, and passage of the national midwifery exam. Apprentice midwives proceeded through a three-part mentoring process – at Level I the apprentice midwife observed 40 births and prenatals under the supervision of her preceptor midwife; Level II required that she be the primary assistant to the supervising midwife for 10 births and prenatals; and as a Level III apprentice she performed primary midwifery care for 15 births and prenatals with the supervision of the senior midwife. Over the course of her training, the apprentice midwife observed or participated in at least 65 deliveries – representing approximately 4,000 to 5,000 hours of birth-related learning – a time commitment that necessitated a training period of five to ten years.\(^\text{12}\)

As a result of the approved licensing process, practicing midwives submitted nominations for the Board of Alternative Health Care. Governor Stephens appointed Dolly Browder to serve on the Board, concluding her journey from court defendant to government bureaucrat.\(^\text{13}\) Over the course of 28 months, Montana midwives
accomplished the institutionalization of midwifery and established a licensing structure still in effect.

The Secrets of Success

A unique linkage of individual strengths, timing, and strategy enabled Montana midwives to deliver swift legislative results. The personalities of the main legislative players – Browder, Jamison, and Peck – rounded out a multifaceted effort strong enough to withstand the attacks of entrenched medical institutions. Representative Ray Peck headlined the bill with his solid, mainstream image. A legislative realist, Peck shifted the bill’s odds in favor of passage by providing much needed credibility and efficient lobbying efforts. Peck habitually performed copious research and fact checking before lending his name to a bill, and his sponsorship meant that other legislators could vote in support of the bill on the strength of Peck’s reputation. His support gave midwifery a scent of centrist normalcy.

Dolly Browder politely overwhelmed midwifery opponents with her grasp of the facts, her knowledge of biology, and her passion for protecting the process of birth. A crusader of the kindest sort, Browder bulldozed antagonists with her consistent push to change minds. As the face of Montana midwifery, she assumed the responsibility for representing midwives to legislators and portraying midwifery in its best light. Browder repeatedly explained her personal motivations, her practice, and the legal actions against her, and conveyed a professional, intelligent, composed, and compassionate image.
Mona Jamison brought all the fervor and ferocity of an impassioned advocate to the fight for HB 458. She loved the challenge of beating the odds and bettering opponents who appeared to have all the advantages. Jamison created solutions, and she recalled the 1989 battle as particularly satisfying:

"I have been lobbying for a lot of years, I've lobbied so many bills, bills that I've gotten passed that if you showed me I probably wouldn't even remember – it's a lot of sessions, and a lot of bills, and a lot of clients. That one [HB 458] is at the forefront with a couple of others. So I was against the establishment. I was very comfortable being against the establishment – no problem whatsoever – actually I kind of enjoyed it."

Jamison strategized on the fly, adjusting her message to her audience, honing the story of midwifery throughout the session. She combined her ability to sense the best frame for midwifery and the most effective ways to approach legislators with a willingness to work tirelessly in reaching out to each individual representative and senator.

Browder, Jamison, and Peck depended on grassroots midwifery supporters who relentlessly contacted legislators, attended hearings, testified, and agitated for midwifery in their communities. Refusing to feel intimidated by the trappings of legislative bureaucracy, they advocated the bill to their representatives and senators in person, in hearings, by phone, and through the mail. They travelled long distances, sat through lengthy hearings, and braved winter weather. They maintained effort and enthusiasm through two legislative sessions and provided pressure to propel legislators to vote in favor of the bill.
The advocates of HB 458 shared an intense work ethic, dedicating innumerable hours and intense energy to delivering results, regardless of investment in time, travel, and personal sacrifice. But midwifery advocates did not face the legislative battle as martyrs or long suffering idealists. They had fun. Peck and Jamison worked well together and savored the victories of the legislative battle. 

Supporters car-pooled to Helena, spent time in committee meetings together, talked with legislators, and shared their commitment to home birth. They enjoyed each other, and their sense of camaraderie created a community around the cause of midwifery. They invested their time and resources but gained lasting satisfaction. It was a grueling fight, but not a dire one.

**Gender**

Midwifery supporters knew the history of the conflict between medicine and midwifery; they were cognizant of the rhetoric surrounding the birth battle. A sense of history informed their choices in framing the debate and presenting HB 458 – the bill and its specifics mattered, but supporters recognized the need to address legislators’ assumptions about midwives, about birth, and about women’s bodies.

As a female profession, midwifery received the same epithets commonly used against women. Historically, physicians portrayed midwives as dirty, unreliable, and illogical, purveyors of superstition and ignorant of modern science. Proponents of HB 458 took that image head-on, emphasizing the scientifically grounded and statistically safe practice of modern midwifery. Midwives
demonstrated their knowledge of the biological birth process as well as their grasp of medical terminology and human anatomy, and detailed the educational processes they pursued to obtain the knowledge and skills necessary for competent and informed practice. Proponent legislative testimony by and about midwives relayed specific strengths of midwifery practice in an organized and logical manner.

Intentionally avoiding a conflict that pitted male doctors against pregnant women, midwifery supporters portrayed birth as a matter of parent choice. The inclusion of the father into the choice equation diverted an exclusive emphasis on women and women’s bodies. Redirecting the focus of legislative discussion to parents’ rights diminished the power of gender stereotypes and allowed the debate to be about choice and freedom for fathers and mothers, for men and women. Bill organizers and strategists asked men to testify at hearings and ensured that legislators saw and heard men articulating the importance of midwifery. Midwifery advocates included men along with women to emphasize the importance of midwifery to parents, not just mothers, and to encourage legislators to support the bill as an endorsement of parental choice.

Yet, at heart, this was about women. Advocates of HB 458 targeted their assault on the Capitol in a gender appropriate form. They arranged for hundreds of women and babies to be physically present in the hearings, at the Capitol, in view of legislators. At each hearing, they “filled the hearing rooms, even with people who didn’t testify. We filled the room with mothers and with babies.”17 Populating hearing rooms and hallways was a highly aggressive act, cloaked in maternal
prerogative. Midwifery supporters donned a non-threatening maternal aura as they cared for their children and breastfed their babies in the Capitol rotunda.

The presence of women and children bolstered midwifery claims that they assisted in a uniquely female experience. For legislators, talking about women and children in the abstract felt very different from bumping into them in corridors, stepping around them in hearings, or being buttonholed by them on the stairway. Midwives claimed the authority to manage a maternal issue, and the physical presence of lactating, pregnant, and mothering women underscored the overwhelmingly feminine nature of reproduction.

Homebirth mothers and babies also exhibited a dramatic rebuttal to opponents’ predictions of death and destruction at the hands of midwives. While bill opponents described the dangers of home birth, legislators looked out onto a hearing room packed with mothers and babies, birthed at home and happily supportive of midwifery care. Hundreds of healthy bodies dispelled the images of doom and gloom, testifying by their presence to the effectiveness of midwifery care.

The gender strategies of midwifery supporters did not cave to misogynistic assumptions about women but instead used them, recognizing and employing cultural constructs about the female body to advance the bill’s passage and the public’s understanding of reproduction and midwifery.

Despite a groundswell of female support for HB 458, female legislators expressed divergent opinions on the bill. During the 1989 session, women held five Democratic Senate seats, one Republican Senate seat, sixteen Democratic
Representative seats, and four Republican Representative seats, resulting in a total female elected representation of 17%. Thirteen Republicans and 18 Democrats voted against HB 458, a relatively even split in the opposition. Ten women opposed the bill, representing 31% of the opposition, much higher than the overall rate, 17%, of women in the legislature. Individuals familiar with the 51st legislature did not note a particular bias among female legislators against midwifery – the higher number of women voting against the bill may have resulted from the urban background of female Senators and Representatives – but it did highlight the lack of unanimity among women on the practice of midwifery.

