CHAPTER 12

Other Mainstream and Alternative Health Care Providers

For more than a decade, Juliana van Olphen-Fehr ran an independent practice as a nurse-midwife delivering babies in women's homes. In the following story, she gives us a sense of what it is like to participate in a home birth:

Late in the evening, Mona's contractions started getting quite intense. She paced around the room while we watched. She'd sit on the toilet frequently and Dave [her husband] rubbed her back when she was on the bed. . . . We tried to encourage Dave to go take a nap but he didn't want to leave Mona for a moment. He finally fell asleep in the bed while it was our turn to rub Mona's back. The night moved into early morning. The clock ticked away. We walked and talked.

It's amazing how long it takes a baby to be born. As time passes slowly, labor gives one the opportunity to reflect on the process of birth. Each contraction comes and goes, [as] the uterus gets smaller and smaller [and] the baby is massaged down further and further into the pelvis. . . . Finally, the uterus, getting more powerful as it decreases in size, pushes the baby out of its first cradle, the pelvis, through the vagina, the passageway to life, into the outside world. The mother, feeling more and more pressure, joins the uterus in its expulsive efforts. She bears down gently and involuntarily at first but then more forcefully and purposefully as the baby approaches birth.

In its natural environment, giving birth is like a musical masterpiece, building to its crescendo when the baby enters the world. Just as a symphony pulls its audience into its powerful rhythm, so does a laboring woman pull in her onlookers. All of those present at birth must be in synch just as all of the instruments in an orchestra must be in synch. This synchronization helps the mother keep her power to create her own masterpiece. . . .

Mona's labor built up to the point where she started to feel the urge to bear down. Her cervix was completely dilated and I felt the baby's head

low in the vagina. She squatted while she pushed during the contractions and walked during the break between them. She found it most comfortable to lean on the banister in her hallway while she pushed. . . . Dave was still behind her, supporting her hips. I encouraged her to push while I got under her to monitor the baby's heartbeat.

Finally, the head appeared. Dave was behind Mona, sitting on the floor, I was beneath her in the front. Together we had our hands around the baby's head, supporting it as we coaxed her to push the baby out slowly. A beautiful little boy was born into Dave's and my hands. I held the baby as Dave eased Mona back onto his lap. His arms were around her as they both welcomed the baby into their arms. My birth assistant covered all three of them with blankets to keep the baby warm with their body heat. We turned the light low so the baby would open his eyes. In happy exhaustion, we sat back and through tears watched this family fall in love with each other. (Van Olphen-Fehr, 1998: 111–113)

Van Olphen-Fehr's story evokes for us both the joy that midwives can find in assisting at childbirth and some of the reasons health care consumers might choose a nontraditional option like home birth. Since this story took place, however, unaffordable insurance premiums have forced virtually all nurse-midwives to abandon independent practice and to work only under direct physician supervision. This situation illustrates the problems faced by nonmedical health care workers in trying to achieve professional status in a system characterized by **medical dominance.**

In this chapter, we first look at the history and current status of four occupations now considered part of mainstream health care—nursing, nurse-midwifery, pharmacy, and osteopathy. As we will see, nursing in general, handicapped by its historically female tradition, has achieved only semiprofessional status, although nurse-midwives have gained a somewhat higher status by carving out a specialized niche for themselves. Pharmacy, on the other hand, is considered a profession, but faces continuing struggles to retain its professional prerogatives, whereas osteopaths have attained professional status parallel to that of medicine. We then consider the history and status of five occupations that, to a greater or lesser extent, remain outside of mainstream health care—chiropractic, lay midwifery, *curanderismo,* Christian Science practice, and traditional acupuncture. The history of chiropractic illustrates how, despite medical dominance, an alternative health care occupation can secure a role for itself by limiting its services to a narrow field. Finally, the histories of lay midwives, Christian Science practitioners, Mexican American **curanderos,** and traditional acupuncturists show how occupations can remain marginal to the health care system, unable in the face of medical dominance to secure more than a small and precarious niche for themselves. Table 12.1 compares the occupational prestige of some of these fields.

Table 12.1 ***Occupational Prestige, Rated by a Random Sample of Americans, 1989***

OCCUPATION	SCORE
Doctors (MD or DO)	86 (highest score possible)
Lawyers	75
Dentists	72
Pharmacists	68
RNs	66
Legislators	61
Chiropractors	60*
LPNs	60
Dental hygienists	52
Real estate sales	49
Waiters	28
Lay midwives	23*

*From 1970 survey; data not available on 1989 survey. In general, scores are highly stable across time, so data on occupational prestige have not been collected since 1989. Note, though, that these scores were obtained prior to the resurgence of lay midwifery.

Source: National Opinion Research Center, *General Social Surveys, 1972–1991: Cumulative Codebook*, July 1991. www.norc.uchicago.edu, accessed August 2005.

Mainstream Health Care Providers

Nursing: A Semiprofession

In everyday conversations, Americans often seem to equate health care workers with doctors. The same is true for sociologists: Although many sociologists have researched doctors, very few have researched nurses. Yet nurses form the true backbone of the health care system, and hospital patients quickly learn that it is nurses who make the experience miserable or bearable and whose presence or absence often matters most. The history of nursing demonstrates the difficulties of achieving professional status for a "female" occupation.

The Rise of Nursing

Before the twentieth century, most people believed that caring came naturally to women and, therefore, that families could always call on any female relative to care for any sick family member (Reverby, 1987). Hospitals, meanwhile, relied for custodial nursing care on the involuntary labor of

lower-class women who were either recovering hospital patients or inmates of public **almshouses.** These beginnings in home and hospital created the central dilemma of nursing: Nursing was considered a natural extension of women's character and duty rather than an occupation meriting either respect or rights (Reverby, 1987). Nevertheless, increasingly during the nineteenth century, unmarried and widowed women sought paid work as nurses in both homes and hospitals. Few of these, however, had any training.

The need to formalize nursing training and practice did not become obvious until the Crimean War of the 1850s, when the Englishwoman Florence Nightingale demonstrated that trained nurses could alleviate the horrors of war (Reverby, 1987). The acclaim Nightingale garnered for her war work enabled her subsequently to open new training programs and establish nursing as a respectable occupation.

Like most of her generation, Nightingale believed that men and women had inherently different characters and thus should occupy "separate spheres," playing different roles in society. To Nightingale, women's character, as well as their duty, both enabled and required them to care for others. She thus conceived of caring as nursing's central role. In addition, because her war work had convinced her of the benefits of strict discipline, she created a hierarchical structure in which nurses and nursing students would follow orders from their nursing supervisors. This structure, she hoped, would provide nurses with a power base within women's separate sphere parallel to that of doctors within their sphere. These principles became the foundation of British nursing. A few years later, when the U.S. Civil War made the benefits of professional nurses obvious to Americans, these principles were also adopted by American nursing.

By the early twentieth century, nursing schools had sprouted across the United States, as hospital administrators discovered that running a nursing school provided a ready pool of cheap labor. Within these hospital-based schools, education was secondary to patient care. A 1912 survey found that almost half of these schools had neither paid instructors nor libraries (Melosh, 1982: 41). Students worked on wards 10 to 12 hours daily, with work assignments based on hospital needs rather than on educational goals. Formal lectures or training, if any, occurred only after other work was done.

This exploitative training system stemmed directly, if unintentionally, from the Nightingale model and its emphasis on caring and duty. As historian Susan Reverby notes (1987: 75), "Since nursing theory emphasized training in discipline, order and practical skills, the ideological justification explained the abuse of student labor. And because the nursing work force was made up almost entirely of women, altruism, sacrifice, and submission were expected and encouraged."

Those women who, by the beginning of the twentieth century, sought to make nursing a profession by raising educational standards, establishing standards for licensure or registration, and improving the field's status found their hands tied by the nature of the field. According to Reverby, to raise its status, nursing reformers

Harper's Weekly, January 12, 1871. National Library of Medicine.

Nurses first won the respect of the American public during the Civil War.

> had to exalt the womanly character and service ethic of nursing while insisting on the right of nurses to act in their own self-interest, yet not be "unladylike." They had to demand higher wages commensurate with their skills and position, but not appear "commercial." Denouncing the exploitation of nursing students as workers, they had to forge political alliances with hospital physicians and administrators who perpetrated this system of training. While lauding character and sacrifice, they had to measure it with educational criteria in order to formulate registration laws and set admission standards. In doing so, they attacked the background, training, and ideology of the majority of working nurses. Such a series of contradictions were impossible to reconcile. (1987: 122)

Political weaknesses also hamstrung nurses' attempts to increase their status. Like other women, few white nurses could vote until 1920, and most nonwhite nurses could not do so until considerably later. Moreover, nurses faced formidable opposition from doctors and hospitals that feared losing control over this cheap workforce. Nevertheless, by the 1920s, most states had adopted licensing laws for nursing schools and nurses. But most laws were weak and poorly enforced, and so the term *registered nurse* became truly meaningful only after World War II (Melosh, 1982: 40).

Education and the Profession of Nursing

Since World War II, the major strategy used by nursing leaders to increase nurses' autonomy and status and improve their working conditions has been to increase educational requirements for entering the field (Melosh, 1982: 67–76). Beginning in the 1960s, the American Nurses Association (ANA) promoted the development of two- and four-year college-based

nursing programs and lobbied to make college education a requirement for nursing. The new college-based programs quickly proved popular, as changing social norms encouraged women to seek a college education in the hopes of improved employment opportunities.

