

Outsiders and the Amateur Legislature: A Case Study of Legislative Politics

ARTHUR ENGLISH

University of Arkansas at Little Rock

JOHN J. CARROLL

Southeastern Massachusetts University

Introduction

Political scientists have concentrated their analyses on the United States Congress and legislatures in the larger states, while developing a literature rich in insight on legislative institutions.¹ But this literature has often overlooked that most typical, albeit declining, legislative phenomena, the amateur or citizens legislatures which are found in the smaller and more rural states. The defining difference between these two types of legislative institutions, i.e., between the "professionalized" Congress, California legislature, and the amateur Rhode Island or Arkansas General Assemblies, is that in the one legislators "legislate" for a living while in the other members serve part-time and draw their principal paychecks elsewhere.

The difference between the two types of legislative institutions is more than just the "job" orientation of the legislator, however. The difference is structural as well. In general, legislators in amateur chambers work together during the afternoons only a few weeks or months a year, turnover is comparatively high (Chaffey and Jewell, 1972), and support staff and institutional resources are few. Professional legislatures in comparison tend to be in session from nine to twelve months every year, they have elaborate and well-paid staffs, and full-time legislators have individual offices, sometimes in their district as well as in the Capitol² (*The Book of the States, 1984-1985*). The result is that citizen legislatures are more loosely structured institutions than professional legislatures³-- they are not "well integrated" social systems in the sense that the Congress is thought to be (Polsby, 1968)-- and as a consequence their decision-making may be less predictable.

A well-accepted concomitant proposition in the literature describing "professional" or "well institutionalized" legislatures is that the legislative process is long and complex and that it is a specialized arena for highly skilled, experienced and powerful players (Polsby, 1968; Jewell and Patterson, 1977; Reid, 1980; Redman, 1973; Levine and Wexler, 1981). The assumption of this literature is that to be successful in the legislative process, external participants need substantial organizational, informational and monetary resources from which to orchestrate pressure and lobbying campaigns (Hrebemar and Scott, 1982) and they are unlikely to be successful without well-developed, and previously tested channels of access to legislators, particularly to legislators in positions of formal power, such as committee chairpersons and other legislative leaders. In consequence, persons who lack such resources and who have not developed access to influence are considered to be "outsiders" to the process and are unlikely to affect legislative outcomes.

While this analysis satisfactorily explains the parameters of influence and decision-making in professional legislatures, it does not adequately define these

boundaries in amateur institutions: We argue in this case study that "outsiders" in a legislative process can often be effective in amateur legislative settings. We so argue because in amateur legislatures processes tend to be less routinized, power less formally stratified (Carroll and English, April 1981), relationships between members less institutionalized (Carroll and English, May, 1981), interest groups fewer, their representation less professional, and their participation more episodic (English and Carroll, 1983).

Furthermore, in amateur legislatures the unpredictability of voting behavior is often reinforced by undisciplined, fragmented party systems in which voting blocks are factionalized and unstable over time and cohere within relatively narrow issue sets (Comner, 1978; Welch and Carlson, 1973; O'Connor, 1973). Of course, this does not imply that amateur legislatures are without their power players and well organized groups. In amateur legislative systems, including the Arkansas General Assembly, there are usually a coterie of senior members who dominate leadership positions (Beth and Havard, 1961; Goss, 1985) as well as hired lobbyists from a handful of well financed interest groups (English and Carroll, 1983).

The concept of outsider is not used here to define those players in the legislative process who hold latent power, choosing to exercise it only at particularly propitious times. Nor do we describe the outsider in terms of deviant, albeit successful alternative legislative-role orientation (Huitt, 1961; Patterson, 1961). Rather, we conceptualize outsiders in the legislative system as individuals or groups who exhibit the following characteristics: (1) they have had no previous pattern of interaction with the legislature; (2) they are without financial or organizational resources to give them leverage with legislators; (3) the issue they espouse is complex, or controversial so that legislators are apprehensive about support it; (4) the issue advanced is staunchly opposed by an interest group which has well-established contacts with legislators.