Montana Identity

During the 51st Montana Legislative Session, doctors and hospital representatives talked about the dire consequences for women birthing at home without access to the latest medical technologies. Midwifery advocates returned again and again to statistics, to Health Department reports, and to personal experience to support their claim that safe and successful birth did not require technological intervention. But technological birth represented an element of American identity, and logic and statistics fell short in combatting it. Convincing legislators to endorse an un-American way of birthing became possible only when Jamison began emphasizing the long history of midwifery in Montana. Playing on the potency of the phrasing, she eventually included in the bill text the statement that midwifery “has been practiced in the state of Montana since territorial days.”18
At every opportunity, Jamison returned to the idea of midwifery as a Montana tradition, a practice with a distinctive Montana history. In Jamison’s hands, midwifery became an integral part of the Montana identity. Home birth represented a proud tradition of adaptation to weather extremes and scarce medical care, with its practitioners displaying resourcefulness, resiliency, and courage. Her argument hit home for representatives and senators, particularly those from rural areas. America endorsed hospital birth, but in Montana, midwifery symbolized a proud rural tradition. Jamison provided the rationale for legislators to choose midwifery without abandoning their pride in American technology by persuading senators and representatives to vote in favor of the Midwifery Bill as an endorsement of Montana identity.

Midwifery supporters acknowledged the obstacles to success – verbalized opposition from institutionalized medicine, and unspoken barriers that existed in legislators’ minds, created by rhetoric about women and birth. HB 458 passed because supporters fought for it on every level – psychologically, procedurally, and politically. As Jamison recalled, the legislative success,

“... showed the vigor and the commitment to the fight, and the effectiveness, both from a lobbying standpoint and from a political standpoint, on how effective we were. That vote showed exactly what we did go through and how well we did it, and how organized we were at every single level.”

The Montana Midwifery Association, homebirth supporters, Browder, Jamison, and Peck all played their parts to effect change in a rapid and robust manner. Energized,
excited, and exhausted, midwives took on the establishment and found validation for a professional practice and way of life they found meaningful.\textsuperscript{20}

Supporters celebrated bill passage as a protection for the practice of midwifery. It also represented a victory for feminism and a triumph for women’s control of their own bodies and the birth process. The tradition of patriarchal trespass in childbirth rendered the success of HB 458 particularly potent. Activist birthers connected the bill to larger issues, to controversy about women’s control over reproduction, to medicine’s disparaging treatment of the female body and the process of birth, to women stepping out and changing the law, changing the government, and reshaping their choices.\textsuperscript{21}

HB 458 did not end discrimination or sexual harassment; it did not terminate violence against women or alter sexist attitudes. It did validate the individual efforts of women who knew they could change the law. Midwifery advocates engaged historical tropes about women and birth and proactively altered Montana statute. As veterans of the birth battle, they used their weapons to protect the practice of midwifery and reproductive choice for future generations of Montana women.


5 Dolly Browder, interview with Darla Torres, March 4, 2002, Missoula, Montana, OH 378-1, Montana Feminist History Project, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.


7 Dolly Browder, interview with Darla Torres, March 4, 2002, Missoula, Montana, OH 378-1, Montana Feminist History Project, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.


11 Dolly Browder, interview with Darla Torres, March 4, 2002, Missoula, Montana, OH 378-1, Montana Feminist History Project, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.

12 Midwifery prenatal exams ran from one to two hours each, occurring monthly over the course of the pregnancy. For a typical pregnancy, the midwife met with the client approximately ten times before delivery and several times after the birth. The birth itself required up to 48 hours of care, resulting in an average hourly commitment per client of 68 hours. Licensing requirements for direct-entry
midwives are listed by the Montana Board of Alternative Healthcare at www.althealth.mt.gov.

13 Dolly Browder, interview with Darla Torres, March 4, 2002, Missoula, Montana, OH 378-1, Montana Feminist History Project, Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula, Montana.


21 As Jamison said, “It was fighting a specific home birth issue, which was really a reflection of the greater societal view on who’s in charge, and who’s in charge of women’s bodies. So this was . . . a breakthrough on a greater issue, than just the issue of home birth.” Mona Jamison, interview with Jennifer Hill, October 29, 2012, Helena, Montana, personal collection of the author.
CONCLUSION

American birth practices, born of allopathic professional aspirations and misogynistic mores, visited incalculable harm on women and infants from the Colonial era to the present day. Despite mounting evidence demonstrating the ineffectiveness and outright danger posed by mainstream medical delivery procedures, obstetric care in the United States remains entrenched in practices the international community and World Health Organization have long labeled as misdirected.

Substandard obstetric outcomes represent an unfortunate American tradition, one that arose from a synchronicity of circumstances. Contemporary medicalized American obstetric practices represent the results of unchecked and unchallenged patriarchal policy, which disregards the needs of American women and children while heralding the benefits of the American medical system.

The process of birth shifted dramatically over the course of American history, beginning as a women-only home-based event and transitioning to the medically managed hospital procedure of contemporary obstetric practice. In Colonial America, physicians perceived the birth process as unworthy of male attention and outside the scope of medical practice, as common, base, and brutish. Midwives and mothers managed childbirth, and while this allowed for female control over parturition, it also curtailed the communication of birthing knowledge and denied pregnant women access to improved obstetric care. Individual midwives gained skills and amassed practical knowledge over the course of their lifetimes, but in the
absence of midwifery organizations or formal training institutions, they often failed to pass on their wisdom to the next generation. Custom relegated Colonial-era birth to the supervision of women, not out of respect for the practice of midwifery and the marvels of female reproductive function, but from a general disregard for women and a particular dismissal of the details of pregnancy and delivery. Lacking access to formalized training, midwives did not document their practices, and performed a devalued yet necessary function.

Female reproduction might have remained outside the realm of institutionalized medicine if the professional aspirations of medical doctors had not encouraged expansion into new territory. Starting in the mid-19th century, physicians faced a competitive healthcare market, with varied health-related practitioners vying for patients. Medical doctors worked to systematize and regulate medical training and licensing in an effort to improve the consistency of medical care and differentiate their profession as an upwardly mobile and value-laden social good. The obstetric specialty, fully organized by the 1880s, followed suit, and devoted concentrated energy and effort to cultivating an improved image and practice.¹ With reorganization completed in the early 1900s, physicians recognized parturient women as a stable and profitable pool of patients. Reframing the condition of pregnancy as an opportunity for male control and assistance, the profession of medicine expounded the new rhetoric of reproduction by carving out ideological space for itself in the delivery process, claiming a salvific role in supervising and intervening in unpredictable and faulty female biology. Obstetric
specialists inserted themselves into the birth equation as purveyors of science and technology, agents of reason in an otherwise flawed and erratic process.

Pregnant women proved stubborn and unwilling to whole-heartedly abandon traditional female birth attendants. Physicians touted their ability to utilize tools, such as forceps, and technologies, such as the anesthetic innovations of ether and chloroform, that were unavailable to midwives. Still, physicians did not achieve widespread success in shifting traditional birth practices until they began targeting the economic and social standing of midwives. Physicians branded midwives as ignorant and un-American, whose practices were far removed from “modern” medical methods. Claiming a role as the arbiters of American birth, physicians argued for medicalization of the entire birthing process. These jeremiads proved so successful that by 1930, 85% of women in America birthed under the supervision of a physician.²

Racist, sexist, and classist tropes convinced many women to utilize male physicians, but the medical profession still faced a significant hurdle – persuading women, who had always birthed at home, that they should travel to the doctor and deliver their babies in the hospital. Early in their existence, hospitals garnered the reputation as low-class birthing institutions by offering medical services to poor women who could not afford to hire a doctor to assist them at home. Hospitals used economically disadvantaged women as training tools to be examined in front of medical students and as the subjects of medical experimentation. Wealthier women, able to purchase the individual services of attending physicians, delivered in their
own homes with privacy intact. But one physician could oversee the delivery of multiple laboring women simultaneously in the hospital setting, returning a greater profit both for himself and the institution. To rehabilitate their image, hospitals created luxury birthing accommodations to lure women of means to birth in the hospital and change the class assumptions about hospital birth. The shift to hospital birth lagged behind the preference for physician-assisted birth, but by the 1950s, especially in urban areas, social norms assumed a physician-assisted hospital birth.\(^3\)

The American birthing revolution, a dramatic change in both birth attendant and location, occurred during the first fifty years of the 20\(^{th}\) century. Based on patriarchal hubris, the “new” birthing traditions claimed perpetuity of existence, and relegated female-attended birthing practices to the dark ages, erasing the relatively recent history of birth at home with the assistance of women. The alteration of birthing practices included a revision of history to remove the memory of successful delivery rates of midwives and place them in the era of witches, magic, and the Black Death.