At the same time, however, the move toward higher education challenged the qualifications of those nurses—the majority—who had not attended college, especially because the college programs did not (and still do not) accept transfer credit from noncollege training programs. The drive toward professional status, or **professionalization,** thus inadvertently limited the ANA's power by alienating most practicing nurses from the organization. As a result, only a small fraction of nurses have ever belonged to it.

The increased emphasis on educational qualifications has reinforced nursing's hierarchical structure. At the bottom of the hierarchy are nursing assistants who, as described in Chapter 10, receive minimal training. Next are the **licensed practical nurses (LPNs),** who have approximately one year of classroom and clinical training and provide mostly custodial care to patients. On the top tier are **registered nurses (RNs).**

Registered nurses themselves divide into four tiers. At the bottom of this hierarchy are diploma nurses, who receive their training through two- or three-year hospital-based diploma programs. Next are nurses who hold associate degrees in nursing from two-year community college programs, and then nurses who hold bachelor in nursing degrees from four-year colleges or universities. Finally, at the top of the RN hierarchy are **advanced practice nurses,** such as nurse practitioners and nurse-midwives, who have postgraduate training in specialized fields. All advanced practice nurses enjoy considerably more autonomy, status, and financial rewards than do other nurses, including the right to prescribe some medications in most states (Bureau of Labor Statistics, 2004; Lewin, 1993). Research published in major medical journals using randomized clinical trials—in which patients were randomly assigned to doctors or to nurse practitioners—find that care provided by nurse practitioners is as good as or better than that provided by doctors (Mundinger et al., 2000; Safriet, 1992; Sakr et al., 1999). Moreover, care provided by nurse practitioners is considerably less expensive than medical care, both because nurse practitioners are paid less and because they typically use fewer expensive tests, treatments, and medications.

Nursing's leadership has achieved considerable success in its push to increase educational qualifications. Between the 1970s and the start of the twenty-first century, the number of diploma nursing schools fell from more than 800 to less than 100; diploma nurses now comprise about 20 percent of all practicing nurses, but less than 5 percent of recent graduates (Bureau of Labor Statistics, 2004; National League for Nursing, 2004). However, because associate degree programs offer a quicker route to paid employment than do bachelors degree programs, the former enroll about 10 percent more students than the latter (National League for Nursing, 2004). But because bachelors degrees are required for most of the better-paying nursing

jobs (in administration and specialized fields), many who start with associate degrees eventually seek bachelors degrees.

The greatest growth in recent years has occurred in graduate degree programs for advanced practice nurses, although only a small fraction of nurses have completed such programs. These programs first appeared during the 1960s, in response to projections of a coming shortage of doctors. They now offer a wide range of career options with considerably more autonomy and higher pay than other nursing work. Those who earn masters degrees may work in fields such as anesthesiology, nurse-midwifery, or radiology, while those who earn doctoral degrees typically seek work as researchers or college professors.

Despite the increase in nurses' education, caring has remained central to nurses' work. Using data collected during three years of observing nurse practitioners and family practice doctors, Sue Fisher (1995) concluded that nurse practitioners spend more than five times as long with each patient as do doctors, using this additional time to gain a **holistic** sense of their patients' clinical problems and social situations. Whereas doctors typically rely on closed-ended questions, tightly control which topics are discussed during patient visits, and seek to close discussions quickly, nurse practitioners rely heavily on open-ended questions, give patients more freedom to open topics, and do not push to close discussions. In addition, whereas many doctors routinely reinforce their dominance both verbally and nonverbally (by, for example, never addressing patients by name or implying that patients cannot accurately describe their own problems), nurse practitioners downplay differences in status between themselves and patients and assume that patients can accurately assess their own situations. On the other hand, like doctors, nurse practitioners retain final authority in patient-provider interactions—opening and closing discussions, asking most of the questions and thus determining which topics will be discussed, and, in the end, defining the nature of the problem.

The Rise of Specialized Nursing

Like the move toward higher education, the rise of specialized nursing has increased the professional status of some nurses. According to sociologist Andrew Abbott (1988), occupations rarely gain full professional dominance over directly competing occupations. Instead, occupations typically achieve professional status by carving out niches for themselves where there is less competition.

Research suggests that nurses can gain increased status through doing what would otherwise be low-status work if that work affords them recognition of their specialized knowledge as well as public respect for taking on work perceived as dangerous and unpleasant (Aiken and Sloane, 1997). This happened serendipitously with the development of "dedicated" AIDS wards (devoted solely to caring for persons with AIDS) during the 1980s. A nationwide survey conducted in 1988 found that compared with nurses on

other wards, nurses on dedicated AIDS wards enjoyed greater professional status, control over their work environment, and professional autonomy, as well as better relations with physicians, less burnout, and less emotional exhaustion (Aiken and Sloane, 1997). On these wards, doctors were willing to cede some autonomy and responsibility to nurses because doctors were not particularly interested in providing the low-technology, palliative care persons with AIDS most often need. In addition, on these units, nurses gained specialized knowledge as great as, if different from, that of doctors. Equally important, whereas on general wards each doctor shares only a handful of patients with each nurse, on dedicated AIDS wards doctors and nurses routinely work together on the same patients, giving doctors more opportunities to witness nurses' expertise and thus making doctors more willing to treat nurses as colleagues. Finally, nurses' willingness to do dangerous and often unpleasant work caring for stigmatized patients enhanced their public image as dedicated professionals.

The Impact of Changing Gender Roles

Changing gender roles in the broader society has the potential either to help or hinder nursing's attempts to professionalize. Over the last three decades, as women have gained entry to other fields, intelligent and motivated women increasingly have chosen to enter medicine, pharmacy, or biological research instead of nursing (*New York Times,* 1999a; D. Williams, 1988); enrollment in nursing programs dropped by almost one-quarter between 1993 and 2003 (National League for Nursing, 2004). As a result, nursing no longer attracts the type of students it once could have counted on for its future leadership. For the same reason, nursing now attracts fewer white students and middle- or upper-class students. Given existing social prejudices, these changes are likely to reduce the status of nursing even if the quality of students remains constant. Finally, because women now *can* enter medicine, the public typically assumes that no intelligent woman would instead choose to enter nursing, and so underestimates the abilities of those who do enter the field (S. Gordon, 2005).

Changing gender roles not only have encouraged women to seek careers other than nursing, but also have opened nursing to men. Men currently constitute about 6 percent of employed nurses and 10 percent of recent nursing graduates (National League for Nursing, 2004). Because nursing is so strongly identified with femininity, working as a nurse presents men with a serious conflict between their gender identity and their work identity. Christine Williams (1989) found that men typically respond to this conflict by stressing the differences between what they do and traditional nursing—de-emphasizing nurturing while emphasizing their technical skills, administrative expertise, or use of physical strength.

Despite these difficulties, working as a nurse offers men substantial benefits. Williams (1989: 95) points out that "as in other female-dominated occupations, men are over represented in the most prestigious and best

paying specialties" and in administrative positions. This occurs for two reasons. First, on average male nurses have more years of education than female nurses do. Second, both male and female doctors more often respect, support, and socialize with male nurses than with female nurses, giving the men help in their careers and encouragement to enter more prestigious subfields. According to Christine Williams (1992), whereas women in nontraditional fields (such as medicine) often encounter a **glass ceiling** caused by conscious discrimination and unconscious social expectations that limit their career progress, men in nursing, as in other predominantly female fields such as social work, encounter a **glass escalator** that moves them into administrative positions unless the men actively resist. It seems, then, that entering a traditionally female field such as nursing benefits male nurses.

Whether the entry of men into nursing will improve the overall status of the field, counteract the loss of academically superior and socially prestigious women students, and raise the status of the field overall, however, remains to be seen.

Nurses and the Changing Health Care System

Since the 1970s **corporatization** and the resulting emphasis on cost control has resulted in worse working conditions and decreased job satisfaction for most hospital-based nurses. To save costs, hospitals try to release patients before their insurance coverage ends, which of necessity means patients are now released sicker and quicker than in the past. Yet to keep their staffing costs as low as possible, hospitals now hire considerably fewer RNs per patient than they used to (S. Gordon, 2005). As a result, the typical hospital ward now has fewer nurses but sicker patients than in the past.

Other changes have also worsened nurses' position. First, because RNs can perform more tasks more efficiently than LPNs, hospitals now save money by assigning to RNs many of the labor-intensive, menial tasks formerly performed by LPNs. Because RNs remain responsible for many administrative and skilled technical tasks, this shift has both deprofessionalized their daily work and dramatically increased their workload (Aiken, Sochalski, and Anderson, 1996; Brannon, 1996; S. Gordon, 2005). Second, hospitals increasingly save money by hiring nurses temporarily (without benefits) or moving full-time nurse employees from ward to ward as needed, leaving nurses with little control over their schedules, the nature of their work, and who they work with. Third, hospitals have saved costs by shifting services from inpatient wards to less-expensive outpatient clinics, where fewer RNs are needed, RN salaries are lower, and their work is less prestigious (Norrish and Rundall, 2001). Finally, nurses are increasingly pressured to work back-to-back shifts and longer hours (often unpaid). Given all these changes, it is perhaps not surprising that enrollment in nursing schools has declined almost steadily since 1990 and that the dropout rate from nursing careers is very high (S. Gordon, 2005).

