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AN ALTERNATIVE BIRTH CENTER IN ANCHORAGE: THE CHILDBIRTH EDUCATION ASSOCIATION SURVEY

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Research Project

I. INTRODUCTION

A movement away from hospital births has been developing in recent years, as more and more women are electing to have their babies born either at home, or in an Alternative Birth Center (hereafter, "A.B.C."). "Parents favoring home birth have very definite convictions as to what's best for mother and child. Generally they want: labor and delivery in one room (without unnatural restraints), husband coaching and supporting his wife throughout, infant nursed immediately and remaining with his or her mother.... They don't want the routine pubic shave, enema and episiotomy.... Above all, they want no drugs or anesthetics."[1]

At the present there is one A.B.C. in Anchorage. Women who don't choose to have their babies born in a hospital setting have few options available. They can have a home delivery attended by a lay midwife (or no attendant at all), or they can deliver in Dr. Hedric Hanson's A.B.C. if they choose to utilize him as their obstetrician. The Childbirth Education Association (hereafter C.E.A.) of Anchorage is investigating this problem by initiating a study to determine if enough community support exists to establish another A.B.C. in this city. Alaska Hospital is scheduled to open an A.B.C. in April, 1980, but it has been unable to assure the public that it will open it because of difficulties in staffing and

financing the new unit. These writers have elected to carry out the C.E.A. study as their research topic for the following three reasons:

1. To learn research technique and methodology.
2. To study community health needs from a nursing perspective.
3. As women, to have other childbirth options available to us.

II. METHODOLOGY

In our study we researched many variables. With the C.E.A. members (clients) we inquired about age, income, level of education, previous childbirth experiences, economic status, and occupation. With nurses and physicians we investigated age, their specific type of practice or licensure (obstetrics, general or family medicine for doctors; associate, diploma or baccalaurate degrees, and midwife certification for R.N.'s), and their number of years of experience in labor and delivery. We expected all of these variables to have an effect on the varieties of responses compiled. For example, a woman who has had an unpleasant childbirth experience in a hospital may favor having her next baby in an A.B.C., while the first time mother-to-be might not. Similarly, a woman with a grade school level of education might be expected to be less receptive to change (from a hospital birth), whereas a college

educated woman may be more open to a less traditional setting. From a nursing perspective, a nurse who is a relatively recent graduate, or who has special midwife training, we expected to be supportive of an A.B.C. Physicians recently graduated from medical school, or doctors in practice for many years who have incorporated home visits in the past were believed to react more favorably towards an A.B.C.

The format of our study was a brief questionnaire directed at these three groups, but all were reached in different ways. The parents' group, specifically the mothers, were mailed a questionnaire. The C.E.A. maintains a mailing list of 900 parents either currently enrolled in childbirth education classes (whom presumably are expecting babies), or those parents formerly enrolled in classes whose infants were born within a year. Because of mechanical problems with the C.E.A.'s printer, questionnaires were sent only to 250 members who were known to be active in the organization.

To reach the nurses we personally visited the Director of Nursing at Providence Hospital, and the Director of In-service at Alaska Medical Center. We explained our research to the directors and received positive responses. We then took our questionnaires to the head nurse in Labor and Delivery at both institutions and asked them to distribute the questionnaires to their staff. We received a 77% return from

Alaska Medical Center and a 26% return from Providence Hospital (41% overall response).

We also visited the offices of the 23 known physicians in Anchorage who deliverd babies (obstetricians, family practicners, or general practioners) at the time of our survey. We were favorably received by the receptionists in all of these offices, and eventually nine questionnaires were returned in the mail (43% response). We "dressed up" for these visits, foregoing the usual student attire, to make a favorable impression upon the receptionists who route the mail.

In all of the three groups we deliberately decided to address only those parents, nurses, and physicians intimately associated with the childbirth process. We reasoned that if there was any support or antagonism towards an A.B.C. in Anchorage, this population subgroup would be most affected and would wield the most power and influence in the community.

Copies of the nurse, parent and physician questionnaires are attached to this report. We attempted to ask similar questions of each group, keeping in mind the perspective of the respondent. For example, if a mother were at an A.B.C. it would be in the capacity of a client, and we asked, "If an A.B.C. were available in Anchorage would you have your baby there?" Likewise, we asked nurses, "...Would you seek employment there?" Of physicians we inquired, "...Would you attend deliveries there?"

III. LITERATURE RESEARCH

It was not the intention of the researchers to take sides by either endorsing or disparaging an A.B.C. in Anchorage. Aside from the learning experience, our purpose was to provide a data base for the C.E.A. in planning, decision-making, and policy formulation in this matter. Literature research we have done in preparation for this project indicated that alternative birth options, both at home and in birthing centers, are increasingly popular in the Lower 48, and safe from a medical point of view. These major points appeared throughout the literature.

In this age of consumerism and self-help groups, it is not surprising to find childbearing women and their partners expressing dissatisfaction with traditional maternity care services. Many lay persons have become increasingly knowledgeable about the process of pregnancy and birth, and wish to share in the responsibility for their own care during this time. Often this leads to conflict with prevailing attitudes of health professionals; when this happens the couple feels frustrated in their attempts to seek a childbearing experience that is not only physiologically healthy but also phychologically satisfying for them.

Disenchantment with hospital obstetrical care is almost certainly one of the reasons behind the increasing number of

home births. Generally the medical profession has not supported home births and, in fact, discourages its own members from attending them. As a result of consumer pressure, the medical profession is beginning to rethink its intransigent insistence towards hospital births. Alternate Birth Centers are evolving as a compromise between parents and the medical profession. All the articles we reviewed stressed that A.B.C.'s are more oriented towards family participation without compromising client safety. Interestingly, many women in our client survey cited the safety features of hospitals as a positive factor in a hospital birth. However, some of the literature we surveyed suggested that hospitals actually precipitate birthing complications (forceps' injuries, fetal compression and oxygen deprivation in induced labors, analgesic medication during labor, increased risks of infection).[2, 3, 4]

Overall, our literature survey showed that A.B.C.'s are popular in the lower 48, do a brisk business, and do not pose any undue risk with careful health screening of applicants. Furthermore, parents utilizing these centers have been very satisfied with their health care.

IV. HYPOTHESES

We proposed the following hypotheses in our research. These hypotheses will be further discussed in the section on findings.

1) Parents (specifically the C.E.A. members) support the establishment of an A.B.C.:

a) Clients would support an A.B.C. because of an increase in control and in family participation in the birth experience.

b) As the level of education and income increases, C.E.A. members would be increasingly supportive of an Alternative Birth Center.

2) Nurses support the establishment of an A.B.C.:

a) The longer a nurse has been active in labor and delivery, the more supportive she/he would be of an A.B.C.

b) Nurses would feel that increased client control and satisfaction would be the most important reasons why clients would desire an A.B.C.

c) Nurses would feel that R.N.'s with experience in hospital labor and delivery rooms, certified midwives, and obstetricians would be qualified to deliver infants in an A.B.C.

3) Physicians support the establishment of an A.B.C.:

a) Physicians would support an A.B.C. if it were in close proximity to a hospital.

b) Physicians would perceive client satisfaction as the most important reason for clients to choose an A.B.C.

c) Physicians would believe obstetricians and gynecologists, other medical doctors, and certified midwives

could deliver babies in an A.B.C.

(The null hypotheses would state that each of these groups would not support the establishment of an A.B.C.)

In the remaining sections we will summarize the main findings of parent, nurse and physician surveys. Of those questions that we asked of all three groups (how desirable is an A.B.C., preferences for prenatal care and birth attendants, where to locate an A.B.C., and ranking of reasons to use an A.B.C.) we will cross-compare the responses. Finally, we will summarize the main conclusions relating to our hypotheses.

V. FINDINGS: PHYSICIANS' SURVEY

We left surveys at the offices of the 23 physicians who deliver babies in Anchorage. Only nine surveys (43%) were returned which is approximately what we anticipated, but, nonetheless, receiving less than ten responses was disappointing. Because of the extremely small sample, it is hazardous to assume statistically accurate conclusions. Six obstetricians and three general practioners completed our survey. Of this number, 89% were between 33 and 45 years of age. Only one physician was 50. Alaska is a young state and physicians practicing in Alaska tend to be younger than physicians in the rest of the United States; we feel that the age group above generally reflects the age group of the physicians in Anchorage. The range of years in practice varied between 4 and 25. Eight

physicians had children and all of these children were born in a hopsital.

This subgroup yielded the fewest items for analysis. Some of the returns were inaccurately completed which reduced our units of analysis even further. We will compare the meager bulk of information with the other two subgroups in the conclusions.

VI. FINDINGS: NURSES' SURVEY

At the time of this survey there were 24 staff nurses working in labor and delivery at Providence Hospital, and eight staff nurses working in labor and delivery at Alaska Hospital. Thirteen surveys were returned (or 41%). We do not have any conclusions as to why the returns were so low, and do not feel that this return is related to poor methodology. One nurse did remark that, "It is hard to get nurses to sit down and fill out surveys."

We ran breakdown analyses and cross-tabulations with several variables (seeking employment in an A.B.C. by age, by type of nursing degree, and by years of experience in labor and delivery) to see if the latter variables influenced the former. When asked if the nurses would seek employment in an Alternative Birth Center there was an even distribution of responses:

31% -- Yes

31% -- Don't know

39% -- No

In the cross-tabulation of seeking employment in an A.B.C. with age, there was no real statistical correlation (tau = .27, significance = .21), although less experienced nurses in labor and delivery said they would seek employment in an A.B.C., while those who worked in labor in delivery for many years (14 or more) tended to say no. Maybe those nurses with less experience have not established firm behavior patterns and opinions regarding labor and delivery and are more open to change.