Our case study of outsider influence is an amateur legislative setting focuses on the 74th (1983) session of the Arkansas General Assembly. That session witnesses a confrontation between an initially unorganized group of midwives with few resources who were attempting to legalize the practice of law midwifery⁴ and the Arkansas Medical Society and Department of Health, groups with well established ties to the General Assembly.

Midwifery in Arkansas

While the practice of lay midwifery has deep roots in 19th and 20 century Arkansas, its character was regionally shaped in the state. In the isolated mountain regions of the Ozarks, the Northwest and North Central portions of the state, midwifery was exclusively the province of white women who were prominent in their local communities because of their curative powers. Sometimes referred to as "white witches" because of their powers and the good they accomplished in the community, the practice of midwifery in the Ozarks had a mystical and magical quality to it (Oakleaf, 1976).

The practice of midwifery had a much different character in the "Delta" counties of South Central and Southeastern Arkansas. Flanked by the Mississippi river, the region's economy is almost exclusively agricultural. Many of the counties there are 40 to 50 percent black,⁵ although blacks constitute only 16.3 percent of the state's total population (*U.S. County and City Data Book*, 1983). The Delta region is poor; pockets of wealth do exist but these are the larger more prosperous farms operated by whites. Thus, while the per capita income of the region hovers around \$7,000,⁶ a

full \$1,000 below the \$8,042 for the state and several thousand below Pulaski County (\$10,368) where Little Rock is located, it does not fully indicate the high level of black poverty present in the Delta.

In the Ozarks midwifery existed because of tradition and the remoteness of the area from health care facilities. In the Delta, midwifery more than existed--it flourished not only because of the grim impoverishment of the black population and the lack of health care facilities (1.7 hospital beds per 1,000 population for the state compared to the recommended average of 4.5 per 1,000 population (Hudson, 1984), but because health facilities for blacks were segregated even when they were available, and white hospitals were exceedingly reluctant to accept expectant mothers who were both poor and black. In 1945, only 10 percent of black women in Arkansas gave birth in a hospital, compared to 60 percent of whites (Hudson, 1984)). Thus, two of Arkansas' most enduring 20th century traditions, segregation and poverty, contributed to the growth and legitimacy of midwifery in the state.

During the 1930's and 1940's the state Health Department became exceedingly concerned about the techniques utilized by the black "granny" midwife who was often illiterate and practiced according to superstition. In viewing midwifery as a necessary evil, the Department sought to upgrade the practice by more effective training and regulation. The expansion of public health facilities as an outgrowth of cooperative federalism provide the required opening. Midwives were required by the state to attend training sessions conducted by the public health nurses and physicians. Enforcement of these policies would have been impossible had it not been for some astute tactics utilized by the Department in dealing with the midwives. First, an energetic and able black public health nurse was hired to design and coordinate the instructional program. Second, the instruction itself was designed to instill a sense of duty in the midwives to adhere to the lessons taught by appealing to their state patriotism and their belief in God. Finally, a system was set-up in which the patient had to have a blue card stamped by a physician certifying them for delivery by the midwife. The new training and regulations apparently had an impact because the infant mortality rate in the state soon began to drop and some midwives began writing after their signature, "A Midwife of the State and from God" (Hudson, 1984).

In 1952 more explicit regulations were promulgated by the Arkansas State Board of Health pursuant to its broad statutory powers to regulate health in the state. Among the myriad of regulations put forth, midwives had to be of "good moral character (and) have the respect of the majority of the people in the community;" "be not less than 21 years or not over 50 years of age when taking up the practice of midwifery;" "be able to read with understanding and to fill out birth certificates properly;" "attend midwife classes as prescribed by the Maternal and Child Health Division of the Arkansas State Board of Health;" "wear a clean washed dress when caring for a patient." Violation of any of the regulations constituted a misdemeanor and could result in the revocation of the permit, a fine, imprisonment, or both.⁷

The 1952 regulations defined the structure of midwifery in Arkansas for better than a quarter of a century until January, 1979, when the Department of Health, still concerned that its procedures left midwifery essentially unregulated in respect to new "counter-culture" midwives entering the state, abolished the program.⁸ The remaining grannies, whose numbers had been greatly thinned by attrition received a form letter telling them that their services were no longer needed and that it was now illegal for them to practice. This edict effectively ended the practice of midwifery by the grannies. Other midwives who were practicing continued to do so without any legitimized status. Thus, by 1979 midwifery in Arkansas had become an illegal and underground occupation, practiced largely by young, counter-culture whites.