The Continuing Doctor-Nurse Game

The dilemmas nurses faced in gaining acceptance as a full profession are reflected in what Leonard Stein (1967) dubbed the **doctor-nurse game.** According to Stein:

> the object of the game is as follows: The nurse is to be bold, have initiative, and be responsible for making significant recommendations, while, at the same time, she must appear passive. This must be done in such a manner so as to make her recommendations appear to be initiated by the physician. (1967: 699)

In other words, inexperienced doctors are expected to use subtle verbal cues to elicit treatment recommendations from more experienced nurses, and nurses are expected to just as subtly make their recommendations (S. Gordon, 2005). For example, an experienced surgical nurse might subtly tell an inexperienced doctor what to do by selecting which instruments to place on the table and by telling the patient step by step what the doctor is about to do. In addition, nurses often do the work of doctors—prescribing drugs, tests, or physical therapy—when doctors are unavailable, but the doctors can still reinforce the doctor-nurse game by loudly stressing that the nurses are simply following the doctors' known preferences rather than making decisions on their own. Even when patients' lives are saved by nurses' quick action, the doctors typically are given the credit by patients, administrators, and other doctors (S. Gordon, 2005).

In recent years, the doctor-nurse game has become less common in areas such as emergency rooms and intensive care units, where the need for split-second decisions makes this sort of subterfuge not only counterproductive but dangerous (Stein, Watts, and Howell, 1990). In the rest of the health care world, however, the game is alive and well (S. Gordon, 2005). Moreover, relationships between doctors and nurses remain so hierarchical that they are sometimes abusive. Almost all nurses who responded to a 2002 national survey reported either experiencing or witnessing incidents in which doctors screamed at nurses, hit or threw things at nurses, abusively criticized them, or in some other way made it difficult for them to function (Rosenstein, 2002).

As these problems suggest, the increased educational qualifications of nursing has enabled it to achieve only **semiprofessional** status, achieving some but not all of the hallmarks of a profession. Although most nurses consider themselves professionals and although nurses have more autonomy and status than in the past, they remain subordinate to doctors. In hospitals and clinics, the status difference between doctors and nurses is immediately visible (S. Gordon, 2005). Doctors rarely or never read nurses' notes on patients' charts, eat with nurses in hospital cafeterias, include nurses in discussions on hospital rounds, or invite nurses to medical mortality review meetings. And doctors expect to be referred to by their title—"Dr. Smith"—while referring to nurses by their first names or simply as "my nurse." In addition, doctors

continue to determine much of nurses' working conditions and to help set educational and licensing standards for nurses. Finally, despite the growth of nursing colleges and graduate degree programs, nursing has yet to develop public confidence that it has the truly independent knowledge base that defines a profession.

Nurse-Midwifery: The Limits of Specialization

The example of nurse-midwifery, one of the oldest forms of advanced practice nursing, illustrates both the benefits and the limitations of seeking professional status for a field by carving out a specialized niche.

Throughout the nineteenth century, almost all American babies were delivered at home by lay midwives who lacked specialized training and worked within their own geographic or ethnic communities (R. Wertz and D. Wertz, 1989). By the 1920s, however, most Americans had come to believe that doctor-assisted childbirth was safer and, certainly, less painful. Yet few doctors were interested in providing care to poor or rural women. Responding to this need, in 1925 the Frontier Nursing Service opened the first school for nurse-midwives, with the aim of serving Kentucky's rural poor. **Nurse-midwives** would be registered nurses who additionally received formal, nationally accredited training in midwifery. The students who trained in Kentucky learned not only to deliver babies but also to provide all needed prenatal and postnatal care. Seven years later, the Maternity Center Association began training nurse-midwives to serve New York City's urban poor.

These two organizations remained the only sources of nurse-midwives until the 1950s, when several universities, responding to widely publicized reports of an impending shortage of doctors, opened training programs. As of 2005, more than forty colleges and universities offer accredited training programs in nurse-midwifery, mostly at the master's level. In addition, the American College of Nurse-Midwives now accredits programs to train individuals who have no nursing background as "certified midwives." These programs combine basic education in health skills and medical science with the usual graduate midwifery curriculum.

Like previous generations of nurse-midwives, current nurse-midwives are expected to work primarily for bureaucratic organizations in underserved poor and rural areas. However, whereas earlier nurse-midwives had functioned largely independent of doctors and hospitals, now nurse-midwives are expected to deliver babies solely in hospitals and to take responsibility solely for normal births, which doctors considered routine, uninteresting, and poorly paid.

From its beginnings, then, nurse-midwifery was designed to avoid threatening medical dominance. Nevertheless, during the 1970s and 1980s growing numbers of nurse-midwives began to pose a threat by opening private practices with only loose connections to the doctors who provided their backup support (Lehrman, 1992).

This threat to medical dominance, however, was short-lived, for changes in insurance coverage during the early 1990s made independent practice virtually impossible for nurse-midwives. The costs of a standard malpractice insurance policy rose from $35 in 1983 to as high as $13,500 in 1998 (R. Gordon, 1989; Rooks, 1997: 86). Insurance became even more expensive for midwives who attended home births, as well as for the doctors who worked with them. This rise in insurance costs is difficult to explain, for only about 10 percent of nurse-midwives (compared with 73 percent of obstetricians) have ever been sued for malpractice (American College of Obstetrician-Gynecologists, 1998; Lehrman, 1992). Similarly, studies consistently find that, for women at low risk of complications, care by nurse-midwives (at home or in hospitals) is at least as safe as medical care in hospitals (MacDorman and Singh, 1999; Rooks, 1997: 295–343). Unfortunately, the rise in insurance premiums has caused nurse-midwives to virtually abandon independent practice, home births, and freestanding birth centers.

On the other hand, nurse-midwives have legal authority to practice and to write prescriptions in all 50 states. Thirty-three states require private health insurers to reimburse nurse-midwives for their services, and all states reimburse midwives for serving **Medicaid** clients. However, these regulations do not apply to employers who **self-insure,** setting aside a pool of money to pay health care costs for their employees rather than offering health insurance as a benefit (American College of Nurse-Midwives, 1998); self-insurance now covers about 70 percent of insured U.S. workers.

In sum, nurse-midwives have gained considerable autonomy and public recognition, as well as an established place for themselves in the health care system, through specialized training and providing care to specific populations. Their ability to gain greater professional status and independence from medical control, however, remains restricted.

Pharmacy: The Push to Reprofessionalize

Unlike nursing, pharmacy meets the three criteria (laid out in Chapter 11) that define a profession: the autonomy to set its own educational and licensing standards and to police its members for incompetence or malfeasance; a body of specialized knowledge, learned through extended, systematic training; and public faith that its work is grounded in a code of ethics. Like medicine, however, pharmacy's history illustrates how corporatization can limit an occupation's ability to retain crucial professional prerogatives. In addition, its history shows how medical dominance limits competing occupations' ability to maintain professional status.

Gaining Education, Losing Professional Prerogatives

Pharmacists' role has changed considerably during the last half century, placing their professional status in jeopardy (Birenbaum, 1982). In the past, pharmacists needed complex skills to store, compound, and dispense the

drugs that doctors prescribed. Now, however, pharmaceutical companies deliver drugs in forms suitable for dispensing, leaving pharmacists with few tasks other than counting, selling, and occasionally advising on drugs to consumers or health care providers. At the same time, whereas before about 1970 more than half of pharmacists owned their own businesses, with the associated responsibilities and rewards, now most work as employees of drugstore chains, supermarket chains, or hospitals. Incomes for pharmacists remain high, with a median income of $77,050 in 2002 (Bureau of Labor Statistics, 2004); but working conditions can be poor, especially in chain stores, where twelve-hour shifts, staffing shortages, and pressure to fill prescriptions quickly are common (Stolberg, 1999). Like doctors, then, pharmacists have experienced proletarianization: They are more economically vulnerable than in the past, have less decision-making autonomy, and no longer set their own working conditions, own their tools or workspaces, or maintain individual relationships with freely chosen clients.

As pharmacists' role has shrunk, however, their education has expanded. Virtually all of the nation's pharmacy schools have replaced their older four- and five-year degree programs with six-year programs leading to doctorates in pharmacy. These new programs place less emphasis on technical aspects of drug manufacturing and more on the complex subject of drug effects and interactions (Broadhead and Facchinetti, 1985: 427). These changes in education, combined with changes in pharmacists' role, have created an identity crisis: pharmacists consider themselves professionals, but increasingly find their professional autonomy constrained (Birenbaum, 1982; Broadhead and Facchinetti, 1985).

The Growth of Clinical Pharmacy

This identity crisis has stimulated interest among pharmacists in regaining their former level of professional status, or **reprofessionalizing.** To do so, pharmacists, beginning in the early 1970s, began touting research studies suggesting that many hospital patients become ill or die because of drug errors—summed up in the influential book *Pills, Profits, and Politics* (Silverman and Lee, 1974: 262) as "wrong drug, wrong dose, wrong route of administration, wrong patient, or failure to give the prescribed drug." Because pharmacists considered themselves more knowledgeable than doctors about drug actions, reactions, and interactions, they argued that the best way to limit drug errors was to encourage **clinical pharmacy,** in which pharmacists actively advise doctors on drug treatment, while less-skilled pharmacy technicians take over the routine tasks of storing and dispensing drugs.

The push for clinical pharmacy garnered unintended support from changes in hospital procedures (Broadhead and Facchinetti, 1985). Most hospitals now have pharmacists dispense and deliver medications to each patient daily. This system gives pharmacists regular access to patient records, including all records regarding drug treatments, health status, and progress. As a result, pharmacists can evaluate the effects—both positive and negative—of

doctors' drug prescriptions and learn to predict when prescriptions are likely to cause health problems.