Mothers delivering in the hospital assumed they were the recipients of tried and tested maternity protocol. They were frequently strapped to the delivery table and left alone in a sterile and unwelcoming environment and unsurprisingly, experienced overwhelming pain during delivery. They asked their doctors for relief, and the practice of widespread anesthetized delivery was born. The era of Twilight Sleep, which began in the early 1900s and extended through the 1970s, medicated women so completely that they lost all memory of the birth process, coming to their
senses hours after the birth with no recollection of the delivery or their baby. Effectively removing women from the process of birth, Twilight Sleep cemented medical control over parturition, proving that medical innovations and pharmaceutical concoctions could accomplish the delivery of a baby. Institutionalized medicine had accomplished complete medical control of all aspects of birth.

In the 1950s, 1960s, and 1970s, the Civil Rights movement, second-wave feminism, and the sexual revolution challenged traditional authority structures, and the heavy-handed medical model came under fire. Its domineering and inflexible structure conflicted with choice and personal adaptation, and a new perspective, drawn from political activism, hippie culture, and feminism found its way into the consciousness of birthing women. Unhappy with current medical options, some women searched for alternatives and began talking about birth practices with friends and acquaintances. This new openness about female reproduction and the mandate to question medical authorities resulted in experimentation and a willingness to attempt delivery outside the protected realm of the hospital and without the patriarchal mantle of the physician. Women performed their own gynecological exams, sought out long-buried information on the processes of pregnancy, helped each other with prenatal care, and began to birth at home with friends assisting.

Certain women felt a calling to help women in labor, and began to accumulate knowledge, share it with other interested women, and attend births.
One group emerged in Santa Cruz, California, with a core of newly self-identifying midwives sharing knowledge and actively seeking to promote birth at home. Operating outside of mainstream culture for several years, they organized a rudimentary midwifery practice and established a birth center. When authorities decided to shut down their operations in 1974, the midwives recognized the challenge to female control of birth and vehemently protested the intrusion. They publicized their story, and women across America found inspiration and encouragement from their resistance.

When Jeannine Walker, one of the midwives charged in the California case, moved to Missoula, Montana, she brought her practical homebirthing experience, confidence to train other aspiring midwives, and a dedication to the expansion of midwifery. In Missoula, Walker encountered growing demand for homebirth midwifery services, and recruited Dolly Browder to assist in the overflow of midwifery clients. A core group of midwives in the Missoula area began meeting to self-educate, discuss birthing techniques, and support each other. For over a decade, Missoula midwives worked in concert with local physicians and hospitals, until, in 1988 and at the request of a Missoula physician, the Montana Board of Medical Examiners charged Browder with practicing medicine without a license. After a three-day court case, the Missoula judge ordered Browder to cease her midwifery practice. Determined to change the law and protect the lay midwives in the state, the homebirth community rallied around Browder and the newly energized Montana Midwives Association prepared for an assault on the Montana legislature.
Homebirth supporters contacted senators and representatives and communicated across the state with a newsletter and phone trees. They organized to lobby legislators during the 51st Montana legislative session, and achieved an exemption for homebirth midwifery from the Medical Practice Act. During the following legislative session in 1991, they gained passage of a licensing bill that established education and experience requirements for professional midwives, and created the Alternative Healthcare Board to oversee the licensing of midwives in the state.

During the legislative process, the midwifery organization demonstrated a political acuity lacking in earlier generations of American midwives. Montana midwives of the late 1980s understood the history of midwifery and its vulnerability to charges of unsanitary and ignorant care, and they structured their message to combat preconceived notions and critiques of the profession. To downplay the perception of midwifery as a women’s-only issue, they emphasized the importance of home birth to parents, and ensured that men, as well as women, testified in hearings on the Midwifery Bill. Midwives who spoke in favor of the bill demonstrated a familiarity with scientific methodology, human anatomy, medical terminology, and statistics. Midwifery proponents advanced their cause in one-on-one conversations with legislators, in which they communicated tailor-made arguments for midwifery based on the constituency and concerns of individual senators and representatives.

Despite a well-rounded lobbying strategy and mobilized statewide support, the cause of Montana midwives faced tremendous opposition at the legislative level
from healthcare organizations and medical practitioners. But midwifery strategists unearthed a potent weapon from Montana’s past. With a rural population and sparse medical services, the far reaches of the state supported midwives and home birth in an era when much of the United States had moved conclusively to physician-assisted hospital birth. In Montana, the work of early Montana midwives lived on in the minds of rural legislators who recalled the midwifery activities of neighbor women in small communities. Midwifery opponents in Montana repeatedly stated, despite a wealth of statistical data proving otherwise, that midwives were uneducated and unsafe. In response, the Montana Midwives Association honed a new and improved rhetorical tool: midwifery was a Montana tradition, a practice that all Montanans could be proud of, and a sign of Montana women’s resilience, strength, and adaptability. Their message convinced legislators, and on April 11, 1989, the Montana legislature effected a change in the law, stating:

“[T]he practice of direct-entry midwifery has been practiced in the state of Montana since territorial days; and . . . it is the intent of the legislature to allow direct-entry midwives to continue serving Montana parents without fear of criminal prosecution.”

The legalization of midwifery in Montana and the successful establishment of a professional midwifery licensing protocol represented a unique partnership between the practicing midwives of early Montana history, and the politicized and organized midwives of Montana’s present. The midwives of 1989 succeeded, in part, because of the work of a group of women long dead, the women who assisted in the delivery of infants across the miles of Montana, who remained in the minds and memories of modern Montana legislators. The unique convergence of the two
groups of midwives – old and young, long-departed and physically present, unorganized and highly politicized – occurred at a fleeting point in Montana history. Had the newest generation of Montana midwives restrained their political activities for just a few short years, or had the previous generation given up their challenging work just a bit sooner, the confluence of their efforts would not have been possible. The old midwives and the new met in the minds of legislators, in the hallways of Helena. Rural legislators in Montana held significant political power in 1989, and their familiarity with the presence and practice of early Montana midwives provided a rebuttal to anti-midwifery lobbyists’ predictions of dead babies and maternal delivery crises. Legislators voted to legalize a Montana homebirth tradition, long practiced but rarely acknowledged.

The midwives of the 1920s and 1930s supported laboring women in homes and maternity hospitals across Montana; the midwives of the 1980s brought homebirth midwifery to the public and political discourse. Modern Montana midwives took issues of personal reproductive choice to the state capitol and educated legislators about such timeless matters as childbirth and breastfeeding, but their efforts depended on a partnership with earlier generations of Montana women.

Montana midwives from Aino Puutio to Dolly Browder respected the process of childbirth and encouraged women in the midst of labor, delivery, and the post partum period. Early 20th century midwives washed dishes and cooked for the family while the mother recuperated; contemporary midwives provide information
to women about available methods of birth control and ways to help children adjust to a new sibling. The details of midwifery practices changed over time, but the midwifery mentality of empathy and support for parturient women endured. The tropes and jeremiads leveraged against midwives also persisted, reflecting the durability of patriarchal assumptions about the female body and its reproductive functions. The story of the legalization of midwifery in Montana can begin to explain both the intransigence of those beliefs, and the strategies necessary to legally protect reproductive options for women, men, and families.

Despite the gains of legalization, state-sponsored legitimacy came at a cost. Midwives in Montana, no longer vulnerable to legal attack from outside interests, practice under the jurisdiction of a board with the authority to suspend licenses and promulgate standards of practice. Midwives who sit on the Alternative Healthcare Board police their fellow midwives and impose penalties on licensees who fail to follow the dictates of board policy, an uncomfortable arrangement for individuals who value personal freedom and spurn institutional bureaucracy.