The educational background of the R.N.'s who answered our questionnaire is as follows:

Certified Nurse Midwife	8%	(One respondent)
Licensed Practical Nurse	15%	(Two respondents)
Associate Degree Nurse	23%	(Three respondents)
Diploma Nurse	31%	(Four respondents)
Bachelor of Science Nurse	39%	(five respondents)

There were no master degree nurses and no Nurse Practioners, presumably because they would be engaged in a higher level of practice as public health nurses or as private practioners, and therefore were not exposed to this survey. Some interesting results emerged in the cross-tabulation of whether they would seek employment in an A.B.C. with their types of nursing degrees:

Nurses in Each Category*	Seek Employment in A.B.C. YES	DON'T KNOW	NO
C.N.M.			1
L.P.N.		1	1
A.D.N.	3		
Diploma			4
B.S.N.	1	3	1

(*NOTE: Nurses were allowed to mark more than one type of nursing degree if it applied.)

We expected to see that as the level of education increased so would the desire to work in an A.B.C., but our results did not confirm this. As shown by the table above, all the Associate Degree nurses (2 years of training) desired to work in an A.B.C., while the Diploma nurses (3 years of training) said they did not. The baccalaureate nurses (4 years of training) were evenly distributed. To investigate this further, the researchers cross-tabulated age and years of experience with the training of the nurses. We discovered all the Diploma nurses to be older than 40, while the Associate Degree nurses were younger (27, 29, 50). Diploma nursing schools are being phased out, and most Diploma graduates completed their training a number of years ago.

As the diploma-type schools of nursing are being phased out, Associate Degree nursing programs are replacing them. Graduates of the newer schools will be younger, and will have

to compete with nurses with more years of schooling (Diploma and Baccalaureate programs). The nurses with the least education will have the least job mobility; public health and nurse practitioner positions go to those with the advantage in formal training. Therefore, if the Associate Degree nurses are at a disadvantage in the job market and limited to hospital staff positions, nursing homes, and doctors' offices, the opportunity to work in an A.B.C. may offer a welcome change in work setting.

We also discovered an interesting correlation between age and years of experience.

Age	Percent of Nurses	Years of Experience	Percent of Nurses
26-30	54%	0-5	55%
40-56	46%	14-30	45%

When broken down into frequencies, we saw a correlation between age and number of years working in labor and delivery. This is logical since one would expect younger nurses to have less experience than older nurses. In addition, there was a gap in our table; we had no nurses between 31 and 39 years of age, and none with experience between 6 and 13 years. The nurses in this category may have returned to school for further education, may be practicing outside the hospital setting (doctors' offices offer better hours for women with families) or may be temporarily out of the job market to raise their families.

Beyond frequency tabulations, this sample is too small to produce statistically significant data when one tries to cross-tabulate variables with each other (age, years of experience in labor and delivery, education). The comments above regarding why younger nurses may be more likely to seek employment in an A.B.C. than older nurses, or those regarding why no nurses between 31 and 39 years answered our survey are not going to have a major impact on decisions or policies of the C.E.A. when or if it elects to establish another A.B.C. Most importantly, the vast majority of nurses felt an A.B.C. would be desirable in Anchorage (see Section VIII).

VII. FINDINGS: PARENTS' SURVEY

In analyzing the parent data, we must reiterate that they do not represent a random sample. The C.E.A. membership of 900 persons probably is not representative of the population of expectant parents in Anchorage; the 250 "active" members who received the questionnaire are not even representative of the total C.E.A. organization. The nonrandomness is reflected in our statistical data.

The parents are an educated, affluent, and younger group. Ninety-nine p- ent have a high school level or better education;

High School Graduate	13%
Some college or vocational training	44%
College graduate	18%
Post-graduate	25%

(In 1978 in Anchorage, only 92% of the general population had high school or higher training.)[5]

Seventy-seven percent of the respondents owned their homes, and the majority were under 35 years of age:

21-25 years	37%
26-30 years	30%
31-35 years	27%
36-38 years	6%

(In Anchorage, 66% of the general population owned their homes in 1978.)[6]

When we asked the women about their occupations, we allowed them to check as many categories as applied:

Homemaker	52%
Employed full-time	28%
Employed part-time	28%
Student full-time	3%
Student part-time	3%

Due to the homogeneity of the respondents, variables such as age, education, occupation, and income did not deviate significantly to yield statistical data.

Slightly less than half of the respondents (47%) were pregnant at the time they answered the survey. Sixty-five

percent of all the women had one or more children:

One child	26%
Two children	27%
Three children	12%
No children	34%

We asked all the women where their children were born. Because some mothers with more than one child delivered their babies in more than one setting, and because some women did not have any children, our percentiles total over one hundred:

Born in a hospital	62.5%
Born at home	16%
Born in an A.B.C.	1%
Born other	1%
No children	34%

The percentage of home births among our respondents is double the number of home births estimated to occur in Anchorage.[7] Of the women who delivered babies in a hospital, we asked them how satisfied they were with their experience:

Very satisfied	26%
Somewhat satisfied	29%
Don't know	2%
Somewhat dissatisfied	20%
Very dissatisfied	22%

We also asked women how satisfied they were with a non hospital birth experience:

Very satisfied	89%
Somewhat unsatisfied	6%

And we asked all the women if they would deliver their babies in an A.B.C. in the future:

Yes	58%
No	15%
Don't know	27%

Some of the results of these frequency tabulations were intriguing, and we looked further into them to see if we could find correlations within the parent data. We wondered if people would use an A.B.C. to save money, and in Anchorage, at least, it appears not. (We regret that we did not ask the parents about medical insurance.) In preparing our research project, the literature search showed that A.B.C.'s in some places could reduce the cost of a hospital birth by as much as one-half for consumers. In these days of lower birth rates in the United States, hospitals are having to compete for maternity patients; an A.B.C. can be a drawing card for these clients and a money maker for the hospitals.[8]

In April, 1980, the researchers contacted the accounting offices of the Alaska Medical Center, Providence Hospital, and Dr. Hanson of Anchorage to obtain the following:

	A.B.C. Delivery	Conventional Hospital Birth (Includes two-day stay)
Alaska Medical Center	$ 700	$1,200
Providence Hospital	-	$1,200
Dr. Hanson*	$1,500	-

*The average obstetrical fee in Anchorage, which includes prenatal care, delivery, and post partum checkup is $700; this is not included in the above amounts with the exception of Dr. Hanson. His fee is all inclusive.

From this breakdown it appears that consumers locally could save $500 by having their babies in an A.B.C., but this may not be a consideration if maternity patients are covered by a medical insurance program that would pay all costs, regardless.

To see if the less affluent respondents would utilize an A.B.C. to save money, we compared home owners vs. renters and whether or not renters (with presumably lower incomes) would have their babies in an A.B.C. There was no significance at all. And, in fact, when we cross-tabulated the owners/renters with parents whose children were born at home (16) or in an A.B.C. (1), it was significant (significance factor = .06) that 75% were owners. If anything, those couples with higher incomes (home owners) might be less likely to have their children born in a hospital.

Classically, education and income have been directly proportional and our survey confirms this. Our respondents are both more educated and more affluent than the general

population, using home ownership as a yardstick for income. A higher level of education (with the implied openness to new ideas, etc.) is probably more likely to be a factor in a couple's decision to have their child in a non-traditional setting, than is their income.

We noticed that 16% of the women had their babies born at home which is an exceptionally high percentage in Anchorage. However, this is unlikely to be an accurate representation of the population at large because of the unrandomness of our survey. This small group of "mavericks" have strong opinions regrading home births. Eighty-seven percent of the women who had their children at home don't want an A.B.C. to be located in a hospital. (Chi Square significance = 0.0014).

We cross-tabulated these women who had home births against whether they would use an A.B.C. in the future. Six said yes, five didn't know, and four would not. While these numbers are not statistically significant, they may interest any health care providers who believe that if an A.B.C. were widely available, then the number of home births would drop. Several respondents offered comments: "The A.B.C. would have to be pretty good to be better than home." "We had a very satisfying home birth experience and would definitely do it again." The implication is that women who are advocates of birthing at home are not going to have their baby in an A.B.C.

or a hospital.

It is interesting to note the different degrees of satisfaction of those women who had traditional hospital versus home births. Of the former group, 55% were satisfied with their experiences (26% very satisfied, 29% somewhat satisfied). But of the women who had a non-hospital (home) birth, 89% were very satisfied. Keeping in mind that this percentage only represents 15 women, and therefore is too small in number to make valid statistical inferences, it is still a striking contrast, especially when only 26% of the women who had conventional births were very satisfied with a hospital delivery. (It may have been helpful to have asked the mothers to name the hospital where their children were born, except that with Alaska's high transiency rate, many of the children may have been born Outside.)

Women were graphic in describing their least-liked features of a hospital birth: "disrespectful treatment, unnecessary and painful procedures;" "being treated like a piece of meat -- like cattle to slaughter;" "you were restricted to who could be a part of the labor and delivery -- I would have liked more company and support during my labor;" "you are not a person -- only an object that needs to be dealt with in a prescribed manner;" "separation from infants, non-support of breast feeding, routine episiotomy." Their responses were less varied in describing aspects they liked best in a hospital

setting: "nothing;" "it was a high risk situation -- I was in need of attention and appreciated it;" "some nurses were so sweet;" "I felt secure that if anything happened, there would be immediate help available;" "safety."