Other support for clinical pharmacy has come from changes in the legal system. Whereas during the 1980s, hospitals discouraged pharmacists from documenting medication errors—out of fear that such documentation might *increase* hospitals' legal liability—from the 1990s to the present, court decisions that held pharmacists legally responsible for monitoring medications have led hospitals to encourage clinical pharmacy as a means of *reducing* hospitals' legal liability. Nevertheless, pharmacists' concern about preserving cordial roles with doctors, who remain the dominant professionals in the health care arena, has led them to use caution in critiquing doctors' medication decisions. As one pharmacist described:

> I would like to talk to the physician face-to-face. You're trying to correct the mistake in a nonthreatening way. You know, "I'm not trying to put you down for making this mistake, but it's something that I want you to reconsider." It's not that I'm afraid to confront a physician, bending over backwards because he's up there and I'm down here. It's just that I want to maintain a relationship and the way you interact is important. (Broadhead and Facchinetti, 1985: 432)

The Development of Pharmaceutical Care

The growth of clinical pharmacy had little impact on pharmacists who worked outside of hospitals and increased divisions between them and hospital pharmacists. The development of "pharmaceutical care," however, has given these two groups a unified program for cementing the professional status of pharmacists (Mount, 1999). **Pharmaceutical care** refers to the idea that pharmacy's central mission should be to advise consumers (rather than doctors, as in clinical pharmacy) regarding the proper use of medications, based on knowledge gathered through **controlled** studies based on **random samples** (Hepler and Strand, 1990). Its rapid adoption by virtually all pharmacy associations reflects both insurers' concerns about cost control and pharmacists' hope that pharmacy care will improve their professional status.

The Impact of Managed Care

Ironically, **managed care** and **utilization review,** which have limited doctors' professional status, have increased the professional power and status of at least some pharmacists. In the last decade, many pharmacists working for health care businesses that use managed care (including insurance plans, hospitals, and nursing homes) have become actively involved in developing **practice protocols** for doctors to follow in prescribing drugs. Pharmacists also may participate in utilization review, monitoring doctors' use of prescription drugs. Similarly, some pharmacists now serve on committees responsible for developing **formularies**—official lists of drugs, published by insurers and other health care businesses, that are considered the most cost-effective treatments

for given conditions and that doctors working with these organizations are expected to prescribe. Formularies offer pharmacists real power. For example, the previously popular antacid Tagamet lost virtually all its sales when pharmacists replaced it on formularies with Zantac, which is both safer and easier to use (*Fortune,* 1999).

The rise of managed care also has improved pharmacists' position by stimulating growth in **disease management.** Disease management (sometimes known as health management) is a form of pharmaceutical care in which pharmacists are responsible for monitoring the use of prescription drugs by certain patients (typically those with chronic conditions that require constant attention to medication). Pharmacists engaged in disease management counsel patients, monitor the impact of medications on patients, and, in some circumstances, prescribe drugs themselves. Managed care organizations have adopted disease management as a way to control costs by preventing medication errors and by shifting care from doctors to lower-paid pharmacists. Some states reimburse pharmacists under Medicaid for disease management of certain groups of patients, and more than half the states give pharmacists legal authority (in collaboration with physicians) to initiate or modify drug treatment (Garrett, 2002).

Osteopathy: A Parallel Profession

Osteopathy exemplifies a health care occupation that has achieved professional status almost equal to that of medicine. Osteopaths function as **parallel practitioners,** performing basically the same roles as **allopathic doctors** while retaining professional autonomy and at least remnants of a fundamentally different ideology about illness causation (Wardwell, 1979). The history of osteopathy demonstrates the benefits and costs of gaining professional status in the face of medical dominance.

Nineteenth-Century Roots

Osteopathy was founded by Andrew Taylor Still, a self-taught allopathic doctor (Gevitz, 1988). In 1864 three of his children died from meningitis. These deaths, coupled with his belief that the use of any drug was immoral, provoked Still to investigate alternatives to allopathic medicine. The system Still eventually developed drew on the popular contemporary concept of "magnetic healing" (Gevitz, 1988: 126–127). **Magnetic healers** theorized that an invisible magnetic fluid flowed through the body and that illness occurred when that flow was obstructed, unbalanced, inadequate, or excessive. They believed that by moving their hands along patients' spinal cords, they could correct problems in the magnetic fluid and thus cure illness. Still adopted this theory essentially intact, although he attributed health and illness to problems in the flow of blood rather than the flow of magnetic fluid.

During the next few years, Still also studied the work of local bonesetters, whose work consisted primarily of setting broken and dislocated bones and

joints and secondarily of treating joint problems through extending and manipulating limbs. Still's experiences convinced him that such manipulations could cure a wide variety of illnesses.

Combining magnetic healing and bonesetting, Still concluded that disease occurs when misplaced bones, especially of the spinal column, interfere with the circulation of blood. He named his new system of spinal manipulation *osteopathy,* from the Greek words for "bone" and "sickness." After the germ theory of disease became widely accepted, Still incorporated it into his theory by arguing that spinal problems predispose individuals to infections and that correcting spinal problems can help the body fight infection. To date, no research has demonstrated clearly whether osteopathic treatment has any effect, whether positive or negative. (The same, of course, could be said for most drugs and procedures used by allopathic doctors, as we saw in Chapter 11.)

Professionalizing Osteopathy

In 1892, Still established the American School of Osteopathy and began accepting students for a four-month course of instruction. Five years later, in 1897, he helped found the American Osteopathic Association (AOA). As Gevitz describes:

> from its inception, the AOA actively worked to secure the conditions necessary for the movement to obtain professional recognition. It fought for independent boards of registration and examination to give the profession autonomy; it significantly lengthened the standard course of undergraduate training and supported ongoing research projects; and it championed a code of ethics while combating the growth of impostors and imitators. (1988: 132–133)

The AOA proved highly successful. By 1901, and despite strong opposition from doctors and medical societies, fifteen states legally recognized osteopathy (Gevitz, 1988: 132). By 1923, osteopathic colleges required as many years of education as medical colleges, and forty six of the forty eight states licensed osteopaths, although many states gave them only limited privileges and required them first to pass a basic sciences examination written and administered by allopath-controlled licensing boards.

Although threats from allopathic medicine have failed to eliminate osteopathy, changes from within raise questions about osteopathy's future as an independent field. By the 1920s, most osteopaths had concluded that to compete with allopathic doctors they would have to offer a similar range of patient services. As a result, osteopaths increasingly treated acute as well as chronic illness. Osteopathic colleges continued to teach spinal manipulation but added courses in surgery and obstetrics, often taught out of medical textbooks. By the end of the decade, in a major break with its founder, the AOA mandated that osteopathic colleges provide a course in "supplementary therapeutics," including drugs. Thus osteopathy began moving toward a merger with allopathic medicine.

Despite these changes, many allopathic doctors still disdained osteopaths. Although osteopathic education had improved, it had not kept up with the changes in allopathic education, leading many states to grant only restricted privileges to osteopaths. To combat this problem, the AOA adopted a series of reforms between 1935 and 1960, including requiring three years of college for admission to osteopathic colleges; improving the curriculum, facilities, and faculty at those colleges; and strengthening internship programs at osteopathic hospitals. Because of these changes, by 1960 osteopaths had received unrestricted privileges to practice in thirty-eight states (Gevitz, 1988: 144).

The Waning of Osteopathic Identity

Despite these reforms, osteopaths still lacked the professional autonomy and status of allopathic doctors, who outnumbered them by at least twenty to one throughout the 1900s (Gevitz, 1988: 146). This situation led osteopaths in California, the state where osteopathy was most entrenched, to strike a bargain in 1962 with their allopathic counterparts. Two thousand of the 2,300 California osteopaths agreed to dissolve their ties with the AOA, stop using their osteopathic degrees, and accept new medical degrees. The California osteopathic hospitals and colleges agreed to become allopathic institutions, and the state osteopathic organization agreed that the state would stop issuing osteopathic licenses.

Although at the time many osteopaths worried that this move would weaken osteopathy, the reverse proved true. Many allopathic and osteopathic doctors alike opposed the merger, making any further mergers unlikely. In addition, the continuing professional problems of the former California osteopaths convinced osteopaths elsewhere that merging would not end their problems. Thus, interest in pursuing a broader merger never developed. Meanwhile, both federal and state legislators and regulators interpreted American Medical Association (AMA) support for the merger to mean that osteopathic and allopathic doctors were essentially equivalent. Partly as a result, by the 1970s osteopaths had received unrestricted privileges in all fifty states and now have essentially the same relationship with insurance providers as do allopathic doctors. As of 2005, there were 54,000 osteopaths practicing in the United States—more than twice the number in practice in 1976 (American Osteopathic Association, 2005).

Osteopathy, then, no longer faces serious threats from the outside. Its existence remains threatened, however, by its success (Gevitz, 1988). Osteopaths now receive training and hospital privileges virtually identical to allopathic doctors and interact with the latter as equals. Although osteopaths occasionally use spinal manipulation, generally they use the same treatment modalities as allopaths. As a result, ties among osteopaths have waned while those to allopathic doctors have grown. At the same time, the virtual elimination of differences between allopathic and osteopathic treatment and theory has reduced osteopaths' sense of a strong separate identity.

On the other hand, the growth of the consumer health movement and the rise of interest in alternative medicine since the 1970s have given a new burst of life to osteopathy. Modern consumers are increasingly sympathetic to osteopaths' orientation toward patient care, which in general is more holistic and humanistic than that found among allopathic doctors. In addition, consumers increasingly have sought less interventionistic treatments, such as osteopathic manipulation, either instead of or in addition to allopathic treatment.

In sum, the history of osteopathy demonstrates the benefits of achieving full professional status as well as the difficulties a parallel health care profession can face in maintaining an independent identity once it no longer faces discrimination from the medical world and once the ideological justification for its separate existence wanes.