Montana midwives serve a variety of women, from those who choose home birth for ideological reasons to clients who embrace midwifery as a lower-cost delivery option. Midwives mirror this variety, with religious convictions and political loyalties as diverse as their clientele. The orchestrated unity evident during the 1989 legislative session requires careful management lest it unravel amidst economic, philosophical, and political differences.
While the legalization of midwifery pushed Montana midwives to establish a tacit group identity, it also revealed the fractures of feminism. Women like Dolly Browder and Valerie Knudsen participated as feminists, but on opposite sides of the issue. Feminist principles abounded, but provided little agreement about the realities of female reproduction. Despite feminist theory investigating the role of reproduction, ordinary women continue to grapple with feminism’s persistent reproductive conundrum. Is birth a feminist issue? Irrefutably, it is a human issue, and one that continues to raise provocative questions of identity and meaning in women’s public and private lives.


4 Excerpted from the text of HB 458, Introduced Bill, Second Reading, Corrected Second Reading, 51st Legislature, Collection No. LR51, Box 12, Folders 12-21, Montana Historical Society Archives, Helena, Montana. See Appendix K for the entire bill text as introduced and with subsequent amendments.
APPENDIX A

COMPUTATION OF MATERNAL AND INFANT STATISTICS
Contentious and emotionally loaded issues surrounding birth generate assumptions and conclusions grounded in bias instead of fact. Statistics about maternal and infant outcomes provide useful information to contextualize reproductive debates.

The Montana State Board of Health collected statistical birth data from 1910 through the present, and data for the years 1910 through 1920 are included in this Appendix as illustrative explanatory tools. The formulas used to compute the statistics are important, particularly as some of them changed over time. A direct comparison from year to year provides highly misleading information if differing formulas generated the rates under consideration. For example, in 1910, the Montana State Board of Health defined the maternal mortality rate as maternal deaths per 1,000 births. As the maternal mortality rate declined, the Board of Health restated the maternal death rate per 100,000 births. The rate generated using 1,000 births as the baseline proved to be so small – 0.10 in 1968 – as to be lacking any informative power. Without knowing the basis of vital statistics computations, comparison of the 1911 maternal mortality rate of 10.3 with the 1950 rate of 128.3 would lead to the erroneous conclusion that Montana women faced an increased risk of death in childbirth, when, in fact, the maternal death rate declined precipitously and the State Board of Health responded by adjusting the rate formula.

The most common birth-related categories are listed below, along with their computational basis:

Birth rate = (live births/population) x 1,000
Infant mortality rate = \( \frac{\text{number of infant deaths/live births}}{1,000} \)

Maternal mortality rate = \( \frac{\text{number of maternal deaths/live births}}{1,000} \)

_Total Births, Infant Deaths_, and _Maternal Deaths_ refer to the total number of each category in Montana for the year listed. For example, during 1913, mothers delivered 8,682 infants, 812 of those babies died, and 80 real women with names, families, and histories lost their lives during labor and delivery.

Table 1. Birth Data, 1910-1920.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Births</th>
<th>Birth Rate</th>
<th>Infant Deaths</th>
<th>Infant Mortality Rate</th>
<th>Maternal Deaths</th>
<th>Maternal Mortality Rate</th>
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<tbody>
<tr>
<td>1910</td>
<td>6,124</td>
<td>16.2</td>
<td>714</td>
<td>116.6</td>
<td>62</td>
<td>10.1</td>
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<td>1911</td>
<td>7,542</td>
<td>19.0</td>
<td>717</td>
<td>95.1</td>
<td>78</td>
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<tr>
<td>1912</td>
<td>8,133</td>
<td>19.6</td>
<td>660</td>
<td>81.2</td>
<td>75</td>
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<tr>
<td>1913</td>
<td>8,682</td>
<td>20.1</td>
<td>812</td>
<td>93.5</td>
<td>80</td>
<td>9.2</td>
</tr>
<tr>
<td>1914</td>
<td>9,969</td>
<td>22.1</td>
<td>834</td>
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<td>100</td>
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<td>11,132</td>
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<td>816</td>
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<td>91</td>
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<td>962</td>
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<tr>
<td>1920</td>
<td>11,862</td>
<td>21.6</td>
<td>862</td>
<td>72.7</td>
<td>104</td>
<td>8.8</td>
</tr>
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</table>

Data compiled from Biennial Reports published by the Montana State Board of Health.
APPENDIX B

ANNUAL MATERNAL DEATHS, 1920-2009
Statistical analysis demonstrates that over the course of Montana history, the dangers of being born far exceeded the risks of birthing a baby. In 2011, five women died in childbirth in Montana, while there were 69 birth-related infant fatalities. Infants faced a risk of death 14 times higher than their mothers.

A review of maternal mortality statistics from 1920 through 2009 shows a steady downward trend in the number of women dying from birth-related causes, dropping to fewer than 10 annually by 1952 and falling even further to five or less by 1965.


<table>
<thead>
<tr>
<th>Year</th>
<th>Maternal Deaths</th>
<th>Year</th>
<th>Maternal Deaths</th>
<th>Year</th>
<th>Maternal Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1920</td>
<td>104.00</td>
<td>1950</td>
<td>20.00</td>
<td>1980</td>
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</tr>
<tr>
<td>1921</td>
<td>89.00</td>
<td>1951</td>
<td>10.00</td>
<td>1981</td>
<td>–</td>
</tr>
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<td>1952</td>
<td>8.00</td>
<td>1982</td>
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</tr>
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<td>Maternal Deaths</td>
<td>Year</td>
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<td>------</td>
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<td>1974</td>
<td>1.00</td>
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<td>1975</td>
<td>3.00</td>
<td>2005</td>
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<td>1976</td>
<td>–</td>
<td>2006</td>
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<td>1947</td>
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<td>1977</td>
<td>1.00</td>
<td>2007</td>
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<td>1978</td>
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<td>1979</td>
<td>4.00</td>
<td>2009</td>
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</tbody>
</table>

Data compiled from Biennial Reports published by the Montana State Board of Health and the State of Montana Vital Statistics Reports.
APPENDIX C

PUERPERAL FEVER IN MONTANA, 1921-1925
The 1925 report of the Montana State Board of Health included a detailed analysis of maternal death, unusual for the Biennial Reports and indicative of an increased concern about puerperal fever in the state. The symptoms of puerperal fever, a life-threatening and often fatal infection of a parturient woman, typically manifested shortly after delivery. The incidence of puerperal fever rose significantly as hospital births became increasingly common. Physicians routinely performed vaginal exams on a series of women without sanitizing their hands or equipment between patients, transferring the infectious bacteria from one woman to the next.

Table 3. Causes of Death, 1921-1925.

<table>
<thead>
<tr>
<th>Disease or Condition</th>
<th>1921</th>
<th>1922</th>
<th>1923</th>
<th>1924</th>
<th>1925</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidents of Pregnancy</td>
<td>10</td>
<td>8</td>
<td>6</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Puerperal Hemorrhage</td>
<td>6</td>
<td>3</td>
<td>6</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Accidents of Labor</td>
<td>5</td>
<td>8</td>
<td>1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Puerperal Septicemia</td>
<td>46</td>
<td>40</td>
<td>39</td>
<td>32</td>
<td>30</td>
</tr>
<tr>
<td>Puerperal Phlegmasia</td>
<td>3</td>
<td>10</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Puerperal Albuminuria and Convulsions</td>
<td>18</td>
<td>13</td>
<td>9</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td>Following Childbirth</td>
<td>4</td>
<td>4</td>
<td>9</td>
<td>5</td>
<td>12</td>
</tr>
</tbody>
</table>

Data from the Thirteenth Biennial Report published by the Montana State Board of Health.

The category Following Childbirth represented additional cases of possible puerperal septicemia. A combination of Puerperal Septicemia and Following Childbirth deaths resulted in the following annual puerperal fever death rates:
Table 4. Puerperal Deaths, 1921-1925.