Midwifery and Politics

At about the time of the 1979 decision to end midwifery in the state, a young woman by the name of Carolyn Vogler moved back to Arkansas from El Paso, Texas, where she had trained in midwifery at the Bethlehem Childbirth Center. Vogler had lived in Arkansas previously and her familiarity with the Delta's poverty and the need for accessible childbirth facilities led her to Dermott, Arkansas. Vogler's charm and intelligence, a significant attribute in her fight to legalize midwifery, won her immediate acceptance among elites in the community, and in July, 1982, she opened the Delta Maternity Center.⁹

The opening of the center brought a quick response by the Health Department which believed that Vogler's practice was medically unsafe and thus a threat to maternal and infant care in the region. In particular, the Director of the State Department of Health charged that Vogler was in direct violation of the state's Medical Practices Act because she was practicing medicine without a license.¹⁰ A suit, instigated by the Arkansas Medical Board, was subsequently filed in Chicot County Chancery Court by physicians outside of Dermott to enjoin Vogler from practicing. This tough response to the opening of the Delta Maternity Center in retrospect was not surprising. Vogler represented a direct challenge to the fears of health professionals by overtly practicing midwifery in an institutionalized setting.

Vogler's position was that of the classic outsider. She was new to the state and lacked alliances with Arkansas political leaders or other established groups. She was, in effect, an individual, acting along in behalf of a cause in which she believed. At the outset, Vogler's financial and organizational resources were minimal, and she was without the funds to launch statewide advertising or lobbying campaigns on her own behalf. Furthermore, her issue was controversial, challenging as it did the historical direction of public policy toward midwifery and the image of her calling as an outdated vestige of a former era. Finally, the Medical Association and State Health Department had vested interests in the status quo, both were well-connected within Arkansas government, and they would prove themselves formidable foes.

At this point it appeared Vogler would have to yield because she lacked the resources to engage in a lengthy - or even short - legal battle, but despite the difficulty of her situation and her outsider status in the political system, she was able to make considerable headway. First of all, in the campaign to legalize lay midwifery Vogler was her own best advocate. While midwifery certainly has a long tradition in Arkansas, many had come to associate it with the delivery of children under substandard conditions by poorly trained birth assistants. This association hit a sensitive cord among Arkansans wary of the state's reputation as an unsanitary backwater. But Vogler did not fit the stereotype that many lay midwives had previously conveyed as backward, incompetent people. She impressed people as intelligent and extremely knowledgeable. Senator Jack Gibson, who was later to champion her cause in the legislature, found Vogler to be "full of spunk and charm."¹¹

Vogler also made convincing arguments. While Arkansas is a poor state, it has good medical facilities although they are concentrated in the urban areas--Little Rock, Hot Springs, and Fort Smith. Physicians and health care professionals are much sparser in the rural areas of the state, such as the Delta, where there is less money and fewer educational, social, and cultural activities. For example, while there are 2,700 physicians in the state or 118.0 per 100,000, urban Pulaski has 322.4 per 100,000 while many of the rural counties have less than 70 physicians per 100,000. In two counties, Lee and St. Frances, there are only 38.6 and 29.2 physicians per 100,000 respectively (*US County and City Data Book*, 1983).

Similarly, while there are 5,776 nurses in the state, 38.9 per 1,000 population, only 192 nurses served a population of 124,236 in the state's six poorest counties.

Given these data it would be an exaggeration to say that health care is inaccessible in places like Chicot County, but it is less accessible per person than in the state and considering the poverty of the region, the cost for many was prohibitive. Maternity care in Arkansas, including doctor's fee and hospital stay, costs between \$1500 and \$2000; Vogler was offering both pre and post natal care, including delivery, for \$300.¹²

Besides her own personal assets and the attractiveness of her issue, Vogler formed an alliance with two of Dermott's most important citizens, Charles S. Gibson, an attorney practicing in Dermott, and his wife Sherri Gibson, one of the town's few community activists. It was the Gibson's who encouraged Vogler to open the Delta Maternity Clinic and let the public judge the merits of her cause. The Gibson's were outraged when Vogler was sued by the medical board and Charles Gibson offered to provide her with free, legal help. More importantly, the Gibson's had resources that Vogler did not and were able to provide the legislative connection that Vogler and other midwives needed¹³--a state legislator who would introduce a bill legalizing midwifery and be its advocate in the General Assembly.