Alternative Health Care Providers

The occupations described to this point all basically share allopathic medicine's understanding of how the body works, and all enjoy significant roles within the mainstream health care system. The occupations described in the remainder of this chapter are sufficiently divorced from mainstream American medicine—neither widely used nor taught in medical schools or other medical institutions—to be considered **alternative** or **complementary therapies,** even if they sometimes are covered by health insurance.

With a few exceptions (such as chiropractic, lay midwifery, and acupuncture), little is known about the effectiveness of alternative healing techniques, which include meditation, reflexology, faith healing, herbal therapies, and colonics. Because allopathic medicine has dominated the American health care system for so long, researching alternative therapies has been all but impossible. Scientific testing requires large investments of time and money, generally available only from the government, universities, or pharmaceutical companies. Until recently, researchers who wanted to study alternative techniques faced nearly insurmountable barriers to obtaining funding, especially from pharmaceutical companies, which have no reason to fund research on herbs or techniques that they cannot patent. In addition, researchers who studied these techniques faced great difficulties in getting their results published in the prestigious medical publications that set the standards for health care practice.

In 1992, however, and in a major break with past policy, the U.S. Congress voted to establish within the National Institutes of Health (NIH) an Office for the Study of Unconventional Medical Practices (later renamed the Office of Alternative Medicine). The major impetus for this legislation came from former California Congressman Berkley Bedell, who had experimented with alternative therapies after his doctors diagnosed him with terminal cancer. His apparently successful experiences convinced him that such treatments warranted wider study and use. Bedell's success in getting this legislation

Key Concepts 12.1

Limited and Marginal Health Care Occupations

		Limited Range of Care	
		Yes	**No**
Marginal social position	**Yes**	Lay midwives	Traditional healers
	No	Chiropractors	Allopathic doctors

passed reflects legislators' recognition of both the soaring costs of mainstream medical care and the growing public interest in alternative health care. In 1999, NIH budgeted $50 million for research into alternative healing, an increase from only $2 million in 1992, and upgraded the Office of Alternative Medicine into a full-fledged NIH center, the National Center for Complementary and Alternative Medicine.

Interest in alternative healing is growing not only among American consumers but also among allopathic doctors. As of 2005, almost 1,000 doctors and allied health professionals belong to the American Holistic Medical Association, and more than 95 of the nation's 125 medical schools require some kind of complementary and alternative medicine coursework (Loviglio, 2005). Even more impressive, a survey distributed to allopathic doctors in several communities in Washington State and New Mexico found that more than 60 percent had referred a patient to an alternative health care provider at least once during the preceding year (Borkan et al., 1994). However, referrals most often occurred when patients requested them, conventional treatment had failed, or physicians believed that the patients' problems were emotional rather than physical.

In the remainder of this chapter, we examine five groups of alternative health care providers. The first two, chiropractors and lay midwives, at least sometimes use the language of science to justify their work. The three remaining groups, curanderos, Christian Science healers, and traditional acupuncturists, base their practices in traditional beliefs unrelated to the Western scientific worldview.

Chiropractors: From Marginal to Limited Practitioners

Unlike osteopaths, **chiropractors** have fully retained their unique identity. (See Key Concepts 12.1.) The history of chiropractic illustrates how marginal practitioners, who treat a wide range of physical ailments and illnesses but have low social status, can become, like podiatrists, optometrists, and dentists, **limited practitioners**—confining their work to a limited range of treatments and bodily parts and thereby gaining greater social acceptance (Wardwell, 1979: 230).

Early History

The roots of chiropractic nearly mirror those of osteopathy. Chiropractic was founded in 1895 by Daniel David Palmer, who coined the term from the Greek words for "hand" and "practice." Like Still, Palmer studied magnetic healing and spinal manipulation and concluded that spinal manipulation could both prevent and cure illness. However, whereas Still argued that spinal problems foster disease by restricting blood flow, Palmer argued that spinal problems foster disease by restricting nerves.

In 1896, Palmer founded the first chiropractic school to teach his techniques of spinal manipulation. The field really began growing after his son, B. J. Palmer, took over the school in 1907. By 1916, about 7,000 chiropractors had opened practices; by 1930, that number had more than doubled, as schools opened around the country (Wardwell, 1988: 159, 174).

Although from the beginning, some allopathic doctors studied chiropractic and taught at chiropractic schools, B. J. Palmer attempted to sharply separate chiropractic and allopathic medicine. Those who shared his philosophy and used only spinal manipulation became known as "straights." Most chiropractors, however, found Palmer's theory of illness too simplistic and limiting, and so adopted a wide variety of therapeutic techniques. These "mixers" treated not only musculoskeletal problems but also other illnesses, as well as providing obstetrical and mental health care (Wardwell, 1988: 162–165).

The Fight Against Medical Dominance

The American medical establishment greeted the emergence of chiropractic with the same hostility it had demonstrated toward osteopathy. To eliminate these competitors, the AMA and its regional organizations during the 1930s and 1940s filed lawsuits—many of them successful—against more than 15,000 chiropractors for practicing medicine without a license.

To further restrict chiropractic, the AMA pressed for legislation requiring prospective chiropractors to pass statewide basic science examinations written by allopathic-controlled boards. Ironically, this requirement strengthened rather than weakened chiropractic by forcing the field to raise its previously low educational standards. (As with early allopathic and osteopathic schools, early chiropractic schools accepted essentially all who could pay tuition and offered only a few months of training.) Standards improved most dramatically during the 1940s, when the National Chiropractic Association (NCA) established accrediting standards for schools and when tuition money from veterans studying chiropractic under the federal GI Bill provided the funds schools needed to meet those standards. Since 1968, all chiropractic schools have required two years of college for admission, and most states require four years of chiropractic schooling for licensure.

Similarly, chiropractic in the end benefited from allopathic medicine's legal war against it. When **Medicare** first began in 1965, Congress bowed

to pressure from the AMA and voted that Medicare would not cover services by chiropractors (or by clinical psychologists, social workers, physical therapists, and others in competition with doctors). Outraged chiropractic patients responded with a massive public letter-writing campaign, which led Congress in 1972 to pass legislation extending Medicare coverage to chiropractic services, despite the lack of scientific research available at the time on its effects. This set the stage for state legislatures to require other insurance plans to reimburse for chiropractic care, at least in certain situations (Wardwell, 1988: 179).

In 1974, the last of the fifty states passed legislation licensing chiropractors. Yet organized medicine continued to limit the ability of chiropractors to practice freely. In addition to fighting legislation designed to allow chiropractors to receive private insurance reimbursement, the AMA banned contact between chiropractors and allopaths, making it impossible for chiropractors and allopaths to refer patients to each other. In response, chiropractors and their supporters filed antitrust suits in the late 1970s against the AMA, various state medical associations, the American Hospital Association, and several other representatives of organized medicine (as well as the AOA), alleging that these organizations had restrained trade illegally. Chiropractors and their defenders eventually won or favorably settled out of court all the suits. As a result, overt opposition to chiropractic ended.

Current Status

These changes have allowed chiropractors to solidify their social position. Use of chiropractic is widespread and increasing across the country. A 2002 national random survey found that 7.4 percent of English-speaking U.S. residents had visited a chiropractor in the last year (Tindle et al., 2005). A separate survey of chiropractors' patient records found that chiropractic patients were typically between 30 and 50 years old and married, and slightly more likely to be female than male (Hurwitz et al., 1998).

For the past 30 years, the 16 U.S. schools of chiropractic have continued to graduate increasing numbers of students. Approximately 49,000 chiropractors work in the United States, most in solo practice (Bureau of Labor Statistics, 2004). Median net income for chiropractors is $81,500—considerably below the $137,000 median for general and family practitioners but for a much shorter work week, averaging about 40 hours (Bureau of Labor Statistics, 2004). These figures alone suggest chiropractic's success.

That success, however, is bounded by chiropractors' status as limited practitioners. Insurers now often pay for chiropractic services—about half of the people who use chiropractic services have full or partial coverage—but usually will do so only for treating specific conditions in specific ways (Tindle et al., 2005). State licensure laws sometimes set similar limits, as does patient demand—despite chiropractic's desires to treat a broader range of problems, most patients go to chiropractors for treatment of

acute lower back pain, and only 1 percent are seen for anything other than musculoskeletal problems (Hurwitz et al., 1998).

Nevertheless, chiropractors continue to push for a wider role in health care. Many chiropractors believe spinal problems underlie all illness and that spinal manipulation can cure most health problems, from asthma to cancer (*Consumer Reports,* 1994). As a result, they believe they can serve effectively as **primary care** providers and now advertise heavily that they offer care for the whole family throughout the life course.

Current research suggests that chiropractic care may help those with acute lower back pain, but is unlikely to help others. One study in which patients with acute lower back pain were randomly assigned to receive chiropractic care, physical therapy, or simply an educational booklet on managing back pain found that both chiropractic and physical therapy were more effective in reducing symptoms than was the educational booklet. However, the improvements were slight, and chiropractic proved no more effective than physical therapy. Moreover, the three therapies did not differ significantly in number of days of reduced activity or in rate of recurrence of back pain (Cherkin et al., 1998). Other studies suggest that spinal manipulation might help some patients with neck pain, but to date none has tested whether manipulation is *more* effective than other treatments or whether its risks (including delays in seeking medical care, strokes brought on by spinal manipulation, and radiation poisoning from the full-body X-rays used by some chiropractors) outweigh any potential benefits (Shekelle, 1998). Finally, no reputable research has yet demonstrated any benefits from chiropractic for health problems other than neck and back injuries. Nor does it seem likely that future research will do so, because the basic principles of chiropractic simply do not mesh with current scientific understanding of human biology.