<table>
<thead>
<tr>
<th></th>
<th>1921</th>
<th>1922</th>
<th>1923</th>
<th>1924</th>
<th>1925</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Puerperal</td>
<td>92</td>
<td>86</td>
<td>70</td>
<td>73</td>
<td>83</td>
</tr>
<tr>
<td>Deaths</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potential</td>
<td>50</td>
<td>44</td>
<td>48</td>
<td>37</td>
<td>42</td>
</tr>
<tr>
<td>Septicemia Deaths</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Puerperal Fever</td>
<td>54%</td>
<td>51%</td>
<td>69%</td>
<td>51%</td>
<td>51%</td>
</tr>
<tr>
<td>Deaths as a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Puerperal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Deaths

From 1921 to 1925, puerperal fever deaths represented as much as 55% of the maternal deaths in Montana, a tragic loss of life from an entirely preventable infection.
APPENDIX D

BIRTH AND INFANT DEATH RATES

BY RACE, 1989-2011
Native birth practices contrasted with Euro-American traditions brought west by immigrants, and new settlers disparaged and restricted local birthing methods. White settlement brought the implementation of Euro-American birthing traditions, including hospitals, drugs, and the Indian Health Service, and most Native American births in Montana now occur according to the medical model.¹

Western medicine visited disproportionate harm to Native maternal and infant health. The Montana Department of Public Health and Human Services compiled birth and death statistics by race, categorizing births and infant deaths as “White,” “American Indian or Alaska Native,” and “Other,” and data from 1989 through 2011 are included in the following table. A comparison of Native American birth percentage (total Native American births for the year/total births) versus Native American infant death percentage (total Native American infant deaths/total infant deaths) revealed that infant deaths in Montana occurred disproportionately among Native American infants. For example, in 1990, Native American and Alaska Native births comprised 13% of infants born in the state, while Native infant deaths represented 20% of the total for the year; in 2011, Native American and Alaskan babies made up 11% of all births in Montana, yet Native American infant deaths accounted for 17% of the annual death toll. Native American infant mortality rates in Montana consistently exceeded white infant mortality rates, demonstrating that Native American infants typically died at a higher rate than white babies, a grim reality yet to receive concentrated public health attention.
Current research validates the effectiveness of traditional Native American practices to improve the health and well-being of infants and mothers. Freedom of movement during labor, birthing positions that utilized the force of gravity and the flexibility of the female pelvis, immediate skin-to-skin contact between mother and infant, and sustained breastfeeding benefitted both mother and child.

Table 5. Infant Birth and Death by Race, 1989-2011.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Births</th>
<th>White Births</th>
<th>AI/AN Births</th>
<th>Other Births</th>
<th>Total Infant Deaths</th>
<th>White Deaths</th>
<th>AI/AN Deaths</th>
<th>Other Deaths</th>
</tr>
</thead>
<tbody>
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<td>1989</td>
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<td>1,391</td>
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<td>10,009</td>
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<td>11,498</td>
<td>10,010</td>
<td>1,363</td>
<td>125</td>
<td>82</td>
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<td>11,468</td>
<td>9,967</td>
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<td>168</td>
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<td>71</td>
<td>54</td>
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Table 5. Infant Births and Death by Race, 1989-2011, continued.

<table>
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<th>White Births</th>
<th>AI/AN Births</th>
<th>Other Births</th>
<th>Total Infant Deaths</th>
<th>White Deaths</th>
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<th>Other Deaths</th>
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<td>2000</td>
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<td>81</td>
<td>66</td>
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<td>1,601</td>
<td>316</td>
<td>70</td>
<td>50</td>
<td>19</td>
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Data compiled from the Montana Vital Statistics 2011 published by the Montana Department of Public Health and Human Services Public Health and Safety Division.

For the years 1989 through 2011, Native American infant death percentage exceeded birth percentage each year, with the exception of 1995.

<table>
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<th>Year</th>
<th>Native American Birth Percentage</th>
<th>Native American Infant Death Percentage</th>
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</thead>
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<td>1989</td>
<td>12</td>
<td>27</td>
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<tr>
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<td>20</td>
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<td>16</td>
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<td>1996</td>
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<td>2006</td>
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<tr>
<td>2007</td>
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<tr>
<td>2008</td>
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<td>2009</td>
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<td>2011</td>
<td>11</td>
<td>17</td>
</tr>
</tbody>
</table>

Calculations based on data compiled from the Montana Vital Statistics 2011 and published by the Montana Department of Public Health and Human Services Public Health and Safety Division.
APPENDIX E

BIRTHS BY LOCATION AND ATTENDANT, 1954-2009
Beginning in 1954, the Montana State Board of Health provided information about the type of birth attendant and the location of birth. As the number of out-of-hospital physician assisted births declined, midwifery births increased.


<table>
<thead>
<tr>
<th>Year</th>
<th>Physician in Hospital</th>
<th>Physician not in Hospital</th>
<th>Other and Midwife</th>
</tr>
</thead>
<tbody>
<tr>
<td>1954</td>
<td>16,868</td>
<td>56</td>
<td>101</td>
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<td>1955</td>
<td>17,043</td>
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<td>109</td>
</tr>
<tr>
<td>1956</td>
<td>17,360</td>
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<td>79</td>
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<td>1957</td>
<td>17,850</td>
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<td>80</td>
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<td>1958</td>
<td>16,959</td>
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<td>73</td>
</tr>
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<td>1959</td>
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<td>1961</td>
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</tr>
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<td>1972</td>
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<tr>
<td>1973</td>
<td>11,163</td>
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<tr>
<td>1974</td>
<td>11,991</td>
<td>23</td>
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<td>1975</td>
<td>11,727</td>
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<td>1976</td>
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<table>
<thead>
<tr>
<th>Year</th>
<th>Physician in Hospital</th>
<th>Physician not in Hospital</th>
<th>Other and Midwife</th>
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<td>1980</td>
<td>13,638</td>
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<td>1982</td>
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<td>1985</td>
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<td>1986</td>
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<tr>
<td>1987</td>
<td>11,686</td>
<td>10</td>
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<td>1988</td>
<td>11,129</td>
<td>21</td>
<td>243</td>
</tr>
<tr>
<td>1989</td>
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<td>1990</td>
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<td>1993</td>
<td>10,866</td>
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<td>10,624</td>
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<td>1995</td>
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<td>1997</td>
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<td>1998</td>
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<tr>
<td>1999</td>
<td>10,438</td>
<td>5</td>
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<tr>
<td>2000</td>
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<tr>
<td>2001</td>
<td>10,657</td>
<td>4</td>
<td>274</td>
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<td>2002</td>
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<td>253</td>
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<td>2003</td>
<td>11,139</td>
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<tr>
<td>2004</td>
<td>11,262</td>
<td>2</td>
<td>262</td>
</tr>
<tr>
<td>2005</td>
<td>11,263</td>
<td>2</td>
<td>291</td>
</tr>
<tr>
<td>2006</td>
<td>12,102</td>
<td>12</td>
<td>374</td>
</tr>
<tr>
<td>2007</td>
<td>11,958</td>
<td>11</td>
<td>432</td>
</tr>
<tr>
<td>2008</td>
<td>12,073</td>
<td>13</td>
<td>465</td>
</tr>
<tr>
<td>2009</td>
<td>11,753</td>
<td>4</td>
<td>447</td>
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</tbody>
</table>

Data compiled from Biennial Reports published by the Montana State Board of Health and the State of Montana Vital Statistics Reports.
APPENDIX F

MONTANA’S RURAL POPULATION PER

U.S. CENSUS BUREAU, 1900-1990
The U.S. Census Bureau calculates rural and urban classifications based on population figures. Incorporated communities with at least 2,500 residents and unincorporated areas with a population of at least 50,000 are defined as urban. Non-urban areas are, by default, considered rural. According to the U.S. Census Bureau, Montana had a predominantly rural population in 1950, but over the course of the following decade transitioned to an urban state, with a 50.2% urban population in 1960.

Table 8. Montana’s Rural Population, 1900-1990.