Dermott is located in Chicot County, one of the four counties which Senator Gibson either fully or partially represented¹⁴. In addition, Senator Gibson was Charles Gibson's cousin. These two connections, personal and constituency, became one when Senator Gibson was invited to tour the Delta Maternity Clinic. In a statement which captures the essence of the amateur legislative orientation, Gibson assessed the situation in the following terms: "What she said sounded good to me and I was impressed with her. I did a little research on my own - not too much - and found that we had one of the highest infant mortality rates in the country along with one of the lowest ratios of physicians to population. That convinced me."¹⁵

With legislative help now available, Vogler and the Gibsons could concentrate on developing a strategy to legalize midwifery in Arkansas. A legal solution through the courts was rejected as being too risky, long, and costly. Winning might help Vogler and the Delta Maternity Clinic but it might not advance the status of other midwives. It was decided to pursue a campaign to convince the General Assembly to legitimize by law the practice of lay midwifery. An internal-external strategy was devised. Senator Gibson would quietly mobilize support in the Assembly, particularly among Delta legislators, while introducing a bill exempting midwives from the state's Medical Practices Act. Vogler would act as the chief spokesperson for the campaign and deal exclusively with the media; the Gibson's would provide legal and moral support, and attempt to broaden the base of the midwifery coalition.

For groups outside the legislative system, creating a favorable climate of opinion for their issue is essential to the ultimate success of the campaign. Favorable media coverage is crucial because it can legitimize an issue for politically cautious legislators who often look for some indication of mass approval before they get behind an issue.

The media campaign was a *tour de force* for the midwives. The Arkansas Medical Society did not seem to realize that the story of powerful doctors picking on a woman who helps poor women had David and Goliath implications. In consequence, the stories in which the doctors were quoted made them seem shrill and unreasonable compared to those written about Vogler, which described her as a cool, reasonable person with a reasonable issue.

The strategy for the media campaign had been worked out before the campaign began in earnest. Vogler was open to the press, but never critical of her tormentors

in the medical community. Indeed, she was frequently quoted as saying she would like to work under a doctor's supervision. When the medical board stated that midwifery was unsafe, she pointed to the high infant mortality rate in the state compared to the low rates in countries where midwives were common. When she was assailed as incompetent, she cited the number of babies she had delivered and cared for. When the doctors said that they could do better, she noted that there were few physicians in the Delta region and that maternity care was expensive.¹⁶

Vogler's media strategy was so effective that her opponents found themselves on the defensive. Indeed, Byron Hawkes, Associate Director of the Maternal Division in the Arkansas Health Department, wrote Vogler a public letter of apology for remarks he had made before the state medical board:

There comes a time in everyone's life and professional career, when arrogance comes face to face with humility... I cannot condone out-of hospital obstetrical delivery of mother and the newborn but I am realistic enough to realize that segments of today's society wish this experience... because of the economic roadblock that now truly exists in Arkansas and in all states. Mrs. Vogler wishes to meet this need and has placed herself into a fighting pose. I admire her stance.¹⁷

Hawkes went on to apologize for "intemperate statements I have made against her" and concluded with an endorsement of her general aims: "I feel absolutely certain that she agrees with me that her position and that of others in this state must be legalized in a formal manner and status be given to the goals this ancient movement deserves."¹⁸ Hawke's letter of apology marked a turning point in the campaign. The midwives thought then they had turned the tide but they still had to deal with the legislature and the legislative process.