Lay Midwives: Limited but Still Marginal

The history of lay midwifery shows the difficulties members of an occupation face in gaining acceptance as limited practitioners when the occupation draws only from socially marginal groups—in this case, women, often from minority groups. Although until the twentieth century lay midwives delivered the majority of American babies, by 2002 lay and nurse-midwives combined delivered only 8.2 percent; of these, 95 percent were delivered by nurse-midwives and only 5 percent by lay midwives (J. Martin et al., 2003). However, these percentages, although small, have increased steadily since 1975, when the federal government began collecting statistics on midwife-assisted births. In this section we consider how these changes came about and how lay midwives have attempted to regain their lost position.

The Struggle to Control Childbirth

Until well into the nineteenth century, Americans considered childbirth solely a woman's affair (R. Wertz and D. Wertz, 1989). Almost all women

gave birth at home, attended by a lay midwife or by female friends or relatives. Although a few local governments during the colonial era licensed midwives, licensure laws did not survive past U.S. independence, so anyone who wanted to call herself a midwife could practice essentially without legal restrictions. Unlike nurse-midwives, who did not exist until the twentieth century, these **lay midwives** had no formal training but rather learned their skills through experience and, sometimes, through informal apprenticeships. Typically, they served only women from their geographic or ethnic community. Doctors (all of whom were men) played almost no role in childbirth, because Americans suspected the motives of any men who worked intimately with female bodies (R. Wertz and D. Wertz, 1989: 97–98). Moreover, doctors had little to offer childbearing women beyond the ability to destroy and remove the fetus when prolonged labor threatened women with death. Midwives, meanwhile, could offer only patience, skilled hands, and a few herbal remedies.

During the late nineteenth century, Americans' willingness to have doctors attend childbirths gradually increased, as did doctors' interest in doing so. As described in Chapter 11, nineteenth-century allopathic doctors faced substantial competition not only from each other but also from many other kinds of practitioners. As a result, doctors attempted to expand into various fields, from pulling teeth to embalming the dead to assisting in childbirth (Starr, 1982: 85). Doctors considered assisting in childbirth especially crucial because they believed that families who came to a doctor for childbirth would stay with him for other services (R. Wertz and D. Wertz, 1989: 55).

As Americans' belief in science and medicine grew during the late nineteenth century, medical assistance in childbirth became more socially acceptable among the upper classes (Starr, 1982: 59). Many women supported this change because it allowed them to obtain painkillers from doctors without feeling guilty for circumventing the biblical command to bring forth children in pain (R. Wertz and D. Wertz, 1989: 110–113). In addition, because midwifery was not a respectable occupation for Victorian women, by the late nineteenth century middle- and upper-class women seeking a childbirth attendant had only two options: lower-class lay midwives or doctors of their own social class. Having a doctor attend one's childbirth thus could both reflect and increase one's social standing (Leavitt, 1986: 39; R. Wertz and D. Wertz, 1989). Ironically, however, doctors probably threatened women's health more than did midwives; although inexperienced or impatient midwives certainly could endanger women, doctors more often used surgical and manual interventions that could cause permanent injuries or deadly infections (Leavitt, 1983: 281–292, 1986: 43–58; Rooks, 1997).

Doctors' desire to obtain a monopoly on childbirth care led them, beginning in the mid-nineteenth century, to voice opposition to midwives. These attacks escalated substantially in the early twentieth century (Sullivan and Weitz, 1988: 9–14). Recent waves of immigrants had swelled the ranks of midwives and made them more visible and threatening to doctors, whose

status, especially in obstetrics, remained low. Moreover, doctors now needed the business of poor women as well as wealthier women because the rise in scientific medical education had created a need for poor women patients who could serve as both research subjects and training material.

To expand their clientele, doctors attempted through speeches and publications to convince women that childbirth was inherently and unpredictably dangerous and therefore required medical assistance. In addition, doctors played on contemporary prejudices against immigrants, African Americans, and women to argue that midwives were ignorant, uneducable, and a threat to American values and that therefore midwifery should be outlawed. For example, writing in the *Southern Medical Journal,* Dr. Felix J. Underwood, the director of the Mississippi Bureau of Child Hygiene, described African American midwives as "filthy and ignorant and not far removed from the jungles of Africa, with its atmosphere of weird superstition and voodooism" (1926: 683).

Although these campaigns cost midwives many clients, they had little effect on the law. Many members of the public, and even many doctors (particularly those in public health), believed that trained midwives could provide satisfactory care, at least for poor and nonwhite women who couldn't afford doctors' services. Consequently, laws passed during this era tended to have quite lenient provisions. In the end, however, imposing lenient laws, rather than laws requiring upgraded midwifery training and skills, resulted in the deterioration of midwifery and its virtual elimination. The only exceptions were in immigrant and nonwhite communities in the rural South and Southwest, where traditional midwives continued to conduct home births until at least the 1950s (Sullivan and Weitz, 1988: 13–14).

The Resurgence of Lay Midwifery

By the second half of the twentieth century, childbirth had moved almost solely into hospital wards under medical care. Although childbearing women were grateful for the pain relief and safety that doctors promised, all too often women nonetheless found the experience painful, humiliating, and alienating. Despite the absence of scientific support for such practices, doctors routinely shaved women's pubic area before delivery, strapped them on their backs to labor and delivery tables (the most painful and difficult position for delivering a baby), isolated them from their husbands during delivery and from their infants afterwards, and gave them drugs to speed up their labors or make them unconscious—all practices that scientific research would eventually find unnecessary or dangerous (Sullivan and Weitz, 1988).

Objections to such procedures sparked the growth of the natural childbirth movement during the 1960s and 1970s and forced numerous changes in obstetric practices. Most hospitals, for example, now offer natural childbirth classes. Critics, however, argue that the real purpose of these classes is to make women patients more compliant and convince them that they have had a natural childbirth as long as they remain conscious, even if their doctors use drugs, surgery, or forceps (Sullivan and Weitz, 1988: 39).

By the late 1960s, many women had concluded that hospitals would never offer truly natural childbirth (Sullivan and Weitz, 1988: 38–39). As a result, a tiny but growing number of women chose to give birth at home. For assistance, they turned to sympathetic doctors and to female friends and relatives, some of whom were nurses. Over time, women who gained experience in this fashion might find themselves identified within their communities as lay midwives. This new generation of lay midwives who attend almost solely home births reflects the broader revolt against medicalized birth (Sullivan and Weitz, 1988: 23–59).

Working as a lay midwife means long and uncertain hours with little pay. Most midwives, however, are motivated by ideological rather than economic concerns (Sullivan and Weitz, 1988: 68–80). Although midwives recognize the need for obstetricians to manage the complications that occur in about 10 percent of births, they fear the physical and emotional dangers that arise when obstetricians employ interventionist practices, developed for the rare pathological case, during all births. Like nurse-midwives, lay midwives strongly believe in the general normalcy of pregnancy and childbirth and in the benefits of individualized, holistic maternity care in which midwife and client work as partners.

No national laws set the status of lay midwives. As of 2005, lay midwifery was definitely legal in twenty-nine states and illegal in sixteen, with their status elsewhere unclear (American College of Nurse-Midwives, 2005). In states where midwifery is illegal, midwives run the risk of prosecution for practicing medicine without a license and for child abuse, manslaughter, or homicide if a mother or baby suffers injury or death.

In states where lay midwifery is legal, midwives typically must abide by regulations restricting them to "low-risk" clients (such as women under age 35) and restricting the techniques they can use (such as forbidding them from suturing tears following deliveries). Licensed midwives typically must have a backup doctor and must transfer their clients to medical care if the doctor so orders. Thus, licensure has given midwives some degree of freedom to practice in exchange for limited subordination to medicine (Sullivan and Weitz, 1988: 97–111).

Research consistently suggests that home births conducted by experienced lay midwives working with low-risk populations are as safe as or safer than doctor-attended hospital births, even taking into account the small number of midwifery clients who develop problems needing medical attention (Lewis, 1993; Sullivan and Weitz, 1988: 112–132). For example, a recent Canadian/United States study compared 5,418 women who chose home birth with a licensed midwife with a similar group of low-risk women who chose hospital deliveries (Johnson and Daviss, 2005). In the end, both groups had similar (very low) rates of maternal and infant mortality and morbidity. However, the home-birthing women received less than half as many medical interventions. For example, only 3.7 percent of those delivered at home had cesarean deliveries, compared to 19 percent of those delivered in hospitals.

Box 12.1 ***Making a Difference: Citizens for Midwifery***

Citizens for Midwifery (CFM) is a national, grassroots, consumer organization, begun by a group of mothers in 1996. The organization's primary goal is to promote the "midwifery model of care." This model is composed of two basic beliefs: (1) that pregnancy and childbearing are safe, normal processes rarely requiring medical intervention and (2) that care of pregnant women should be holistic, individualized, and delivered in an integrated fashion from the prenatal through postpartum periods. Through its website (www.cfmidwifery.org), publications, and media outreach programs, CFM offers information to consumers about the nature of midwifery, the benefits of using a midwife, and how to find and select a midwife.

CFM also works to improve the legal status of midwives (especially licensed lay midwives) and to improve access to midwives for childbearing women across the nation. Its website offers information to consumers and midwives alike about how to craft a persuasive letter to the editor or to a legislator, how to lobby effectively for legal change (including nitty-gritty details on the most effective ways to communicate by phone, in writing, or in person), and how to critically evaluate and use scientific studies on midwifery and hospital birth outcomes. As of 2005, CFM has supported midwives and consumers in their legal battles in sixteen states, three of which have since legalized licensed midwifery.

As a result, those who delivered at home avoided the lingering discomfort, pain, and loss of energy that plagues many who experience medical interventions during birth. In addition, the home births cost about one-third the price of hospital deliveries, and mothers' satisfaction with their care at home was very high.