In the next section the responses of the parents, nurses and physicians to (essentially) the same questions will be analyzed.

COMPARISON TABLE OF THREE SUBGROUPS

	Parents (89 Returns)	Nurses (13 Returns)	Physician (9 Return
1. Desireability of A.B.C. (Somewhat or very)	91%	92%	100%
2. Prenatal Care Preference In A.B.C.			
Obstetrician	58%	100%	100%
Certified Nurse Midwife	35%	92%	100%
Other MD	-	69%	89%
RN with labor and delivery experience	-	46%	22%
3. Delivery Attendant Preference In A.B.C.			
Obstetrician	46%	100%	39%
Certified Nurse Midwife	45%	91%	100%
Other MD	-	66%	79%
RN with labor and delivery experience	-	83%	11%
4. Where to Locate A.B.C.			
In a hospital	42%	69%	100%
Not in a hospital	32%	8%	-
Don't know/either place	26%	23%	-

5. Reasons to Use A.B.C.	Most Cited	Least Cited	Most Cited	Least Cited	Most Cited	Least Cited
Low cost		30%		50%		33%
Non-hospital environment		36%			80%	
Continuity of care				33%		50%
Participation of family and friends	22%					
More client control	28%		41%			16%
More client satisfaction	21%		33%		20%	
More safety than a home delivery		21%		16%		

VIII. COMPARISONS OF RESPONSES OF ALL THE GROUPS AND CONCLUSIONS

Not surprisingly, all three groups felt an A.B.C. in Anchorage would be desirable. In fact, not a single respondent checked "don't know," "somewhat undesirable," or "very undesirable."

When we asked parents, nurses and doctors to indicate their preferences for prenatal care-givers and delivery attendants in an A.B.C., they could choose among obstetricians, other physicians, Certified Nurse Midwives, R.N.'s with labor and delivery experience, lay midwives, and others. The parents were asked to check two choices but health care professionals were allowed to check as many as they wanted; this was an oversight that was not discovered in proofreading. (See Comparison Table on previous page, and attached copies of the questionnaires.)

Parents were overwhelmingly in favor of obstetricians and Certified Nurse Midwives for both prenatal and delivery care. This seems reasonable when considering that both of these professional groups are childbirth specialists. The health professionals were somewhat evenly distributed in their responses on their preferences, with the exception of their perceptions of the functions of an R.N. with labor and delivery experience. Forty-six percent of these nurses felt they could give prenatal care, and 83% felt qualified to be deliv ry

attendants. Only 22% of the physicians felt nurses should be able to give prenatal care, and even less (11%) thought nurses with experience in labor and delivery should actually deliver infants. This is a wide disparity in the perceptions of responsibilities of experienced R.N.'s. The vast majority of labor and delivery nurses feel qualified to deliver babies; in fact, it is their responsibility to "catch" babies if the physician doesn't quite make it. Perhaps this occurs more often than doctors realize. (Recently an obstetrician stated to one of these researchers that he did not see the need to come to the delivery room to "catch" babies in normal deliveries, because R.N.'s were more than qualified. He added that most physicians still are not ready to relinquish this control in the delivery room.)

The researchers puzzled over this contradiction in which the vast majority of labor and delivery nurses felt qualified to deliver babies in an A.B.C., while the vast majority of physicians who responded felt the nurses were not. Perhaps the physician is aware only of his/her own practice, and knows only of the times when he or she arrived too late and had to rely on a nurse in the delivery room. But the nurses see all the doctors, and may have a better perspective on a wider scale of how often they and their peers attend deliveries in the absence of physicians. These nurses may feel qualified to attend

births because they actually are "catching" babies, on a scale that doctors are limited in perceiving.

Health professionals overwhelmingly preferred an A.B.C. in a hospital setting, but the actual consumers of health care, the parents, were not so certain. Less than a majority of the latter preferred a hospital location (42%); a third wanted an A.B.C. in a non-hospital setting and a fourth either didn't know or it didn't matter. Doctors and nurses appear to be biased in favor of their traditional turf, and it looks as though their clients are challenging this assumption.

When one looks at the most important reasons the parents cited in their decision to utilize an A.B.C., they were rather equally divided on "more client control," "more client satisfaction," and "participation of family and friends." Hospitals traditionally have not given a maternity patient much, if any, control over her birth experience, and there is no hospital to this researcher's knowledge that allows a woman to invite her family and friends to participate. One parent noted on the questionnaire she returned that if one can control a situation, then it follows that one will be more satisfied. In this light where the consumers of maternity care are indicating they want more control of the process, then it is easier to understand why they want to dissassociate from a hospital setting where control is in the hands of others.

The least cited reasons by parents to use an A.B.C. seem to correlate with this. "A non-hospital environment for patients who are uncomfortable in a hospital setting," "lower cost," and "more safety than a home delivery" are the least important reasons to use an A.B.C. from their perspective. They don't elect an alternate birth setting because hospitals intimidate them, or because they worry about the safety of home births. It seems that what parents want is more control of their birth experience.

The nurses also cited the "more control/more satisfaction" reasons as their perceptions of why parents would use an A.B.C. But the doctors did not pick up on this. Eighty percent thought patients would use an A.B.C. because it offered a "non-hospital environment," and we have already seen that this was actually one of the least important reasons given by the parents. Additionally, the physicians cited "more client control" as being one of the least important reasons a couple would use an A.B.C., but the clients see this as the most important reason! (See Comparison Table.)

Due to the format of the three questionnaires, it is not possible to statistically compare items of data from the parent survey to those of the nurses and physicians, and vice versa. This would present a formidable programming task beyond the capabilities of these researchers. However, because of the

few respondents in each of the professional groups it is unlikely that this lack impairs this study.

IX. SUMMARY AND CONCLUSIONS

Our small sample sizes derived from the physician and nurse surveys and the unrandomness of the parent group has affected the statistical results of this project. Ordinarily, statistical research requires samples of at least 35 items to have any validity, and with nursing and medical samples, only 13 and 9, respectively, our data is obviously hampered. Furthermore, our parent group respondents are almost "too alike" to show up any differences. The 16 respondents to the parent survey who had their children at home are the only exception to this. But, colloquially speaking, they "stuck out like sore thumbs" in the computer print outs. It was only the input from this group that yielded data that was statistically significant, but in terms of the needs of this research, its validity is of minor importance.

This is certainly not to say that no information can be extrapolated from the C.E.A. project. Most importantly, all three groups in this survey unanimously believe that an A.B.C. in Anchorage would be either somewhat or very desirable, and this seems to support our three main hypotheses (see Section IV: "Parents...nurses...physicians support the establishment of an A.B.C.")

Reviewing the parent sub-hypotheses:

1a) Parents would support an A.B.C. because of an increase in control and in family participation in the birth experience.

1b) As the level of education and income increases, C.E.A. members would be increasingly supportive of an A.B.C.

Our data only coufirms the former; the parent group was too homogeneous to affirm 1b

The results of the nursing hypotheses are also mixed:

2a) The longer a nurse has been active in labor and delivery, the more supportive she/he would be of an A.B.C.

2b) Nurses would feel that increased client control and satisfaction would be the most important reasons why clients would desire an A.B.C.

2c) Nurses would feel that R.N.'s with experience in hospital labor and delivery rooms, certified midwives, and obstetricians would be qualified to deliver infants in an A.B.C.

Our first hypotheses is not supported, and our data suggests that older nurses would not want to be employed in an A.B.C. (although this doesn't necessarily mean they don't support it). Items 2b) and 2c) appear to be supported by our data.

Finally, to review our physician hypotheses:

3a) Physicians would support an A.B.C. if it were in

close proximity to a hospital.

3b) Physicians would perceive client satisfaction as the most important reason for clients to utilize an A.B.C.

3c) Physicians would believe that obstetricians, other medical doctors, and certified midwives could deliver babies in an A.B.C.

One hundred percent of the physicians in the survey thought an A.B.C. should be located in a hospital, but none of them perceived client satisfaction as an important reason for parents to opt for an A.B.C. Our data agrees with 3c) above.

In addition to the hypotheses, a few other points that emerged in the questionnaires bear repeating:

1) Home births would not necessarily decline in Anchorage with the establishment of an A.B.C.; women whose children were born there seem to feel very strongly that there is no place like home.

2) The participation of friends and family members is important to some parents; the health professionals did not perceive this.

3) A majority of nurses and doctors selected a hospital as the best location for an A.B.C., while only a minority of parents agreed with this.

4) Eighty-nine percent of the mothers who had babies at

home were very satisfied and only 6% were somewhat unsatisfied. Of women with conventional hospital births, only 26% were very satisfied, and 42% were somewhat or very dissatisfied.

5) Although locally A.B.C.'s appear to save money for sonsumers, this is not a major reason why parents would select this childbirth setting.

6) R.N.'s with experience in labor and delivery feel qualified to deliver babies, while their medical colleagues do not appear to share this opinion.

These researchers feel that these additional six findings could provide some insights for health care planners; a gap may possibly exist between what the public wants and what the nursing and medical professions think they (the parents) want. The desirability of an Alternative Birth Center in Anchorage has been positively established, but it's implementation remains a challenge.

ENDNOTES

[1]"Hospital Births vs. Home Births," Fredelle Maynard, Woman's Day, June 28, 1977.

[2]Women's Day, p. 12, 162.