Midwifery and the Assembly

Given its basic structure and ideological orientation, the Arkansas General Assembly might be considered a forbidding institution by any group seeking to write its preferences into law, and especially by a group with a mixed popular image which has attacked the interest of one of the state's established political forces. The Arkansas legislature is a part-time institution which meets for 60 legislative days every two years. Like other southern legislatures, its membership is senior, heavily Democratic, overwhelmingly male and largely conservative (English and Carroll, 1983). In recent sessions, for example, it refused to ratify the Equal Rights Amendment, and was one of only two states to pass a bill mandating the balanced treatment of creation science.¹⁹

If the Assembly's reputation was not enough to dissuade Vogler and her allies from seeking a legislative solution, there are pitfalls inherent in the legislative process itself. In the Arkansas General Assembly, a bill may meet a quite death in several ways. Some bills, for example, are killed by farming them out to an interim committee for "further study." Or a bill may make it to the floor, as most do, only to await action on the calendar indefinitely. This technique allows the sponsor to say a bill got to the floor, even though there was no action on it. And if a bill fails passage a "clincher" motion may be immediately moved, which if adopted means that the previous vote can only be expunged by a two-thirds or better majority (Rules of the House of Representatives, 1977). Commonly, a bill will be defeated on the floor or left to languish in committee or on the calendar because its sponsor chooses not to be its advocate.

But the reputation of a legislative body and the pitfalls of the legislative process do not determine the fate of individual bills in an amateur Assembly. In an amateur legislative setting, the odds of passing a bill increase sharply because of the

deinstitutionalized nature of the body. It would seem, given the short length of the session in amateur legislatures, the relative lack of staff, and the large amount of time that legislators spent home in the district, that many bills are processed rather than deliberated, and some bills are adopted which would be killed if given less hurried consideration. Rosenthal (1981) found for example, that amateur legislatures, especially those which are southern and rural, had a much higher average bill adoption ratio (from 1963-1974) than professional legislatures like Massachusetts, Ohio, Wisconsin and New York.²⁰

Another important consideration that enlarges the opportunities for the successful passage of bills in an amateur legislative setting is the strong constituency orientation of legislators, which can override leadership influences, ideology and other factors. In Arkansas, legislators spend most of their time in their home districts responding to constituent problems (English and Carroll, 1983).

Finally, while many legislative bodies - amateur and professional alike--have a conservative bent, some issues, like midwifery are not easily reconciled to ideological stereotype. Midwifery is an ideologically complex issue because while it immediately suggests a feminist counter-culture orientation, it also taps legislators' pragmatic desires to provide services to constituents.

Thus, when the bill exempting midwifery from the state's Medical Practices Act was introduced by Gibson in the Senate, the midwives found many of the legislators receptive to it. They also found the medical committee inattentive and unorganized. The Arkansas Medical Association had concentrated their early efforts on a judicial remedy and had not paid adequate attention to the impending legislative battle.²¹ With the medical establishment unprepared, the midwifery forces lobbied the legislators directly by organizing a network of supporters, friends, and clients.

This lobbying coalition consisted of Vogler, the Gibsons, Father Joe Blitz, Director of the Office of Justice and Peace, Catholic Diocese of Little Rock, and Dr. John Wolverton, a supportive physician. This group lobbied the legislators individually, in addition to going on the record at a public hearing before the Senate's Public Health, Welfare, and Labor Committee on the need and merits of midwifery.²² For his part, Senator Gibson practiced pluralistic politics with his colleagues to a tee: "I got me a midwife, a doctor, a Catholic priest and went to work."²³ The bill (SB203) to exempt midwives from the state's Medical Practice Act streaked through the Senate 25-7.²⁴

By the time the bill reached the House, however, the legislative climate had drastically changed. The medical profession was now alerted to the possible passage of a bill legalizing midwifery in the state and legislators supportive of midwifery were less numerous and influential in the lower chamber. The bill got an early "do pass" from the House Public Health Committee, but by the time it reached the floor the doctors were prepared for it. Despite an unusual suspension of the rules (again illustrating the unpredictable nature of the legislative process in Arkansas), which allowed Vogler, Father Joe Blitz, and Dr. Wolverton to address the entire House, a grassroots lobbying campaign by the Arkansas Medical Society, which mobilized local doctors to call their legislators, culminated in a 33-43 defeat.²⁵ The resistance of the House to the Senate's bill mandated a compromise strategy by the midwifery forces. Rep resentative Gino Mazzanti, another Delta legislator, forged the compromise in the House. Initially, he proposed an amendment to the bill, based on the national poverty line, which would have legalized midwifery in 30 counties. When this-amendment failed to win support, Mazzanti changed the poverty threshold to permit midwifery in those counties in which 30 percent or more of the population had incomes below the poverty line.²⁶ This would have legalized the practice of midwifery in 11 counties. This version did not pass either. Finally, a 32.5 percent