<table>
<thead>
<tr>
<th>Year</th>
<th>Montana Population Residing in Rural Areas of the State</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900</td>
<td>65.3%</td>
</tr>
<tr>
<td>1910</td>
<td>64.5%</td>
</tr>
<tr>
<td>1920</td>
<td>68.7%</td>
</tr>
<tr>
<td>1930</td>
<td>66.3%</td>
</tr>
<tr>
<td>1940</td>
<td>62.2%</td>
</tr>
<tr>
<td>1950</td>
<td>56.3%</td>
</tr>
<tr>
<td>1960</td>
<td>49.8%</td>
</tr>
<tr>
<td>1970</td>
<td>46.6%</td>
</tr>
<tr>
<td>1980</td>
<td>47.1%</td>
</tr>
<tr>
<td>1990</td>
<td>47.5%</td>
</tr>
</tbody>
</table>

Data compiled from the U.S. Census Bureau publication, “Urban and Rural Populations: 1900 to 1990.”
APPENDIX G

C-SECTION RATES IN THE UNITED STATES
Reproductive health experts insist that the C-section rate in the United States exceeds optimal levels, but obstetric procedures continue without significant alteration. The Centers for Disease Control noted that C-sections carried a high cost for women and infants: “Cesarean delivery involves major abdominal surgery, and is associated with higher rates of surgical complications and maternal rehospitalization, as well as with complications requiring neonatal intensive care unit admission. In addition to health and safety risks for mothers and newborns, hospital charges for a cesarean delivery are almost double those for a vaginal delivery, imposing significant costs.”

Women who delivered via C-section faced a heightened risk of death and infection, as well as greater incidence of pulmonary embolism, hysterectomy, and kidney failure. The increasing rate of inductions – the administration of artificial hormones to initiate the process of labor – resulted in additional incidents of maternal hemorrhage and contributed to emergency labor situations that resulted in C-sections. Despite documented risks to mothers and infants, doctors perform routine C-sections and pregnant women continue to request the surgery.

Cesarean delivery rates climbed steadily starting in the 1930s, when C-section became a routine medical procedure. The U.S. C-section rate stood at 2.9% in 1930, 4.5% in 1965, 5.5% in 1970, 10.4% in 1975, 16.5% in 1980, and 22.7% in 1985. Even in rural states like Montana with less accessible hospital services, the C-section rate jumped dramatically from 19.1% in 1996 to 29.4% in 2007. Despite government warnings and international outcry, the C-section rate in the United
States rose alarmingly from the late 1990s, currently averaging over 30% of all births. In contemporary America, one out of every three infants enters the world via a surgical procedure.


<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>21%</td>
<td>21%</td>
<td>22%</td>
<td>23%</td>
<td>24%</td>
<td>26%</td>
<td>28%</td>
<td>29%</td>
<td>30%</td>
<td>31%</td>
<td>32%</td>
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</tbody>
</table>

Data compiled from Centers for Disease Control, NCHS Data Brief No. 35, March 2010.
APPENDIX H

CURRENT INFANT MORTALITY RATES BY COUNTRY
The Central Intelligence Agency collects data from countries around the world to assess global infant mortality rates, and uses the information “as an indicator of the level of health in a country.” This table lists all of the countries with better infant survival rates than the United States, as well as a sampling of nations with higher mortality rates. A full listing, including all of the countries that fare worse than the United States, is available online from the Central Intelligence Agency.7


<table>
<thead>
<tr>
<th>Country</th>
<th>Infant Deaths/1,000 Live Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monaco</td>
<td>1.81</td>
</tr>
<tr>
<td>Japan</td>
<td>2.17</td>
</tr>
<tr>
<td>Bermuda</td>
<td>2.47</td>
</tr>
<tr>
<td>Singapore</td>
<td>2.59</td>
</tr>
<tr>
<td>Sweden</td>
<td>2.73</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>2.89</td>
</tr>
<tr>
<td>Macau</td>
<td>3.15</td>
</tr>
<tr>
<td>Iceland</td>
<td>3.17</td>
</tr>
<tr>
<td>Italy</td>
<td>3.33</td>
</tr>
<tr>
<td>France</td>
<td>3.34</td>
</tr>
<tr>
<td>Spain</td>
<td>3.35</td>
</tr>
<tr>
<td>Finland</td>
<td>3.38</td>
</tr>
<tr>
<td>Anguilla</td>
<td>3.42</td>
</tr>
<tr>
<td>Norway</td>
<td>3.47</td>
</tr>
<tr>
<td>Germany</td>
<td>3.48</td>
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<tr>
<td>Guernsey</td>
<td>3.49</td>
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<tr>
<td>Malta</td>
<td>3.62</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>3.67</td>
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<tr>
<td>Belarus</td>
<td>3.67</td>
</tr>
<tr>
<td>Netherlands</td>
<td>3.69</td>
</tr>
<tr>
<td>Andorra</td>
<td>3.73</td>
</tr>
</tbody>
</table>
Table 10. Infant Mortality by Country, 2013, continued.

<table>
<thead>
<tr>
<th>Country</th>
<th>Infant Deaths/1,000 Live Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ireland</td>
<td>3.78</td>
</tr>
<tr>
<td>Switzerland</td>
<td>3.80</td>
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<tr>
<td>Jersey</td>
<td>3.90</td>
</tr>
<tr>
<td>South Korea</td>
<td>4.01</td>
</tr>
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<td>Israel</td>
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<td>Slovenia</td>
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<td>Denmark</td>
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<td>Austria</td>
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<tr>
<td>Isle of Man</td>
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</tr>
<tr>
<td>Belgium</td>
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<td>Luxembourg</td>
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<td>Liechtenstein</td>
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<td>European Union</td>
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<td>United Kingdom</td>
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<td>Portugal</td>
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<tr>
<td>Wallis and Fortuna</td>
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<tr>
<td>Taiwan</td>
<td>4.55</td>
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<tr>
<td>San Marino</td>
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<tr>
<td>New Zealand</td>
<td>4.65</td>
</tr>
<tr>
<td>Cuba</td>
<td>4.76</td>
</tr>
<tr>
<td>Canada</td>
<td>4.78</td>
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<td>French Polynesia</td>
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<td>Guam</td>
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<td>5.82</td>
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<td><strong>United States</strong></td>
<td><strong>5.90</strong></td>
</tr>
<tr>
<td>Croatia</td>
<td>5.96</td>
</tr>
<tr>
<td>Bosnia and Herzegovina</td>
<td>5.97</td>
</tr>
<tr>
<td>Lithuania</td>
<td>6.09</td>
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</table>
Table 10. Infant Mortality by Country, 2013, continued.

<table>
<thead>
<tr>
<th>Country</th>
<th>Infant Deaths/1,000 Live Births</th>
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</thead>
<tbody>
<tr>
<td>Serbia</td>
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<td>Poland</td>
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</tr>
<tr>
<td>Cayman Islands</td>
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<td>Slovakia</td>
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<td>Gibraltar</td>
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<td>Qatar</td>
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<td>Estonia</td>
<td>6.82</td>
</tr>
<tr>
<td>Virgin Islands</td>
<td>6.94</td>
</tr>
<tr>
<td>Saint Pierre and Miquelon</td>
<td>7.12</td>
</tr>
<tr>
<td>Russia</td>
<td>7.19</td>
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<tr>
<td>Chile</td>
<td>7.19</td>
</tr>
<tr>
<td>Kuwait</td>
<td>7.68</td>
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<tr>
<td>Puerto Rico</td>
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</table>

This table includes a selection from the Central Intelligence Agency’s 2013 data. A full listing of countries and rates can be accessed at www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.htm.
APPENDIX I

51ST LEGISLATIVE SESSION MEMBERS
Democratic Senators:
Hubert Abrams
Esther Bengston
Chet Blaylock
Paul Boylan
Dorothy Eck
Mike Halligan
Judy Jacobsen
Greg Jergeson
J.D. Lynch
Richard Manning
Joseph Mazeukek
William Norman
R.J. Pinsoneault
Bob Pipinich
Paul Rapp-Svrcek
Pat Regan
Lawrence Stimatz
Fred VanValkenburg
Eleanor Vaughn
Mike Walker
Cecil Weeding
Bob Williams
William Yellowtail