[3]Journal of Reproductive Medicine, p. 291.

[4]Ms., p. 109, 113, 114.

[5]1978 Population Profile.

[6]Ibid.

[7]Undocumented information obtained through knowledgeable sources; i.e., lay midwives and nurses working in hospital labor and delivery settings.

[8]Canadian Nurse, p. 33.

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LEGISLATION AND NURSE-MIDWIFERY PRACTICE IN THE USA

Report on a Survey Conducted by the Legislation Committee of the American College of Nurse-Midwives

Reported by

Alice M. Forman and Elizabeth M. Cooper

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FOREWORD

In the twenty years since it was founded, the American College of Nurse-Midwives (ACNM) has achieved public and professional recognition of its competence and authority to certify nurse-midwives, to establish qualifications, standards and functions for the practice of nurse-midwifery, to approve nurse-midwifery educational programs, and to develop guidelines for nurse-midwifery services and for the continuing education of nurse-midwives.

A number of states have enacted separate legislation specifically recognizing the practice of nurse-midwifery. In other states, nurse-midwives practice under a variety of legal arrangements. Of the states which specifically recognize nurse-midwifery, some by statute or administrative regulation provide that graduation from a program approved by the American College of Nurse-Midwives and/or certification by the College shall, either alone or in conjunction with other qualifications, entitle a nurse-midwife to practice. Other states have specifically authorized nurse-midwives to practice in accordance with the College's Statement of Qualifications, Standards and Functions. We hope to see every state adopt legislation fully recognizing nurse-midwifery and the role of the ACNM. Until that happens, there is an urgent need for a legislation survey report summarizing current law and practice in the various states. The ACNM Legislation Information System, and in particular Alice Forman and Elizabeth Cooper, have rendered an invaluable service to the profession and to the public by conducting such a survey.

The legislation survey report is the product of countless hours of research, analysis and writing. It shows what an intelligent and dedicated group of non-lawyers can accomplish. This report summarizes in one source up-to-date information about the current legal status of nurse-midwives in all fifty states (as well as the District of Columbia, Guam, Puerto Rico, and the Virgin Islands), the qualifications for practice, the place to apply for licensure, the agencies (if any) employing nurse-midwives for full clinical practice, local ACNM affiliation, and a key source for legislation information. Citations are provided to relevant statutes, regulations and court decisions. The discussion of the legal status of nurse-midwifery in each jurisdiction takes into account not only statutes, regulations, judicial decisions, and Attorney Generals' opinions, but in addition, joint statements on nurse-midwifery developed by interdisciplinary professional groups as well as actual and current practice in each state. Reference is also made to pending legislation in some states which would fully recognize the practice of nurse-midwifery.

The law is in a constant state of change; recent statutes, cases and rulings are often unavailable because of delays in reporting, indexing and the like. Therefore, completeness and absolute accuracy may not be possible in a survey of this kind. However, the method and devotion which characterize this survey suggest that it must come very close to total accuracy.

The American College of Nurse-Midwives is to be congratulated upon the publication of this excellent survey. Not only is it an indispensable guide for everyone concerned with the delivery of modern health care to pregnant women and to infants, but it should provide a sound basis for progress in the achievement of uniform laws according full recognition to the practice of nurse-midwifery and to the role of the ACNM in developing and enforcing standards for the profession.

New York
March, 1976

Harriet F. Pilpel, J.D.
Eve W. Paul, J.D.

General Counsel,
The American College of Nurse-Midwives

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PREFACE AND ACKNOWLEDGMENTS

This report and the survey on which it is based were undertaken primarily by nurse-midwives for nurse-midwives and others actively involved with developing nurse-midwifery services and educational programs throughout the USA.

As we view the project now it seems like a case of "fools rush in where angels fear to tread." When we launched the data collection we were less aware of our naïveté than of the pressures of necessity. In the process of trying to answer a few basic questions about legislation and the practice of nurse-midwifery we discovered a whole new world of ideas to cope with. Clearly nothing involving human beings — infinitely variable and constantly changing — is really as simple and tidy as it seems at first. In particular, keeping this report up-to-date has prolonged its production. As it goes to press we know that portions of it are already past history and that others will be by the time it reaches its readers. Changes in legislation and professional practice in the health field today seem to be even more rapid and widespread than when we began our survey. Recognizing this, we are already preparing revised reports to appear in subsequent issues of the *Journal of Nurse-Midwifery*. Meanwhile, we would welcome the latest news and documents pertinent to nurse-midwifery from those readers who find us lagging behind the times.

All along the way through planning, data collection, analysis and reporting we have been blessed with help from many individuals and groups who with infinite patience and trust provided encouraging support and expertise. Most importantly, we acknowledge the help and support of the following:

Organizations and Institutions

The American College of Nurse-Midwives, Board of Directors

The A.C.N.M. Foundation Board of Trustees

Department of Public Health Administration, The Johns Hopkins University

Department of International Health, The Johns Hopkins University

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The publication of this report has been made possible by the generous financial support of The National Foundation - March of Dimes. We gratefully acknowledge their help and the interest in this project of their Director of Health Personnel Development.

We also thank Renate Wilson, our Technical Editor, and our secretaries, Jane Cook and Marlene DuVal, for their help and cooperation.

The most essential contributors to this whole effort, of course, were those who provided the basic information — our network of key sources. Most of them are still active and listed along with the information from their respective states in Part III of this report. We sincerely hope that they and their predecessors will feel rewarded by the unique digest of country-wide information which their efforts produced.

Finally, we would like to acknowledge the Editorial Board of the *Journal of Nurse-Midwifery* for reserving an entire issue of the Journal for this publication of this special legislative survey report and for entrusting us with the total responsibility for carrying this project to fruition.

ACNM
Washington, D.C.
March, 1976

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INTRODUCTION

The word "legislation" often has a soporific effect on nurse-midwives who are busy with clinical services. The language of law is dull or unintelligible. The dynamics of political forces seem unmanageable or incomprehensible. The safest position for a practitioner is probably to stick with practicing nurse-midwifery and avoid the unknown of the world beyond. However, nurse-midwives along with others interested in the development of nurse-midwifery have found that an important aspect of getting nurse-midwifery services started is assurance of the legality of their practice. Mounting uncertainties about whether or not state laws permit, or appropriately support, nurse-midwives to function fully in the management of normal pregnancies have led the American College of Nurse-Midwives (ACNM), through its Legislation Committee, to make a survey of the relevant legislation, the results of which are presented in this report.

As was true for undertaking the survey of legislation pertaining to nurse-midwifery, the purpose of the present report is to provide information which is useful to those involved in learning, practicing, or administering nurse-midwifery services. Although the term "survey" may imply an academic study, the content is intended to be of practical value to practitioners, and the report was indeed written for nurse-midwives by nurse-midwives. Part I, Survey Methods, describes both how the information on legislation was collected and how ACNM is organized to provide current information on a continuing basis. Part II, Survey Findings, summarizes significant differences in state laws and other provisions relating to nurse-midwifery and draws attention to problem areas. While not intended as an exhaustive analysis of similarities and differences in various state laws affecting nurse-midwifery, the main purpose of presenting the descriptive tables of information was to answer several frequently asked questions about the country as a whole. In the process of organizing the data we have become increasingly aware of the important difference between a survey of legislation pertinent to nurse-midwifery and an intensive study of its legal status. The latter task we have avoided, in the hope that it will some day be undertaken by legal experts.

Part III, the Directory of Information, in addition to answering several practical questions about how and where nurse-midwives may practice in each of 50 states and four jurisdictions (District of Columbia, Guam, Puerto Rico, Virgin Islands), includes a brief summary of the legal bases for either permitting or prohibiting nurse-midwifery. These capsule accounts are more by way of introductions to official documents than legal analyses. In scope and language they are the stuff of legal primers intended for novices rather than for experts in legislation or litigation. Our sources included responses to structured questionnaires, legal documents, and a multitude of informal communications from on-the-spot informants.

References to legislative and source documents in Part III may be disappointing to an expert on bibliographic style, but they are the result of an earnest attempt to help the readers of this report locate the actual documents and pieces of laws which are pertinent. Legal styles often require a decoding manual, and literary reference styles do not fit comfortably the requirements for identifying a legal document. It must also be noted that Part III reflects the legal and actual status of nurse-midwifery practice in the United States as of 1975. This should be kept in mind in using the Directory of Information, as changes were under way in several states even then, and other changes are expected in the near future. The most current information available can be obtained from the Legislation Information System at ACNM headquarters in Washington, D.C.

PART I

METHODS AND ORGANIZATION OF THE SURVEY

Many of the methods of collecting information for this survey of legislation pertaining to current nurse-midwifery evolved in the course of the survey. Plans and processes for the first "one-shot" effort, which was limited in scope and time, gradually developed into a continuing information system which now provides for constant updating of information, along with a reservoir of historical perspectives. Hence, the purposes of this section are two-fold: to describe how the data presented in Parts II and III of this report were obtained and to illustrate the goals of the Legislation Information System of the American College of Nurse-Midwives (ACNM).

In keeping with these aims, the following presents information on survey objectives, data sources, questionnaires, administrative organization, and financing with respect to (1) the initial survey in 1970-71; (2) the pilot project for a continuing survey method conducted in 1973-75; and (3) the current ACNM Legislation Information System.