Despite evidence such as this, medical opposition to licensed midwifery remains strong and public support weak, although insurance companies do cover midwifery services in some states. Thus lay midwives, even where licensed, cannot claim to have achieved social acceptance even as limited practitioners. Box 12.1 describes the work of Citizens for Midwifery, a grassroots organization dedicated to improving the position of midwives (especially licensed lay midwives) and promoting their use.

Curanderos

Curanderos are folk healers who function within Mexican and Mexican American communities (Perrone, Stockel, and Krueger, 1989; Roeder, 1988). In the United States, curanderos are used primarily by immigrants, as well as by some U.S.-born Mexican Americans, especially those who live in close-knit communities in the Southwest. In Denver, for example, doctors familiar with the Mexican American community estimate that between 100 and 200 curanderos work out of their homes, advertising primarily by word of mouth (*New York Times,* 1999b). Some work for free, and some charge fees ranging from

$5 to $100. A survey conducted in Denver found that 29 percent of adult Hispanic patients at a low-income clinic had visited a curandero at least once during their lives (*New York Times,* 1999b). Most did not use curanderos as a primary source of health care but instead went in addition to seeing a doctor, when medical care had failed, or when distance or poverty limited their access to medical care.

Theories and Treatments

Curanderos recognize both Western categories of disease, such as colds, and unique categories of illness, such as susto (Roeder, 1988). A common diagnosis, *susto* refers to an illness that occurs when fright "jars the soul from the body, in which case treatment consists of calling the soul back" (Roeder, 1988: 324). Curanderos also sometimes trace illness to supernatural forces such as *mal de ojo,* or the evil eye.

Curanderos treat illness in a variety of ways, including herbal remedies, massage, prayer, and rituals designed to combat supernatural forces. They believe illness reflects all aspects of an individual's life—biology, environment, social setting, religion, and supernatural forces—and thus must be treated holistically. As a result, curanderos often spend considerable time listening to their clients. The successes curanderos sometimes achieve in treating their clients' illnesses thus derive not only from their knowledge of herbs and the healing powers of their clients' faith but also from the simple healing power of a sympathetic listener.

Becoming a Curandero

Individuals become curanderos through apprenticeships, typically with family members. Successful curanderos find that their practices evolve gradually from part-time work, paid primarily in goods and services, to more or less full-time, cash businesses.

The story of Gregorita Rodriguez, a *curandera* (female curandero) living in Santa Fe, New Mexico, who specializes in massage treatments, illustrates this process:

> Gregorita traces her own career as a *curandera* back to her grandmother, Juliana Montoya, who taught Gregorita's aunt, Valentina Romero, the art of *curanderismo.* When any of Gregorita's seventeen children became ill, she took them to her Aunt Valentina for treatment. *La curandera* taught Gregorita, encouraging her by asking, "Why don't you learn? Look, touch here." Using her children's bellies as a classroom, Gregorita felt the different abdominal disorders and learned how to manipulate the intestines to relieve the ailments. Another of her patients during this learning period was her husband. Responding to his complaints, Gregorita said, "Maybe I can do something for you." Mr. Rodriguez replied, "No, no, no! You are not going to boss me!" So, off he went to see Aunt Valentina, who was elsewhere delivering a baby. Finally, Gregorita got her chance. Her husband was desperate and allowed her to learn, all the time howling about how much she

> was hurting him. "Cranky," she described him, "especially when I felt a big ball in his stomach and had to work very hard. Slow, slow, I fixed him and he got better. When he went to my aunt, she said he was okay now. After that I treated my husband and one of my sisters and then her family. That's the way it started." (Perrone et al., 1989: 108–109)

After that, neighbors began to come for treatment and Gregorita's reputation grew; but she was reluctant to compete with her aunt for business. In 1950, Aunt Valentina died and Gregorita came into her own, her credibility already well established.

Because she lacks any recognized training in health care, Gregorita cannot legally charge fees or bill insurance companies as a curandera. To circumvent these legal restrictions, she has become licensed as a massage therapist and bills her clients as such. As this suggests, even a folk healer who appears to function completely outside the bounds and control of the Western scientific world cannot avoid its authority altogether.

Christian Science Practitioners

Theories and Treatments

Christian Science is a Christian sect founded in New England in about 1875. Christian Scientists believe God creates only good, while evil, sickness, suffering, and death exist only because mortals believe in them. The practitioner's job, then, is to lead the sufferer, through prayer, study, and talk, to reject the "counterfeit reality" of the "material self" and to achieve the true reality of divine perfection.

According to Margery Fox:

> Ideally, Christian Science treatment should be entirely and exclusively metaphysical. Practitioners are not even supposed to listen too attentively to patients' symptoms lest they be tempted to accept them as real; also, they idealize "undifferentiated" treatment not directed toward a specific problem. There should be no counseling of patients on a human level, no appeal to psychological processes. (1989: 107)

Reality, however, rarely matches this ideal. Practitioners spend much of their time talking with clients about the emotional and moral problems underlying clients' "counterfeit" physical problems. Healing seems to rely heavily on practitioners' persuasive verbal skills (M. Fox, 1989).

Becoming a Practitioner

As with curanderos, becoming a practitioner is a gradual process (M. Fox, 1989). Most practitioners (almost all of whom are women) begin by healing family members and friends. During weekly religious services, satisfied patients may announce successful treatment by a particular practitioner.

Over time, if a practitioner's personality and reputation seem suitable, other friends and acquaintances might turn to that practitioner for assistance. Eventually, individuals may apply to the central church office for listing in *The Christian Science Journal.* Approval comes after the practitioner submits letters of support from members of the congregation testifying to his or her effectiveness. After this, practitioners can open full-time offices. Currently, the *Journal* lists several thousand practitioners. The geographic distribution of practitioners across regions and between urban and rural communities reflects the distribution of the population as a whole. Care by practitioners is covered under Medicare, Medicaid, and many private health insurance plans (*Journal of the American Medical Association,* 1990).

Christian Scientists' opposition to medical care has precipitated a long history of legal battles in which doctors or states have sued for the right to force individuals to accept medical treatment. In general, courts have ruled that because Christian Scientists never seek medical care, doctors have no legal standing and cannot force care on adults. However, courts have ruled in favor of forcing care on children, arguing that the state has the right and duty to protect the health of children, and have found parents guilty of child abuse or involuntary manslaughter when children who received only spiritual treatment have died. (This chapter's ethical debate, Box 12.2, discusses the issues involved in the decision to refuse mainstream medical care.)

Acupuncturists

Theories and Treatments

If anything, acupuncturists' ideas regarding health and illness bear even less relationship to the ideas of Western medicine than do those of curanderos and Christian Science practitioners. Acupuncture is one of the oldest forms of healing known. Its recorded history goes back 2,000 years, with strong prehistorical evidence going back to the Bronze Age.

Like all traditional Chinese medicine, acupuncture is based on the concept of *chi* (Fulder, 1984). This concept, which has no Western equivalent, refers to the vital life force, or energy. Health occurs when chi flows freely through the body, balanced between *yin* and *yang,* the opposing forces in nature. Because any combination of problems in the mind, body, spirit, social environment, or physical environment can restrict chi, treatment must be holistic.

Following this theory, traditional Chinese healers consider both symptoms and diagnosis unimportant and focus instead on unblocking chi. Acupuncture is based on the theory that chi runs through the body to the different organs in channels known as meridians, which have no Western equivalents. To cure a problem in the colon, for example, acupuncturists apply needles to the index finger, which they believe connects to the colon via a meridian. In this way, they believe, they can stimulate an individual's chi and direct it to the parts of the body where it is needed. Acupuncturists decide on

Box 12.2 ***Ethical Debate: Choosing Alternative Options***

John and Mary Miller, high school teachers in a medium-sized New England town, are the parents of two healthy toddlers. On the advice of their chiropractor and several of their friends, they have decided not to have their children receive the usual childhood vaccinations against measles, mumps, rubella, polio, tetanus, and other infectious diseases. John and Mary's parents, on the other hand, are horrified at their decision, for they still remember the days when many children died from infectious diseases in the United States. Although the Millers recognize the dangers these diseases can present, they argue that these diseases are now rare, and so the benefits of vaccination are outweighed by their dangers, which they believe include higher risks of autism, meningitis, and other diseases. So far, John and Mary remain committed to their decision, although they worry about the legal consequences of ignoring laws requiring childhood vaccinations, and they do sometimes wonder if they have made the right choice.

As memories of infectious disease epidemics have faded, more and more parents have decided against having their children vaccinated. In the United States, religious, philosophical, and health care concerns—as well as Internet rumors—are feeding this trend; in Great Britain, an estimated 30 percent of school-age children have not received the basic measles/mumps/rubella vaccination. Do parents have the right to refuse vaccinations or, more broadly, to refuse mainstream medical care for themselves or their children, without interference from doctors and the courts?

As in the ethical debate on truth-telling to patients (see Chapter 11), the central issues in this case are autonomy and paternalism. However, here the issue is not personal paternalism by doctors but state paternalism—the idea that the state has an obligation to protect the welfare of its citizens, even when doing so means going against citizens' wishes.

Restricting individual autonomy is a serious matter, for it implies that an individual is not competent to decide what is in his or her own best interest. As the word implies, *paternalism* suggests that an individual is more like a child or even an animal than an adult human. Requiring motorcyclists to wear helmets, for example, suggests motorcyclists are too ignorant or stupid to assess for themselves the advantages and disadvantages of helmets.