Republican Senators:
Gary Aklestad
John Anderson
Tom Beck
Al Bishop
Robert Brown
Bruce Crippen
Gerry Devlin
Bill Farrell
Delwyn Gage
Jack Galt
Thomas Hager
“Swede” Hammond
Ethel Harding
John Harp
Matt Himsl
Sam Hofman
Loren Jenkins
Thomas Keating
Harry McLane
Darryl Meyer
Dennis Nathe
Jerry Noble
Tom Rasmussen
Elmer Severson
Peter Story
Gene Thayer
Larry Tveit

Democratic Representatives:
Kelly Addy
Bob Bachini
Francis Bardanouve
Robb Blotkamp
Dorothy Bradley
Vivian Brooke
Dave Brown
Jan Brown
Vicki Cocchiarella
Dorothy Cody
Ben Cohen
Mary Ellen Connelly
“Fritz” Daily
Paula Darko

Republican Representatives:
Ole Aafedt
William Boharski
Bud Campbell
Robert Clark
John Cobb
Duane Compton
Roger DeBruycker
Orval Ellison
Ralph Eudaily
Leo Giacometto
Bob Gilbert
William Glaser
Susan Good
Budd Gould
Democratic Representatives, cont.:
Ervin Davis
Gene DeMars
Jerry Driscoll
Jim Elliott
Bob Gervais
Stella Jean Hansen
Hal Harper
Dan Harrington
John Johnson
Mike Kadas
Tom Kilpatrick
Berv Kimberly
Francis Koehnke
“Mac” McCormick
Mary McDonough
“Red” Menahan
Janet Moore
Linda Nelson
Jerry Nisbet
Helen O’Connell
Mark O’Keefe
Robert Pavlovich
Ray Peck
Joe Quilici
Bob Raney
Robert Ream
Angela Russell
Ted Schye
Gary Spaeth
Carolyn Squires
“Spook” Stang
Don Steppler
Jessica Stickney
William Strizich
John Vincent
Vernon Westlake
Timothy Whalen
Diana Wyatt

Republican Representatives, cont.:
Ed Grady
Larry Grinde
Bert Guthrie
Thomas Hannah
Marian Hanson
Harriet Hayne
Robert Hoffman
Dennis Iverson
Betty Lou Kasten
Vernon Keller
Roger Knapp
Thomas Lee
Robert Marks
John Mercer
Richard Nelson
Thomas Nelson
Lum Owens
John Patterson
Mary Lou Peterson
John Phillips
Jack Ramirez
Dennis Rehberg
Jim Rice
Rande Roth
Bruce Simon
Richard Simpkins
Clyde Smith
Wilber Spring
Bernie Swift
Charles Swysgood
Bob Thoft
Fred Thomas
Norman Wallin
Tom Zook
Republicans controlled the Senate and Democrats ran the House of Representatives. Governor Stan Stephens, a Republican from Havre with a background in broadcasting, served as a legislator for 16 years before his successful run for governor in 1988.8

In the House of Representatives, 23 legislators voted against HB 458, also called the Midwifery Bill, in the final floor vote. The majority were from urban districts.

Bob Bachini (D) – Havre
William Boharski (R) – Kalispell
Dorothy Bradley (D) – Bozeman
Dorothy Cody (D) – Wolf Point
"Fritz" Daily (D) – Butte
Bob Gilbert (R) – Sidney
Susan Good (R) – Great Falls
Budd Gould (R) – Missoula
Larry Grinde (R) – Lewistown
Stella Jean Hanson (D) – Missoula
Hal Harper (D) – Helena
Betty Lou Kasten (R) – Brockway
Tom Kilpatrick (D) – Laurel
Robert Marks (R) – Clancy
Helen O’Connell (D) – Great Falls
Robert Pavlovich (D) – Butte
Joe Quilici (D) – Butte
Jack Ramirez (R) – Billings
Dennis Rehberg (R) – Billings
Jim Rice (R) – Helena
Ted Schye (D) – Glasgow
Jessica Stickney (D) – Miles City
Diana Wyatt (D) – Great Falls
In the Senate, nine legislators opposed the bill in its final form:

Paul Boylan (D) – Bozeman
Gerry Devlin (R) – Terry
Dorothy Eck (D) – Bozeman
Thomas Hager (R) – Billings
Judy Jacobson (D) – Butte
Greg Jergeson (D) – Chinook
J.D. Lynch (D) – Butte
Dennis Nathe (R) – Redstone
Bob Williams (D) – Hobson
APPENDIX J

HB 458 CALENDAR OF ACTIVITY
1989 Session
HB 458 – Sponsored by Peck
1/26/89    Introduced
1/27/89    Referred to Human Services and Aging
2/6/89     Hearing
2/10/89    Hearing
2/11/89    Committee Report – Bill Passed as Amended
2/15/89    Corrected Committee Report – Bill Passed as Amended
2/16/89    2nd Reading – Passed as Amended (74/25)
2/18/89    3rd Reading – Passed (75/23)

Transmitted to Senate
2/28/89    Referred to Public Health, Welfare & Safety
3/13/89    Hearing
3/21/89    Committee Report – Bill Concurred as Amended
            (minutes dated 3/17/89)
3/22/89    2nd Reading Concurred as Amended (39/10)
3/27/89    3rd Reading Concurred (41/9)

Returned to House with Amendments
3/30/89    2nd Reading Amendments Concurred (74/24)
3/31/89    3rd Reading Amendments Concurred (88/10)
4/6/89     Signed by Speaker
4/6/89     Signed by President
4/7/89     Transmitted to Governor
4/11/89    Signed by Governor, Effective 4/11/89
APPENDIX K

HB 458 TEXT AND AMENDMENTS
A full transcription of HB 458 as introduced and its various amendments follows, with one exception. The House Committee on Human Services and Aging voted on and passed HB 458 as amended on February 10, 1989. The committee did not include the full text of its amendments in the original report, and revised the record and submitted a Corrected Committee Report on February 15, 1989. In each version of the bill, new changes are highlighted in bold print and eliminated wording is shown with a strikeout. The full and final text of the bill as signed by the Governor and included in the MCA concludes the text listing.

1. Bill Text as Introduced:
A bill for an act entitled: “An act establishing parents’ rights regarding the birth of a baby; exempting direct-entry midwives from the medical practice act; and amending section 37-3-103, MCA.”

Parents have a right to give birth where and with whom they choose.

This chapter does not prohibit or require a license with respect to…The practice of direct-entry midwifery. For the purpose of this section, the practice of direct-entry midwifery means the advising, attending, or assisting of a woman during pregnancy, labor, or the postpartum period.

2. Bill Text as Amended:
A bill for an act entitled: “An act establishing parents’ rights regarding the birth of a baby; exempting direct-entry midwives from the medical practice act; and amending section 37-3-103, MCA; and providing an immediate effective date.”

Whereas, the practice of direct-entry midwifery has been practiced in the state of Montana since territorial days; and whereas, it is the intent of the legislature to allow direct-entry midwives to continue serving Montana parents without fear of criminal prosecution; and whereas, the legislature urges direct-entry midwives to establish standards of practice during an upcoming legislative session.
Therefore, the legislature of the state of Montana finds it reasonable and necessary to maintain the current status of direct-entry midwives in the state.

Parents have a right to give birth where and with whom they choose.
This chapter does not prohibit or require a license with respect to...the practice of direct-entry midwifery. For the purpose of this section, the practice of direct-entry midwifery means the advising, attending, or assisting of a woman during pregnancy, labor, or the postpartum period.

**This act is effective on passage and approval.**

3. Bill Text Amended and Corrected:
A bill for an act entitled: “An act establishing parents’ rights regarding the birth of a baby; exempting direct-entry midwives from the medical practice act; and amending section 37-3-103, MCA; and providing an immediate effective date.”

Whereas, the practice of direct-entry midwifery has been practiced in the state of Montana since territorial days; and whereas, it is the intent of the legislature to allow direct-entry midwives to continue serving Montana parents without fear of criminal prosecution; and whereas, the legislature urges requests direct-entry midwives to establish standards of practice during an upcoming legislative session.