INITIAL SURVEY

In 1970, the need for information about laws which either permitted or prohibited nurse-midwifery practice in various states was urgent. Nurse-midwifery services could not expand without determination of the extent of legal as well as professional support for nurse-midwives to function fully in the states and jurisdictions of the United States. At the same time, no single good source of information existed for the country as a whole; the American College of Nurse-Midwives (ACNM) had in its files data and documents on less than half of the states, and much of that information was obsolete. Furthermore, no federal government agency, national organization, or law library had complete, current and readily accessible information on laws and practices relating to nurse-midwifery. To fill this gap and meet the increasing demands for information, the ACNM Legislation Committee conducted a country-wide survey in 1970-71.

The main objectives of the initial survey were to determine

- What state laws were permissive, restrictive, or ambiguous with respect to nurse-midwifery practice;
- How state laws were affecting, or likely to affect in future, nurse-midwifery practice;
- What guidelines should be used in developing a sound legal base for nurse-midwifery practice.

Data Collection

Survey questionnaires were designed for the purpose of obtaining copies of current laws and data concerning nurse-midwives and lay midwives practicing in each state and jurisdiction. Along with these questionnaires, letters of explanation about the survey were sent to state health departments in 50 states and to health departments of four jurisdictions (District of Columbia, New York City, Puerto Rico, Virgin Islands). At the same time, duplicate survey materials were sent to nurse-midwives in 42 of the states and jurisdictions where they could be located.

By March 1972, one year after the first mailing of survey questionnaires, responses had been received from 94 percent of the health departments, with 74 percent responding to the first mailing, and 20 percent to a second mailing. For the remaining 6 percent (3 states), information was obtained through other sources such as State Boards of Medical Examiners, State Boards of Nursing, and knowledgeable nurse-midwives. In general, nurse-midwives proved to be important sources of information on many other states also, as they both interpreted the purposes of the survey to their respective health departments and produced useful and often important infor-

mation which had not been included in health department responses.

Reports of Results

Even before responses had been received from all states, reporting of the survey results was begun. A series of preliminary reports provided information on (1) patterns of legislation and the practice of nurse-midwifery; (2) legal bases for practice in states where nurse-midwifery was officially recognized; (3) a directory of licensing authorities; and (4) a list of institutions and agencies which employed certified nurse-midwives for practice. Also, the survey results were presented at the 16th International Congress of Midwives, Washington, D.C., November 3, 1972 (1). Furthermore, as the survey progressed its state files were frequently used for reference by the ACNM Legislation Committee in responding to letters of inquiry and in advising the ACNM Board of Directors and membership.

Administration and Financial Support

A "shoestring operation" characterizes rather nicely the administration, organization, and financial support for the first survey effort. Nurse-midwife members of the ACNM Legislation Committee were primarily responsible for voluntarily carrying out the project in their spare time. Research consultation, secretarial staff and office facilities were provided by The Johns Hopkins University School of Hygiene and Public Health under its DHEW Nurse Faculty Research Development Grant, and by funds from the ACNM.

Conclusions

Although this first survey yielded much useful information concerning state laws and the practice of midwifery, it also revealed the need for a more efficient system of collecting, reporting, and financially supporting such survey information on a continuing basis. Parts of the survey questionnaire were misunderstood by respondents. Some health departments were not able to provide pertinent public documents and data requested. Delays in obtaining information and analysis problems retarded the process of reporting. This meant that parts of the completed reports were obsolete by the time they were distributed. Expenditures in time and money for the whole project were far beyond the resources of the ACNM and its individual Legislation Committee members. Although these administrative and financial difficulties were formidable, the value of legislation information had increased, along with a growing realization of its practical potential for the establishment of nurse-midwifery practice. Experience with this initial survey thus formed the basis of recommendations to develop a continuing legislation survey method.

(1) Forman, A.M., Legislation and the practice of nurse-midwifery in the United States: Patterns, guidelines, and issues. *New Horizons in Midwifery*. London, International Congress of Midwives and American College of Nurse-Midwives, 1973, pp. 192-9.

CONTINUING SURVEY METHOD: A PILOT PROJECT

In order to implement recommendations for a continuing legislation information system pertinent to nurse-midwifery, the ACNM Board of Directors supported the ACNM Legislation Committee in its proposal to the A.C.N.M. Foundation to sponsor a pilot project. Its main objectives with respect to nurse-midwifery legislation were

- To identify a network of informants or "key sources," one for each state;
- To construct a questionnaire suitable for collecting essential information; and
- To develop an arrangement for making the system financially self-supporting.

In keeping with the first two objectives, a new survey was conducted in 1973 designed to obtain more complete, accurate, and current information on legislation and the practice of nurse-midwifery in the USA. This time the revised, pretested questionnaire was mailed to selected "key sources" in each of 50 states and 4 jurisdictions (District of Columbia, Guam, Puerto Rico, and the Virgin Islands). Although the 1970-71 survey had included New York City as a separate jurisdiction because its health code for nurse-midwives was different from New York State laws, the 1973 survey did not study the city separately because recently amended state laws regarding nurse-midwifery were applicable in the city and state alike.

Informants

The new group of 54 "key sources" (one residing in each state or jurisdiction) were, with few exceptions, nurse-midwives who had either provided useful information during the previous survey or had expressed interest in nurse-midwifery legislation, especially in their respective states. This approach to the selection of informants resulted from experience with the 1970-71 survey, in which informants who were involved specifically with nurse-midwifery had proved more effective than had health departments in providing informal information about the application of state laws and news of changes in process, as well as formal data and documents. Accordingly, the list of approximately 30 effective informants in the 1970-71 survey was expanded to include other interested nurse-midwives whose cooperation was solicited.

Although the initial response to this soliciting of key sources was excellent (only a few states were unrepresented), maintaining a complete and stable network for data collection was hampered by a 50 percent turnover rate among the key sources, nurse-midwives tending to move out of areas where practice opportunities were limited. However, despite continuing changes in key sources the network was gradually strengthened by new methods

of key source selection. These reflected the ACNM membership's growing awareness of the project goal to create a self-sustaining system, and also of the importance of being involved with legislation relating to the development of nurse-midwifery. In some states, key sources assumed responsibility for finding their own replacements among interested nurse-midwives. In other states, ACNM Chapters selected their key sources to represent them in the legislation information system. (1)

Data Collection

The revised questionnaire used in the 1973 survey was designed to improve data collection by changing items from the previous questionnaire which had been misinterpreted by informants or had thwarted efforts at analysis. The reconstructed questionnaire was then pretested with nurse-midwives who were ACNM Chapter chairpersons in ten states, randomly selected among those chairpersons who were not also key sources. Nine out of ten questionnaires were returned and proved so complete that no further modifications in the questionnaire seemed necessary.

While the response rate for the first mailing of revised questionnaires was only 50 percent, extensive follow-up of nonrespondents, and in states without key sources, brought in essential information for all of the 54 states and jurisdictions. In order to achieve this, persistent and varied follow-up methods had to be used not only where no questionnaire was returned but also where questionnaires were submitted but information was ambiguous or missing and documentation was required. These follow-up methods comprised three main approaches. Reminders and requests for clarification or for documents were sent by mail. When responses were still inadequate, key sources were contacted by telephone, and finally, where key sources were unavailable or did not send information as agreed, other sources were contacted such as key sources in neighboring states, regional representatives to the ACNM Board, or officials in state agencies. Personal contact by telephone proved the most effective means for getting results. Also, telephone communication, in contrast to letters, appeared more efficient in terms of project staff time and funds required. However, these efforts to get complete information prolonged the data collection phase of the project so that its timetable had to be extended by several months.

The project's reference files were greatly improved by the inflow of new laws and other pertinent documents. Many were received along with 80 percent of the questionnaire responses. Even after submitting their initial questionnaires, key sources continued to provide copies of more recently passed or proposed legislative bills, state board rules and regulations, etc. These voluntary efforts of the key sources have become an important element in the self-sustaining data collection system.

(1) Information on the key sources (names, mailing addresses, ACNM Chapter and Region affiliations) are listed for each state and jurisdiction in Part III of this report. Recent changes in key sources are available from the ACNM Legislation Committee.

Exploration of Funding Methods

Plans for achieving the third objective focused on finding ways of financing which would make the information system self-supporting, i.e., by sale of annual subscriptions to a series of periodic (semi-annual or quarterly) survey reports; by sale of individual reports; and/or by fees charged for the use of the legislation document files. The following questions had to be answered:

- How much could be realized from the sale of annual survey reports and from user fees for the legislation files?
- How many individuals, institutions, and agencies would subscribe on an annual basis and at what price?
- To what extent would these sources cover costs of collecting, processing, and distributing information annually?

It was found that although income from the sale of individual reports and from user fees might be incorporated more easily into the administrative management services of ACNM, these approaches were less likely to be significant sources of income. Conversely, while an annual subscription system seemed to be a more promising source, arrangements for soliciting and maintaining subscriptions were likely to present the ACNM with an excessive administrative and financial burden. Consequently, a fourth method is being tried out. Mutually advantageous arrangements have been made with the *Journal of Nurse-Midwifery* to publish and distribute periodic reports from the ACNM Legislation Information System, thus reducing the system's printing and distributing costs. On the other hand, subscriptions to the *Journal* may increase because it will publish updated legislation information in subsequent issues. However, to make the data collection part of the system self-supporting, other sources of income must be found.

Administration and Financing

Although the ACNM Legislation Committee was responsible for conducting the pilot project, the members' functions were reorganized in order to make more efficient use of their time and of project funds. A task force of three members concentrated on the resurvey. A fourth member explored methods of funding, while the remaining committee members assumed primary responsibility for other new activities of the Committee.