Does the need for paternalism outweigh the desire for autonomy in this case? One way to

treatment through taking a complete history, palpating the patient's abdomen, measuring his or her blood pressure, and reading the twelve pulses recognized by Chinese medicine.

Acupuncture is still used extensively in China, both alone and in conjunction with Western medicine, and is used increasingly in the West. To ascertain its impact, the U.S. National Institute of Health organized a Consensus Development Panel on Acupuncture in 1998. (A consensus panel is a group of experts from diverse backgrounds brought together to reach joint conclusions on a topic.) The panel's final report concluded that acupuncture definitely alleviates nausea and some types of pain and definitely does not help in stopping smoking. The report also noted that acupuncture has fewer harmful

decide is to consider in the abstract the relative value and appropriate roles of autonomy and state paternalism. We might, for example, conclude that leaving children unvaccinated is unsafe but still believe that protecting individual autonomy is more important than protecting individuals from themselves. Another way to decide is to evaluate the scientific evidence for and against vaccinations to see whether vaccinations are as safe and the risks of infection to the unvaccinated as dangerous as most doctors claim. In this case, the scientific evidence is very strong: A recent review conducted by the prestigious Institute of Medicine resoundingly supported the use of vaccinations (Stratton, Wilson, and McCormick, 2002). Still, sometimes scientists have been proven wrong in the long run.

In this situation, the ethical dilemma is complex because many people's health is at stake. Whenever an unvaccinated child becomes infected with a disease, he or she can spread the disease to other children who have not yet been vaccinated, to children who cannot be vaccinated because their immune systems are weak (due to preexisting disease or chemotherapy), and to adults whose vaccinations have worn off with time. Unvaccinated children thus place whole communities at risk; in the past few years, several outbreaks of infectious diseases that occurred in the United States have been traceable to unvaccinated children. The issue, then, is not simply whether the Millers have the right to decide for themselves what sort of health care they want but also whether they have the right to make decisions that place both their children and others at risk. To evaluate this situation, one must also decide, first, whether parents or the state can best and most appropriately judge children's interests and, second, in what circumstances state intervention is justified.

Sociological Questions

1. What social views and values about medicine, society, and the body are reflected in this debate? Whose views are these?
2. Which social groups are in conflict over this issue? Whose interests are served by the different sides of this issue?
3. Which of these groups has more power to enforce its view? What kinds of power do they have?
4. What are the intended consequences of the various policies under consideration? What are the unintended social, economic, political, and health consequences of these policies?

side effects than modern medicine does and that many accepted Western medical practices have no greater scientific evidence of efficacy. The World Health Organization, meanwhile, considers acupuncture effective for treating about fifty disorders, including the common cold, bronchial asthma, childhood myopia, and dysentery (Wolpe, 1985: 420).

The Impact of Medical Dominance

Widespread American interest in acupuncture began during the 1970s, when the People's Republic of China first opened to U.S. travelers. Early travelers brought back near-miraculous tales of acupuncture anesthesia and treatment. Because American doctors had no scientific model that could account for

acupuncture's effects, these tales threatened their position and worldview (Wolpe, 1985). As a result, various well-known doctors publicly denounced acupuncture, claiming it worked only as a placebo or only because Chinese stoicism or revolutionary zeal allowed them to ignore pain, even though acupuncture also had worked on animals and on Western travelers to China.

To remove this threat to their cultural authority, doctors endeavored to control the definition, study, and use of acupuncture (Wolpe, 1985). This proved relatively easy for, unlike chiropractic or osteopathy, acupuncture at the time had few American supporters. Consequently, in their writings and public pronouncements, doctors could strip acupuncture of its grounding in traditional Chinese medical philosophy and define it simply as the use of needles to produce anesthesia. Pressure from medical organizations led the National Institutes of Health to adopt a similar definition in funding research on acupuncture. At the same time, pressure from doctors led most states to adopt licensure laws allowing any doctors, regardless of training, to practice acupuncture but forbidding all others, no matter how well trained, from doing so except under medical supervision. Thus, for many years, most traditional acupuncturists in the United States worked illegally within Asian communities.

During the past decade, however, as acceptance of alternative healing traditions has increased, the position of acupuncturists has improved. Some insurance companies will reimburse nondoctors for acupuncture treatments, and most states now allow nondoctors to perform acupuncture, although some of these states require medical supervision or require acupuncturists to be licensed by medically dominated boards (Acupuncture Alliance, 2002). Use of acupuncture remains rare; national random surveys of English-speaking U.S. residents conducted in 1997 and 2002 found that the percentage reporting use of acupuncture held steady at 1.0 percent, with about half of these patients reporting some insurance coverage for treatment (Tindle et al., 2005). These figures suggest that acupuncture remains a marginal therapy and occupation, posing little threat to medical dominance.

Conclusion

As the discussions in this chapter have suggested, the health care arena is much broader than we usually recognize. Many alternatives to medical treatment exist far beyond those discussed herein. Most of these alternatives function not so much in opposition to mainstream health care as in parallel, with those seeking care jumping back and forth across the tracks. For example, a woman might deliver her first child with a doctor, her second with a nurse-midwife, and her third with a lay midwife; and a man who experiences chronic back pain might see a chiropractor or acupuncturist either before, after, or in addition to seeing a medical doctor.

This chapter has highlighted the factors that help health care occupations gain professional autonomy in the face of medical dominance. Timing certainly seems to play a role: Those occupations that emerged before medical

dominance became cemented, such as osteopathy and chiropractic, have proved most successful. Social factors, too, consistently seem important: Health care occupations with roots in and support from higher-status social groups have a better chance of winning professional autonomy than do those with lower-status roots and supporters.

Other occupations seem to retain some autonomy—if a marginal position in the health care arena—because they pose little threat to medical dominance. Curanderos, for example, attract a small clientele of poor Mexicans and Mexican Americans who might not be able to pay for medical care or to communicate effectively with medical doctors anyway. Doctors thus have little incentive to eliminate curanderos' practices. Acupuncturists, on the other hand, have attracted not only Asians and Asian Americans but also well-educated whites—including individuals with the skills and resources to publicize the virtues of acupuncture. Consequently, doctors have had a far greater vested interest in restricting acupuncturists' practices and in co-opting acupuncture for their own purposes.

Not surprisingly, developing professional autonomy seems most difficult for those, like nurses, who work directly under medical control. In contrast, those such as Christian Scientist practitioners have considerably more leeway to develop their practices without interference from medical doctors.

Finally and ironically, strict licensing laws, even when devised by doctors opposed to a field's growth, in the end can help occupations gain professional autonomy by forcing them to increase standards and thereby enabling them to gain additional status and freedom to practice.

To date, medical doctors have succeeded in retaining their professional autonomy and dominance partly because of their greater ability to provide scientific data supporting their theories and practices—or at least to convince the public that they have such data. It remains to be seen whether, with the increased federal support for research on alternatives and despite medical control of funding and publication mechanisms, those who favor alternative health care options will be able to use this research to increase scientific credibility and public support for their practices.

Suggested Readings

Chambliss, Daniel F. 1996. *Beyond Caring: Hospitals, Nurses, and the Social Organization of Ethics.* Chicago: University of Chicago Press. A wonderful study of the social position of nurses in the health hierarchy and the consequences of that position for both nurses and patients.

Gordon, Suzanne. 2005. *Nursing Against the Odds: How Health Care Cost Cutting, Media Stereotypes, and Medical Hubris Undermine Nurses and Patient Care.* Ithaca, NY: Cornell University Press. The title tells it all. Gordon's book clearly describes the problems at the heart of modern nursing.

Root-Bernstein, Robert and Michele. 1997. *Honey, Mud, Maggots, and Other Medical Marvels.* New York: Houghton Mifflin. The authors, a physiologist

and a historian, explore how modern medical researchers are investigating and, in some cases, validating "folk medicine" treatments from around the world, such as bloodletting and dirt-eating.

Vincent, Peggy. 2002. *Baby-Catcher: Chronicles of a Modern Midwife. A*n engaging and fascinating memoir written by an obstetrical nurse who became a nurse-midwife specializing in home births.

Getting Involved

Midwives Alliance of North America. 4805 Lawrenceville Hwy., Suite 116–279, Lilburn, GA 30047. (888) 923-6262. www.mana.org. Promotes communication between lay midwives and nurse-midwives and the legal rights of both groups.

Review Questions

How did the early history of nursing make it difficult for nurses to increase their status or improve their working conditions?

How have nurses attempted to professionalize? Why haven't these strategies succeeded?

How have changes in the health care system affected nurses' occupational status and position?

What factors have led to the development of clinical pharmacy, pharmaceutical care, and disease management? What factors have restrained their growth, or could do so in future?

How did osteopaths attempt to professionalize? What factors enabled them to succeed? What price has osteopathy paid for its success?

To what extent and in what ways have chiropractors succeeded in improving their occupational status?

How and why did doctors gain control over childbirth?

What factors led to the growth of nurse-midwifery? of lay midwifery? What is the difference between the two?

How do individuals become traditional healers? How does medical dominance affect their work and their lives?

Internet Exercises

1. The federal government's main website for consumer health is www.healthfinder.com. Browse the site, looking for links to web pages related to fraud and quackery, accountability, and treatment errors. Do the site's organizers appear as concerned about fraud and similar problems among mainstream practitioners as among alternative practitioners? In what ways, if any,

does the site's handling of alternative medicine differ from its handling of mainstream medicine?

2. Using the Internet, find policy statements related to home birth and midwifery from a variety of organizations (such as the World Health Organization, the Midwives Alliance of North America, the American College of Obstetricians-Gynecologists, and the American College of Nurse-Midwives). How do their positions differ? What evidence do they use to justify their positions?