poverty threshold was agreed upon, legalizing midwifery in six counties.²⁷ The vote on the unamended midwifery bill was then expunged and the bill as amended passed by a vote of 52-20. The bill was signed into law as Act 838 by Governor Bill Clinton, who expressed his reservation that midwives provide substandard care. Despite this objection, Governor Clinton, with a reputation as a progressive but pragmatic governor, chose not to oppose the bill because a large number of midwives were practicing in the state and because he had strong electoral support in Southeastern Arkansas, which he did not wish to jeopardize.²⁸ Thus, the practice of lay midwifery was legalized in just six of Arkansas' 75 counties, all located in the South Central and Southeastern portion of the state. The midwives had not been able to legalize midwifery throughout the entire state, but they had been able to legitimize its status in six counties despite strong opposition from the medical community.

Discussion

This legislative history demonstrates the remarkable fluidity of politics in an amateur legislative system. Act 838 was placed on the legislative agenda and passed by a midwife who had never been active in politics before, an activist priest, a pro-midwifery physician, a junior Delta legislator, and two dedicated Dermott activists. These were meager resources by the standards of a professional legislature, yet sufficient to thwart the interests of the medical community as represented by the Arkansas Medical Society and the Department of Health.

This case demonstrates that a victory of this kind, incomplete though it was, can be secured in a legislative setting which lacks the well-institutionalized structures of professionalized bodies. In the Arkansas Assembly, specialization among legislators in a valued trait, as it is in professional legislatures (English and Carroll, 1983; Whistler and Dunn, 1983) but amateur legislators have wider discretion. Senator Gibson waged a successful campaign among his colleagues despite only two years experience in the Senate and a seat on the Committee on Agricultural Economics and Industrial Resources, a specialization presumably not well suited to leadership on a public health measure (Wahlke, *et al.*, 1962; Carroll and English, May 1981).

In addition, as in local legislatures, such as city councils and school committees, the ideological nature of issues is likely to be obscured by amateur legislators' concerns about constituency needs and practicality. Midwifery, for example, is a "new" issue among feminists who oppose the invasion of their persons by the male-dominated technology of the modern obstetrical ward (Warshaw, 1984), and it is sometimes viewed as a liberal issue because its services are primarily for the poor. In the Assembly, many legislators saw midwifery as a constituency measure of direct benefit to persons who could not otherwise afford health care. Carolyn Vogler presented it well in her statement to the press: "Midwifery is a feminist issue, a rich person's issue, a right to life issue, a religious issue, a survivalist issue, and a poor people's issue. It cuts across all classes of people. It's everybody's issue."²⁹

This case also illustrates that incrementalism is an intrinsic characteristic of the state legislative process. The midwives did have some resources in the fight to legalize their craft: a highly skilled spokesperson, a legislative champion and free legal advice; the A.M.A. had established legislative contacts, substantial resources, and a grassroots lobbying network as their chief weapons. Both sides would have conceded nothing if they didn't have to, but faced with each other's "real" power position, some change was inevitable. Indeed, an axiom of the legislative process is that if you can't get a full loaf, get half, and if you can't get half, get something.

Most significantly, this case study also demonstrates that outsiders in an amateur legislative system can win political battles, if they are willing to develop coalitions and to define their issues carefully. Perhaps the single most disturbing aspect of our national political system is its dominance by large groups to the exclusion of individual citizens. But in the amateur, state legislative system, interest groups are not as systematically represented as they are in professionalized institutions. Interest groups, including potentially powerful organizations, may be intermittently represented and inadequately informed about matters of concern to them. This was crucial to the outcome in this case. In consequence, this group of legislators, in the absence of strong voting pressures to the contrary,³⁰ proved receptive to a novel legislative proposal which they believed was convincingly presented.