Office space and administrative support were provided by The Johns Hopkins University School of Hygiene and Public Health under a contract with ACNM. A member of ACNM and of the Hopkins faculty served as Project Director. Paid staff were limited to a technical editor and secretary who were employed part-time.

Financial support for this pilot project was initially provided by a grant of $4800 from the A.C.N.M. Foundation to the American College of Nurse-Midwives, which in turn contracted with The Johns Hopkins University School of Hygiene and Public Health to conduct

the project in the Department of Public Health Administration. An additional grant of $7500 was awarded to ACNM by The National Foundation - March of Dimes for preparation, publication, and distribution of the project report.

Timetable for the Pilot Project

In planning the pilot project, the timetable for its completion was estimated to be one year, i.e., six months for conducting the resurvey and reporting the results and an additional six months for exploring funding methods for the continuing Legislation Information System. This estimate proved to be rather optimistic. Data collection alone continued from March 1973 through May 1975.

There were many reasons for extending the time required for completion of the project, most important among them the fact that the volunteer staff responsible for conducting the project were ACNM Legislation Committee members who had numerous other commitments. Progress on the project was also delayed by pretesting the survey questionnaire by mail; difficulties in finding nurse-midwives to serve as key sources for states where nurse-midwifery practice is not established; efforts to contact key sources who were in the process of moving from one state to another; belated responses by key sources to the questionnaire and to follow-up requests for clarification on documents; and a large volume of correspondence in response to the upsurge of requests for recent information on legislation and nurse-midwifery. Also, there were new activities, such as a Legislation Workshop and a Consultation Service which were initiated by the Committee and which needed time and attention from the project staff, as well as the need for repeated revision of survey reports due to the large volume of new legislation and the increase in nurse-midwifery services. On the other hand, the extra time expended on this project will probably have improved the quality of the ACNM legislation information and the system for collecting, reporting, and using it.

ACNM LEGISLATION INFORMATION SYSTEM

The current ACNM Legislation Information System is now an established and vital activity conducted by the ACNM Legislation Committee with approval from the ACNM Board of Directors and participation from ACNM Chapters across the country. In order to help potential users to understand the system, this section will describe where it came from, what it is composed of, what it can do, how it works, and how it can be used.

Where It Came From

Experience with the 1970-71 and 1973-75 surveys had confirmed the assumption that planning for development of nurse-midwifery services requires knowledge of pertinent current legislation. Furthermore, maintaining an up-to-date reservoir of information requires methods of collecting data on changes in legislation and practice as they occur, which is almost daily. Equally important are means of making data available to users at reasonable prices. Finally, the surveys revealed that to be effective, an information system must be country-wide because state laws affecting nurse-midwifery practice vary widely. While such variation can be an obstacle to the expansion of nurse-midwifery, it also provides an excellent chance to compare advantages and disadvantages of the different legal bases for practice, and can guide the development of model laws for nurse-midwifery.

What It Is Composed Of

Important components of the system are (1) a Task Force that conducts activities, (2) comprehensive reference files of legislation information for each state, (3) legal consultation, and (4) ACNM documents and statements of other professional groups relative to legislation and new roles of health personnel.

The Task Force is composed of several ACNM Legislation Committee members and approximately fifty-four key sources. National Committee members are responsible for planning and conducting activities of the information system. The key sources, most of them members of the ACNM residing in each of the 50 states and 4 jurisdiction of the United States, form the network for communication on legislation and practice of nurse-midwifery. Because they are regarded as the experts with respect to their own states, close communication is maintained between these key sources and the Legislation Committee members through guidelines for their activities, correspondence, telephone calls, reports, and annual meetings. Key sources were important participants in the 1974 Legislation Workshop which drafted the ACNM *Position Statement on Legislation*.

The comprehensive files which are compiled separately for each state and jurisdiction contain the following main types of information pertinent to nurse-midwifery:

- Copies of laws and official statements of organizations or agencies;
- ACNM Legislation Survey questionnaire responses;
- News items and magazine articles about legislation and nurse-midwifery services in the respective states; and
- correspondence and notes on telephone communications with key sources and others concerned with nurse-midwifery. The materials date back to those collected in connection with the 1970-71 surveys.

The legal counsel available to the National Committee is Harriet Pilpel, General Counsel to the ACNM, and her associates. Legal consultations for key sources are usually obtained within their respective states.

Important ACNM documents which are used as a basis for activities of the information system include those on: ACNM *Philosophy; Qualifications; Standards*

and Functions; Position Statement on Nurse-Midwifery Legislation; and *Guidelines for Establishing Nurse-Midwifery Practice* (see Appendix A-D). Other important reference documents are the joint statements of the American College of Obstetricians and Gynecologists, the Nurses Association of the American College of Obstetricians and Gynecologists, and the American College of Nurse-Midwives; position statements of the American Nurses Association regarding nurse-midwifery and the expanded roles of nurses; the American Medical Association guidelines for physician assistants; and Department of Health, Education and Welfare publications on professional certification, licensure and statistics pertaining to health resources, as well as the ACNM *Guidelines for Establishing Nurse-Midwifery Services*, in particular the chapter on legislation.

What It Can Do

The potential functions of the legislation information system could be almost countless but for the constraints of funds, time, and expertise. However, experience with the ACNM legislation surveys indicated several main areas of activities for which there is increasing demand and which would appear feasible for the ACNM. With respect to legislation and nurse-midwifery these are *research, education,* and *consultation.*

Research would include a range of systematic investigations, such as data collection and analysis for country-wide legislation surveys, intensive studies of factors associated with permissive and restrictive legislation, descriptive case studies of how nurse-midwifery practice is legally established, and testing of "model" laws. Although in order to be useful, some types of studies need the expertise of trained investigators and lawyers, others could be effectively conducted by perceptive nurse-midwives. Often those at the grass roots, who shun matters of legislation as mind-boggling or dangerous, become politically quite sophisticated through a common-sense involvement with finding out whether or not they can practice nurse-midwifery in their own states.

Education with respect to legislation on nurse-midwifery is a primary purpose of the system's research activities. An urgent need for it was emphasized by participants involved in the ACNM Legislation Workshop of 1974, which drafted the ACNM *Position Statement on Legislation* and worked on strategies for establishing nurse-midwifery practice. The scope of such educational efforts is expanding with publications, annual meetings and correspondence with key sources, and workshops. Survey reports, guidelines, and position statements are distributed with correspondence and with annual reports to the membership, as well as through the *Journal of Nurse-Midwifery.* The aim of these educational activities is to reach a widening circle of people involved with establishing a sound legal base for nurse-midwifery, first the Committee members and key sources, then the ACNM Board of Directors and membership, and then others concerned with nurse-midwifery.

Consultation is closely related to the educational and research functions of the system. Even when legislation information was meager, the Committee responded informally to requests for advice and assistance in determining the legal status of nurse-midwifery in particular states or in changing their laws in order to establish nurse-midwifery practice. Now, with an extensive information base for reference and the mechanism provided by the ACNM Consultation Service, the Committee is able to work more effectively with local groups on legislative matters relating to nurse-midwifery. Consultation establishes what information is needed, how to get it, and what it means, as well as how to use it.

How It Works

The system is based on a two-way flow of information within its basic network, in which the center is the ACNM Legislation Committee and its peripheral units are the key sources in each state. Local information pertinent to legislation and nurse-midwifery is sent from the key sources to the ACNM Legislation Committee, which in turn sends out national information to the key sources. Information also flows between key sources. To encourage this communication and eliminate delays encountered by going through the National Committee, each key source is provided with a list of the names and addresses of her counterparts in other states. Other important points of contact in the operation of this communications system are the ACNM Board of Directors and the ACNM Executive Secretary at headquarters, who channel information to other ACNM committees by correspondence and at Board meetings. The six regional representatives on the Board of Directors are in a position to strengthen efforts of the key sources in their respective regions and maintain communication among them.

How It Can Be Used

Potential and actual uses of the information system are beginning to emerge from experience with the collection and distribution of legislation survey data. Precise mechanisms for using the system to establish and expand the practice of nurse-midwifery remain to be explored. However, the power of information is clearly and impressively evident, and an effective self-sustaining information system should be a stimulant and guide to action.

PART II

SURVEY FINDINGS

Part II of this report of the ACNM-sponsored survey of current nurse-midwifery legislation and practice presents findings relating to the United States as a whole. The main purpose of the following tables of information is to answer questions that have frequently been asked of the Legislation Committee of the ACNM. During the past few years, inquiries about legislative and legal aspects of nurse-midwifery practice in the United States have come from a wide variety of individuals and groups — students, practitioners, legislators, professional organizations, state health departments and boards authorized to control professional practice, the public media and federal agencies — and they reflect the interests of several professions, among them general medicine, social work, nursing, nurse-midwifery, obstetrics, and law.

This general purpose will also have more practical implications. While answering specific questions, the tables should provide a guide for action and help in focusing plans designed to expand and strengthen nurse-midwifery services. The data show where there are no nurse-midwifery services, where the laws are restrictive, where the legal bases are weak and where they are strong. These signs and symptoms, as it were, are a guide to diagnosis, while the ACNM *Position Statement on Nurse-Midwifery Legislation* and the ACNM *Guidelines for Establishing Nurse-Midwifery Practice* presented in Appendix C and D will assist in defining essential elements of treatment.