Therefore, the legislature of the state of Montana finds it reasonable and necessary to maintain the current status of direct-entry midwives in the state until the 1991 regular session.

Parents have a right to give birth where and with whom they choose.

This chapter does not prohibit or require a license with respect to...the practice of direct-entry midwifery. For the purpose of this section, the practice of direct-entry midwifery means the advising, attending, or assisting of a woman during pregnancy, labor, natural childbirth, or the postpartum period.

This act is effective on passage and approval.

4. Bill Text with Further Amendment (3rd Reading):
A bill for an act entitled: “An act establishing parents’ rights regarding the birth of a baby; exempting direct-entry midwives from the medical practice act; and amending section 37-3-103, MCA; and providing an immediate effective date.”

Whereas, the practice of direct-entry midwifery has been practiced in the state of Montana since territorial days; and whereas, it is the intent of the legislature to allow direct-entry midwives to continue serving Montana parents without fear of criminal prosecution; and whereas, the legislature requests direct-entry midwives to establish standards of practice education and experience to practice as a midwife and to present those standards to the next regular session during an upcoming legislative session.
Therefore, the legislature of the state of Montana finds it reasonable and necessary to maintain the current status of direct-entry midwives in the state until the 1991 regular session.

Except as otherwise provided by law, parents have a right to give birth where and with whom they choose.

This chapter does not prohibit or require a license with respect to...the practice of direct-entry midwifery. For the purpose of this section, the practice of direct-entry midwifery means the advising, attending, or assisting of a woman during pregnancy, labor, natural childbirth, or the postpartum period.

This act is effective on passage and approval.

5. Bill Text with Senate Amendments:
A bill for an act entitled: “An act establishing parents’ rights regarding the birth of a baby; exempting direct-entry midwives from the medical practice act; providing immunity from liability for health care providers rendering birth-related services in emergency situations; and amending section 37-3-103, MCA; and providing an immediate effective date.”

Whereas, the practice of direct-entry midwifery has been practiced in the state of Montana since territorial days; and whereas, it is the intent of the legislature to allow direct-entry midwives to continue serving Montana parents without fear of criminal prosecution; and whereas, the legislature requests direct-entry midwives to establish standards of education and experience to practice as a midwife and to present those standards to the next regular legislative session.

Therefore, the legislature of the state of Montana finds it reasonable and necessary to maintain the current status of direct-entry midwives in the state until the 1991 regular session.

Except as otherwise provided by law, parents have a right to give birth where and with whom they choose.

A direct-entry midwife shall file an affidavit with the Department of Commerce certifying that he or she has completed the emergency childbirth training segment of a state-approved emergency medical training program within 12 months of the effective date of this act.

This chapter does not prohibit or require a license with respect to...the practice of direct-entry midwifery. For the purpose of this section, the practice of direct-entry midwifery means the advising, attending, or assisting of a woman during pregnancy, labor, natural childbirth, or the postpartum period. A direct-entry midwife may not
dispense or administer a prescription drug, as those terms are defined in 37-7-101.

Limits on Liability of health care provider in emergency situations. (1) A physician licensed under Title 37, Chapter 3, a nurse licensed under Title 37, Chapter 8, or a hospital licensed under Title 51, Chapter 5, rendering care or assistance in good faith to a patient of a direct-entry midwife in an emergency situation, is liable for civil damages for acts or omission committed in providing such emergency obstetrical care or assistance only to the extent that those damages are caused by gross negligence or by willful or wanton acts or omissions. (2) The limitations on liability provided in subsection (1) do not apply in the following cases: (A) The physician, nurse, or hospital had provided prior medical diagnosis or treatment to the patient for a condition having a bearing on or relevance to the treatment of the obstetrical condition that required emergency services. (B) Before rendering emergency obstetrical services, the physician, nurse, or hospital had a contractual obligation or agreement with the patient, another health care provider, or a third-party payer to provide obstetrical care for the patient.

This act is effective on passage and approval.

6. Bill Text as Signed:
A bill for an act entitled: “An act establishing parents’ rights regarding the birth of a baby; exempting direct-entry midwives from the medical practice act; providing immunity from liability for health care providers rendering birth-related services in emergency situations; and amending section 37-3-103, MCA; and providing an immediate effective date.”

Whereas, the practice of direct-entry midwifery has been practiced in the state of Montana since territorial days; and whereas, it is the intent of the legislature to allow direct-entry midwives to continue serving Montana parents without fear of criminal prosecution; and whereas, the legislature requests direct-entry midwives to establish standards of education and experience to practice as a midwife and to present those standards to the next regular legislative session.

Therefore, the legislature of the state of Montana finds it reasonable and necessary to maintain the current status of direct-entry midwives in the state until the 1991 regular session.

Except as otherwise provided by law, parents have a right to give birth where and with whom they choose.

A direct-entry midwife shall file an affidavit with the Department of Commerce certifying that he or she has completed the emergency childbirth training segment of a
state-approved emergency medical training program within 12 months of the effective date of this act.

This chapter does not prohibit or require a license with respect to...the practice of direct-entry midwifery. For the purpose of this section, the practice of direct-entry midwifery means the advising, attending, or assisting of a woman during pregnancy, labor, natural childbirth, or the postpartum period. A direct-entry midwife may not dispense or administer a prescription drub, as those terms are defined in 37-7-101.

Limits on Liability of health care provider in emergency situations. (1) A physician licensed under Title 37, Chapter 3, a nurse licensed under Title 37, Chapter 8, or a hospital licensed under Title 51, Chapter 5, rendering care or assistance in good faith to a patient of a direct-entry midwife in an emergency situation, is liable for civil damages for acts or omission committed in providing such emergency obstetrical care or assistance only to the extent that those damages are caused by gross negligence or by willful or wanton acts or omissions. (2) The limitations on liability provided in subsection (1) do not apply in the following cases: (A) The physician, nurse, or hospital had provided prior medical diagnosis or treatment to the patient for a condition having a bearing on or relevance to the treatment of the obstetrical condition that required emergency services. (B) Before rendering emergency obstetrical services, the physician, nurse, or hospital had a contractual obligation or agreement with the patient, another health care provider, or a third-party payer to provide obstetrical care for the patient.

This act is effective on passage and approval.
APPENDIX L

LEGALIZATION OF DIRECT-ENTRY MIDWIFERY
Efforts to legalize direct-entry midwifery began in the 1970s with the natural birth movement and continue, as only 28 states currently license Certified Professional Midwives, or CPMs. CPMs typically work outside of established medical bureaucracy, assisting in the delivery of infants at homes and birth centers. Below is a listing of states that legalized direct-entry midwifery, as well as the date of effective legislation.

South Carolina, 1976
Arizona, 1978
New Mexico, 1978
Delaware, 1978
New Hampshire, 1979
Arkansas, 1983
Texas, 1983
Louisiana, 1985
Montana, 1991
Washington, 1991
New York, 1992
Colorado, 1993
California, 1993
Oregon, 1993
Florida, 1995
Alaska, 1999
Minnesota, 1999
Vermont, 2000
Tennessee, 2000
New Jersey, 2002
Utah, 2005
Virginia, 2005
Wisconsin, 2006
Missouri, 2007
Maine, 2008
Idaho, 2009
Wyoming, 2010
Indiana, 2013

As of May, 2013, midwifery supporters advocated legal change in thirteen states, while the remaining nine – Connecticut, Kentucky, North Dakota, West
Virginia, Georgia, Hawaii, Kansas, Nevada, and Oklahoma – remain opposed to the licensing of lay midwives.⁹
During the course of my oral history research with practicing midwives in Montana, I regularly inquired about Native birth practices. In more than twenty-five interviews, not a single individual knew of any Native home births attended by a midwife, and most pointed to the Indian Health Service’s provision of maternity care as prohibitive of any need for midwifery services among the Native population. This does not preclude the possibility that mothers of Native American descent birth at home or follow cultural birthing traditions, but does point to the need for additional research on childbirth practices among Native Americans.


information/vitalstats.


8 Information compiled from the Copper Book, “Lawmakers of Montana, Legislative Session of 1989.” 328.33M76L, Montana Historical Society Research Center, Helena,

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