Thus, the midwifery struggle in Arkansas belies the axiom that many Americans hold about the political system--that little can be done to influence it. This case shows that citizens can influence their public officials if they organize, and that tenacity and constituency contacts will be persuasive in what is often an interest group vacuum. Indeed, legislators continue to believe that elections are decided by how responsive they've been to constituents (Whistler and Dunn, 1984, p. 47; Fenno, 1978), and they will listen if pushed.

The idea has also become current that legislators may risk popular support if they become identified with vested interests. This populist sentiment was echoed by a public health department official who at the end lamented: "We got beat by a little girl and a country legislator."³¹

Endnotes

¹Students of Political Science are familiar with the emphasis in the literature on congressional studies. Recent impressions, however, bolstered by the greater number of political scientists working with state data suggest that there are an increasing number of studies on state legislative politics being published. While this may be true, we found in a survey of the articles published from 1980 through the first two numbers of 1985 in *The American Political Science Review* and *The Journal of Politics* but 11 articles which dealt with state legislative politics to 45 on the Congress. For these two prestigious journals, the emphasis on congressional studies continues.

²Comparing some of the structural characteristics of the Arkansas and Rhode Island general assemblies with the California legislature is revealing. The biennial salary for California legislators is \$56,220 while it is \$15,000 and \$600 for Arkansas and Rhode Island legislators respectively. In terms of staff, California legislators have available central staff in the legislature as well as individual staff in the legislature and home district. Arkansas and Rhode Island legislators have access to central staff but must either share support staff with other legislators year round (Rhode Island) or in the Arkansas legislator's case may employ individual part-time staff through his or her regular session or interim maintenance allowance (\$308 weekly in session; \$420 monthly interim). Length of session provides perhaps the starkest structural contrast among these legislatures. The Arkansas General Assembly meets *bernoulli* for 60 days although regular sessions are almost always a bit longer. The Rhode Island General Assembly is constitutionally mandated for 60 days and members are not paid for additional days in session. The California legislature, on the other hand, is in session on a year-round basis.

³The *Book of States*, 1984-85 specifically notes the following legislatures as professional bodies according to their criteria of time in session, compensation, and

occupational self-definition of members: California, Illinois, Massachusetts, Michigan, New Jersey, New York, Ohio, Pennsylvania and Wisconsin.

⁴The practice of midwifery in Arkansas has been defined in several ways by law and administrative regulation. In 1952 the State Board of Health acting under the authority of Acts 1913, No. 96 (Arkansas Statutes of 1974) promulgated rules and regulation which said "The term midwife shall be held to mean any female other than a physician who shall attend or agree to attend any woman during childbirth and who shall accept any pay or other remuneration for services." According to Act 838 adopted in 1983, "The practice of lay midwifery means and includes any act or practice of attending women at or during childbirth." And according to the regulations promulgated on August 3, 1984 by the Arkansas Department of Health, a lay midwife is "any person, other than a physician or licensed nurse midwife who shall manage care during the ante-partum, intrapartum or postpartum periods; or who shall advertise as a midwife by signs, printed cards or otherwise. This definition shall not be construed to include unplanned services provided under emergency, unplanned circumstances."

⁵According to the U.S. Bureau of Census, *County and City Data Book*, 1983, the percentage of black population in each of the six counties in which midwifery was legalized is Chicot, 52.9; Monroe, 40.8; Phillips, 52.9; Lee 54.8; St. Francis, 46; and Woodruff, 31.

⁶We averaged the per capita incomes of the six counties in which midwifery was legalized to derive a per capita for these counties of \$6,908.

⁷The regulations specifically indicated, in accordance with Act No. 96 of 1913, Section 28, that a fine of not less than ten dollars nor more than \$100 be assessed or imprisonment not exceeding one month, or both.

⁸Telephone interview with Dr. Byron Hawkes, former Director of the Maternal Division in the Arkansas Health Department, June 5, 1985.

⁹Phone interview with Sherry Gibson, a Dermott community activist, September 2, 1983.

¹⁰Chapter 72-604 of the Arkansas Statutes notes a number of occupations which are exempt from the medical practices act although they may be subject to other pertinent state laws, e.g., physician therapist, osteopathy, cosmetology. Midwifery was not included in the statute.

¹¹Phone interview with Senator Jack Gibson, September 4, 1983.