Four main topics are addressed by the series of ten tables relating to legislation and the practice of nurse-midwifery:

- The nature of relevant legislation
- The extent of practice of nurse-midwifery and of lay midwifery
- Patterns of legislation and practice
- The control of practice

Each table will be discussed with the aim of clarifying ambiguities and stimulating interpretation, in the hope that our reservoir of information will become increasingly useful.

In these tables, states and jurisdictions are grouped according to characteristics of pertinent legislation and nurse-midwifery practice. Reasons for assigning states to particular categories may be found both in the definitions provided and in Part III of the report, the *Directory of Information*, which summarizes the legal status of nurse-midwifery, and the extent of practice, by states and jurisdictions. Three major terms used in classifying states with respect to legislation and the practice of nurse-midwifery are defined as follows for the purpose of this discussion of survey findings:

Laws and legislation are general terms, both denoting legislative statutes or regulations promulgated by official agencies authorized by legislative statute.

Nurse-midwifery refers to practice by a Certified Nurse-Midwife (CNM), as defined by ACNM, and also by those who are recognized by laws specifying that the midwife must be a registered nurse and a graduate of an approved school of nurse-midwifery.

Definitions of other key words are included in the discussions of the respective tables.

Besides clear limits to the framework of analysis, i.e., the four main topics outlined above, there are other limitations which must be taken into consideration when interpreting the data presented. Currency and completeness of the tabulated information are limited by the sources and time period of the survey. Main sources of information were volunteers who were interested novices in the field of law, and documents made available by state agencies. While the cut-off date for purposes of analysis was May 1975, laws changed subsequently and new documents were received.

Some measure of the extent of recent developments, legislative and otherwise, pertaining to nurse-midwifery is provided by the following summary of changes reported by the ACNM Legislation Information System for the period 1971-1975 (May):

- Twenty-two states passed legislation enabling the practice of nurse-midwifery.
- Two states passed enabling legislation, although implementation is uncertain because other legislation is open to restrictive interpretation.
- In three states, joint statements recognizing the practice of nurse-midwifery were accepted by state professional organizations.
- In two states, enabling legislation was introduced in legislative sessions in 1975.

To allow for this process of evolution, it is planned to provide updated reports on legislative and other changes pertaining to nurse-midwifery practice in subsequent issues of the *Journal of Nurse-Midwifery*. We would appreciate being alerted to changes which are not reflected in this report.

NATURE OF NURSE-MIDWIFERY LEGISLATION

The nature of legislation pertaining to the practice of nurse-midwifery in states and jurisdictions of the USA is reflected in Tables 1 to 3, which attempt to answer the following questions:

Table 1: Where are state laws permissive, restrictively interpreted, or clearly prohibitive of the practice of nurse-midwifery?

Table 2: Where do public laws or official regulations recognize nurse-midwifery specifically and what is the form of recognition?

Table 3: Where are nurse-midwives able to practice fully under laws which *do not* recognize nurse-midwifery specifically and what is the legal basis for their practice?

Table 1 — Intent of Legislation Pertaining to Nurse-Midwifery

The 50 states and 4 jurisdictions (District of Columbia, Guam, Puerto Rico, Virgin Islands) are grouped in Table 1 according to whether their respective laws are permissive, restrictively interpreted, or clearly prohibitive with respect to nurse-midwifery practice. In this context, *permissive* means that statements in laws are either not prohibitive or supportive; *restrictive interpretation* refers to situations where a state Attorney General's opinion, given in writing in response to a request for interpretation of laws, has found that the practice of nurse-midwifery is in conflict with one or more existing laws; and *clearly prohibitive* refers to laws containing statements which specifically prohibit the practice of midwifery by anyone other than a licensed physician.

The classification of each state in Table 1 is mainly based upon a review of current laws, primarily the following generic set of legislative statutes: (1) nurse practice acts, (2) medical practice acts, (3) nurse-midwife acts, where they exist, and (4) midwife acts, where they exist. Also reviewed were official rules and regulations relating to the practice of medicine, nursing, and midwifery as promulgated by state Boards of Medicine, Nursing, or Public Health. For some states, it was necessary to examine hospital health codes. However, in most cases the pertinent information was found in the statutory definitions of medical, nursing, or midwifery practice. Salient clues were also found in exemption sections of the various laws which list categories of practitioners not subject to the respective restrictions. Usually those exempted were other health personnel licensed by the state.

The list of 49 states and jurisdictions with *permissive laws* contains those where laws do not provide specifically for nurse-midwifery practice as well as states with laws which recognize nurse-midwifery. However, as subsequent tables show, nurse-midwives are not actually practicing in all of the states that have permissive laws.

In each of the 5 states designated as having restrictive interpretations of laws pertaining to the practice of nurse-midwifery, these interpretations are given in written opinions by the respective state Attorneys General. Their delineation of legal bases for not recognizing nurse-midwifery reflects differences in the contexts of current state laws, historical interpretations, and individual orientations of the incumbent Attorney General. Nevertheless, critical issues uniformly focus on the question of who can practice midwifery legally — physicians, lay midwives, nurses under supervision of physicians, or certified nurse-midwives. The main problem is that old laws are not suited to new situations. Where old laws specify in detail limitations to lay midwifery practice and nursing functions, today's nurse-midwife, a new professional with better preparation for providing maternity care, is prevented from functioning. Another critical area relates to definitions of the practice of medicine. Is midwifery included in that? If certified nurse-midwives practice fully in keeping with their advanced preparation, are they illegally practicing medicine? In dealing with these questions, the state legal authorities seem to weigh strictly legalistic views against human considerations of legislative intent. Special features of the legal interpretations for each of these five states are summarized and documented in Part III of this report.

As consideration is given to changing the restrictive legislation in these states, it is worthwhile to examine the laws and experience of states where nurse-midwifery practice is officially recognized.

Table 2 — Specific Recognition of Nurse-Midwifery

The 18 states and jurisdictions which recognize nurse-midwifery practice specifically in public laws or official regulations are grouped in Table 2 according to the actual form of official recognition. *Recognition of nurse-midwifery* in this context means that specific reference is made, in a law or a statutory rule, to nurse-midwives, nurse-midwifery, or certification by the ACNM. A *legislative statute* is a law enacted by a state legislature. A *statutory agency* refers to the state agency, such as the Board of Health or Board of Medical Examiners, which is authorized by a legislative statute to define rules and regulations for professional practice. In addition, there are *joint statements* which define standards for practice as agreed upon by state professional groups, such as nurses associations, medical societies, or hospital associations, that are recognized by the state authorities although not empowered by legislative statutes; there are 7 of these in Table 2. Although such joint statements do not have the power of statutes, they command considerable respect when promulgated by recognized interdisciplinary professional groups.

While Table 2 shows a fairly even distribution of states under each of the four categories, two of these states have uniquely ambiguous arrangements. New Mexico recognizes the practice of nurse-midwifery in rules and regulations promulgated by two statutory bodies. This means that nurse-midwives must meet qualifications for practice set by two separate state agencies. Another unique situation exists in Maryland where, although a "joint statement" specific to nurse-midwifery has been endorsed by the state's medical society and nurses association, nurse-midwives must continue to be licensed under provisions of the lay midwife act which includes specifications inappropriate for nurse-midwifery practice.

An important recommendation for nurse-midwifery legislation as defined by the ACNM in its *Position Statement on Nurse-Midwifery Legislation* (Appendix C) is

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TABLE 1. INTENT OF LEGISLATION PERTAINING TO NURSE-MIDWIFERY BY STATES AND JURISDICTIONS

States and jurisdictions with permissive laws

	Kansas	
Alaska	Kentucky	Oklahoma
Arizona	Louisiana	Oregon
Arkansas	Maine	Pennsylvania
California	Maryland	Puerto Rico
Colorado	Minnesota	Rhode Island
Connecticut	Mississippi	South Carolina
Delaware	Montana	South Dakota
District of Columbia	Nebraska	Tennessee
Florida	Nevada	Texas
Georgia	New Hampshire	Utah
Guam	New Jersey	Vermont
Hawaii	New Mexico	Virginia
Idaho	New York	Virgin Islands
Illinois	North Carolina	Washington
Indiana	North Dakota	West Virginia
Iowa	Ohio	Wyoming

States with restrictive interpretations of laws

Alabama
Massachusetts
Michigan
Missouri
Wisconsin

States with clearly prohibitive laws

None

statutory recognition of nurse-midwifery. Nineteen states and jurisdictions, as listed in the first three groups of Table 2, have laws in keeping with this recommendation. In 8 other states — Alaska, Colorado, Mississippi, Nevada, North Carolina, Oregon, Tennessee, Washington — statutory authorities are now processing rules and regulations which specifically recognize nurse-midwives.

In the 7 states and jurisdictions which recognize nurse-midwifery in joint statements approved by their respective professional organizations, nurse-midwives benefit from the official support of medical and nursing groups. However, the extent and duration of this kind of recognition is less certain than for that of statutory agencies, even though the standards for nurse-midwifery practice defined by these joint statements are often as detailed and rigorous as those defined by statutory bodies. While specific recognition of nurse-midwifery in state laws is recommended as the best legal basis for practice, nurse-midwives are in fact practicing legally without such recognition in several states.

Table 3 — Legal Basis for Nurse-Midwifery Without Specific Recognition

In 23 states and jurisdictions which do not specifically recognize nurse-midwifery in their laws, nurse-midwives are nonetheless able to practice fully because other laws provide a legal base for their practice. Table 3 shows the states grouped according to various types of laws under which nurse-midwives practice. In this context, *do not specifically recognize* means that state laws make no reference to nurse-midwifery or certification and other standards of the ACNM; *practice fully* means that qualified nurse-midwives are responsible for management of normal pregnancies in all aspects of the maternity cycle, including labor and delivery; and *legal base for practice* refers to the primary statutes which support nurse-midwifery practice.