¹²Testimony by Carolyn Vogler before the Senate's Public Health, Welfare and Labor Committee, February 2, 1983.

¹³The first author of this article attended a workshop of the Arkansas Association of Midwives in October, 1982, at the Delta Maternity Center. Attending that meeting were about eight midwives, not including two grannies who briefly stopped in.

¹⁴Senator Gibson represents District 35 in the Arkansas Senate which consists of Desha, Drew, and parts of Ashley and Chicot Counties.

¹⁵Phone interview with Senator Jack Gibson, September 4, 1983.

¹⁶For an example of this strategy, see Vogler's letter to the editor, "Hospitals and Doctors, Yes, but Not Actual Care," *Arkansas Gazette*- September 16, 1982.

¹⁷See "An Apology to Vogler," *Arkansas Gazette* (September 25, 1982).

¹⁸*Ibid.*

¹⁹The other state to have passed a creation science law was Louisiana. The Arkansas law was found unconstitutional in the case of *McLean, et al. vs. the Arkansas Board of Education, et al.*, U.S. District Court, Eastern District Arkansas, January 5, 1982.

²⁰Rosenthal's data from 1963-1974 show that amateur legislatures pass a substantially higher percentage of bills introduced than professional legislatures, although certain legislatures do not fit the generalization. Georgia and Arkansas, for example, had .60 and .58 rate of adopted bills; Nebraska, .63; South Dakota, .51; Idaho, .55. On the other hand, Rhode Island during this period only had a .20 rate, Wyoming, .38, and Mississippi, .36. On the professional legislatures side, all of those noted by the 1984-85 *Book of the States* (see footnote 3) had rates of .26 and below, with the exception of California and Illinois which had rates of .42 and .43 respectively. More recent data drawn from the *Book of the States* show that Arkansas for the 1981 session had a .63 adoption rate, California for the 1980-82 session had a .48 rate; and Rhode Island, for its 1981 annual session including resolutions had a .43 rate and a .52 rate for the 1982 session.

²¹Phone interview with Ken LeMatis, lobbyist for the Arkansas Medical Association, September 11, 1983.

²²See statements of Carolyn Vogler, Father Joe Blitz, and Dr. John Wolverton in favor of SB203 before the Public Health, Welfare and Labor Committee of the Arkansas General Assembly, February 2, 1983.

²³Phone interview with Senator Jack Gibson, September 4, 1983.

²⁴See "Senate Approves Bill to Legalize Midwifery," *Arkansas Gazette* (February 25, 1983).

²⁵See "Physician Opposition Kills Bill to Legalize Midwifery," *Arkansas Gazette* (March 9, 1983).

²⁶*Ibid.*

²⁷*Ibid.*

²⁸See "Clinton Signs Midwife Bill, Cities Concern", *Arkansas Gazette*, (March 29, 1983). It is interesting to note that Clinton also signed into law that same day a bill which permitted nurse-midwives to practice in the state under the regulation of the state nursing board. That bill has been introduced by the medical community to short circuit the lay midwifery bill. It also is interesting to note that Clinton had unexpectedly been upset by Frank White in the 1980 gubernatorial election because of what many thought was inattention to voter interests. Clinton regained the governorship in 1982, after apologizing for his mistakes. His attention to the midwifery issue therefore suggests that he did not wish to repeat her earlier mistake and risk alienating the large number of citizens living in Southeastern Arkansas who were most directly affected by the bill.

²⁹Phone interview with Carolyn Vogler, September 11, 1983.

³⁰On the effect of party on voting see Susan Welch and Eric H. Carlson, "The Impact of Party on Voting Behavior in a Non-partisan Legislature," *American Political Science Review*, Vol., 67, No. 3, (September, 1983 (854-867)); and John J. Carroll and Arthur English, "Constitution-Making Roles and Delegates Behavior," *Polity*, Vol. 17, No. 3, (Spring 1985, 586-594).

³¹Phone interview with Carolyn Vogler September 11, 1983, and February 20, 1984. This quote was repeated to Vogler by John B. Currie, the consumer representative on the State Medical Board who heard Joe K. Verser, Secretary of the Medical Board, say it in a meeting after the midwifery bill passed.

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