A more general concept of the legal base for practice takes into consideration all laws pertaining to the practice of personnel providing health services. In the case of

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TABLE 2. SPECIFIC FORM OF RECOGNITION OF NURSE-MIDWIFERY IN LAWS OF STATES AND JURISDICTIONS

Legislative statute only

California
Montana
Ohio
Puerto Rico
Utah
West Virginia

Rules of a statutory agency only

Connecticut
Guam
Kentucky
New Hampshire
New Jersey
New Mexico (a)
Pennsylvania
South Dakota
Virginia

Legislative statute *and* rules of a statutory agency

Arizona
Florida
New York
Virgin Islands

Joint statement of state interdisciplinary professional organizations

Colorado
District of Columbia
Maine
Maryland
Mississippi
South Carolina
Vermont

(a) Rules of *two* statutory agencies apply to nurse-midwifery practice in the state.

nurse-midwifery this means that practice may be permitted not only where there are supportive laws but also where there are no prohibitive ones. In order to establish this broad legal base for practice, it is necessary to examine the following statutes in particular: (1) medical practice acts, (2) nurse practice acts, (3) physician assistants acts, (4) lay midwife acts. In some cases it is important to examine also general health statutes and hospital codes.

In several states listed in Table 3, statutes which are identified as the primary legal basis for nurse-midwifery practice include provisions for licensure. This is usually true of lay midwife and physician assistants statutes. In the case of nursing statutes, frequently no special licensure is required of nurse-midwives besides licensure as a professional nurse. Even in Oklahoma and Texas, where general statutes refer to the practice of midwifery, no special licensure is required.

In some states — Arkansas, Connecticut, Iowa, Nebraska, Washington — nurse-midwives can practice on a variety of legal bases while in Kansas and North Dakota, where laws are not clearly prohibitive, there is no apparent legal basis for practice.

This overview of the nature of laws pertaining to nurse-midwifery practice has shown where laws are permissive and what the various legal bases for practice are. The question now is whether nurse-midwives do in fact practice in all of these states and jurisdictions.

EXTENT OF PRACTICE

Table 1 listed 49 states and jurisdictions which have laws permissive of nurse-midwifery practice. However, in only 38 of these is midwifery actually practiced, and in several of them only lay midwives are practicing.

Table 4 — Extent of Actual Midwifery Practice

Table 4 shows the distribution of states and jurisdictions in answer to the following questions:

- Where are nurse-midwives actually employed to practice under laws of states and jurisdictions?

TABLE 3. LEGAL BASIS FOR NURSE-MIDWIFERY PRACTICE IN THE ABSENCE OF SPECIFIC RECOGNITION IN LAWS OF STATES AND JURISDICTIONS

Nursing practice statutes

Alaska (a)
Arkansas (b)
Connecticut (b)
Georgia
Idaho
Illinois
Iowa (b)
Louisiana
Minnesota
Nebraska (b)
Nevada (a)
North Carolina (a)
Oregon (a)
Rhode Island
Tennessee (a)
Washington (b)

Lay midwife statutes

Arkansas (b)
Delaware
Hawaii
Indiana
Maryland
Washington (b)
Wyoming

Physician assistants statutes

Arkansas (b)
Connecticut (b)
Iowa (b)
Washington (b)

General health statutes

Nebraska (b)
Oklahoma
Texas

(a) State Board rules and regulations pertaining specifically to nurse-midwifery are under consideration
(b) Practice is permitted under alternative statutes

Note: [illegible] and North Dakota have no apparent legal basis for practice, although their laws are not clearly prohibitive

- How does practice by nurse-midwives relate to that by lay midwives in these states and jurisdictions?

The designation *lay midwife*, in this context, refers primarily to a practitioner who has had no formal training or recognized professional education in midwifery and who may or may not be subject to a licensing procedure. On the other hand, a *nurse-midwife* is a registered nurse who has also fulfilled requirements for ACNM Certification as a professional nurse-midwife.

Most of the 38 states and jurisdictions listed in Table 4 have nurse-midwives who are practicing under the current laws. In 17 of these, only nurse-midwives are employed for full practice, while in 15 other states and jurisdictions lay midwives as well as nurse-midwives practice. In a third group of 6 states, where only lay midwives are currently practicing under their respective state laws, there are three exceptions — Alabama, Alaska, Missouri — where nurse-midwives in special situations do practice under federal or municipal laws, rather than under laws of their respective states. Although the remaining 16 states have neither nurse-midwives nor lay midwives practicing under state laws, in 4 of these — Michigan, Nebraska, Nevada, South Dakota — nurse-midwives are employed to practice fully in special situations.

The relationships between legislation and actual practice with respect to all 54 states and jurisdictions are presented in Tables 5 and 6. Listings of agencies that employ nurse-midwives for full clinical practice are included in the *Directory of Information by States and Jurisdictions* (Part III of this report). Information is also provided on specific qualifications for practice.

Trends in the distribution of practicing nurse-midwives and lay midwives are associated with improvements in health care delivery systems and changes in population demands. Interest in the development of nurse-midwifery services has been increasing along with measures aimed at phasing out lay midwifery. Significant differences in how the two types of midwives practice and where they practice, as well as differences in their preparation for practice, are reflected in these trends. Certified nurse-midwives always practice in connection with medically directed services in which they are usually employed as salaried staff. By contrast, lay midwives are usually self-employed independent practitioners who are under the indirect control of state or local health agencies. Also,

TABLE 4. EXTENT OF ACTUAL MIDWIFERY PRACTICE UNDER LAWS OF STATES AND JURISDICTIONS

Full practice by nurse-midwives only

California	Maryland	Pennsylvania
Connecticut	Minnesota	Utah
District of Columbia	New Hampshire	Vermont
Guam	New Jersey	Virgin Islands
Illinois	New York	Washington
Maine	Ohio	

Full practice by both nurse-midwives and lay midwives

Arizona	Mississippi	South Carolina
Florida	New Mexico	Tennessee
Georgia (a)	North Carolina	Texas
Kentucky	Oregon	Virginia (a)
Louisiana	Puerto Rico	West Virginia (a)

Full practice by lay midwives only

Alabama (a), (b)	Arkansas	Missouri (a), (c)
Alaska (b)	Hawaii	Oklahoma

(a) No new licenses are currently issued to lay midwives

(b) Exception: Nurse-midwives practice in federal government hospitals

(c) Exception: Nurse-midwives practice fully in hospitals and areas designated by the St. Louis Department of Health and Hospitals.

nurse-midwives are usually employed by hospitals in urban areas, while lay midwives function outside of hospitals and, with few exceptions, in rural areas where hospitals and physicians are scarce.

In two states — Virginia and West Virginia — whose rural populations have been served for centuries by lay midwives, and where now both nurse-midwives and lay midwives practice, recent changes in laws provide for the development of nurse-midwifery and the phasing out of lay midwifery. As this occurs in these two states and elsewhere, there will be increasing need for nurse-midwifery services in rural areas. To plan for those developments we need to examine first the current distribution of midwifery services in relation to pertinent state laws which are either permissive or restrictive.

PATTERNS OF LEGISLATION AND PRACTICE

Tables 1 to 4 have shown the nature of present nurse-midwifery legislation and the extent of actual practice. These two components are joined in Tables 5 and 6 to provide a clearer picture which highlights those areas where, in the country as a whole, nurse-midwifery practice is relatively weak. A comparison of the latter with more developed settings may permit the formulation of strategies for change.

Table 5 — Patterns of Legislation and Actual Practice of Nurse-Midwifery

Table 5 is designed to answer these questions:

- What is the relationship between laws pertaining to nurse-midwifery and its actual practice?
- Where are nurse-midwives not working even though the laws are permissive?

All 50 states and the 4 jurisdictions of the District of Columbia, Guam, Puerto Rico, and the Virgin Islands are assigned to one of three main groups of Table 5, i.e., those with

Permissive laws and fully practicing nurse-midwives (Group I);

Permissive laws but *no* fully practicing nurse-midwives (Group II);

Restrictive interpretation of laws and *no* fully practicing nurse-midwives (Group III).

Groups I and II are further subdivided to provide greater detail on the strengths and weaknesses in current nurse-midwifery practice in the country as a whole. Group I differentiates between the 23 states and jurisdictions with laws or joint statements that specifically support nurse-midwifery practice (I.A) and the 9 states with laws which do not specifically support it (I.B). In almost half of these 32 states and jurisdictions, lay midwives also are known to be practicing legally. Group II focuses on the extent of practice by lay midwives in 17 other states where laws are permissive but no nurse-midwives are practicing. In 4 of these lay midwives are practicing (II.A) while in 13 neither lay midwives nor nurse-midwives are practicing (II.B).

Most of the qualifying terms used in the classification of states in Table 5 have been defined in earlier sections of this report. For instance, working definitions were given for *permissive laws, specific recognition, lay midwives, nurse-midwives,* and *restrictive interpretation.* Another important term requiring definition is *official regulation.* In this context it includes the joint statements approved by recognized professional organizations as well as the rules and regulations promulgated by statutory bodies such as state Boards of Health.

Table 6 — Index of Patterns of Legislation and Practice

This table presents the information from Table 5 in an alphabetical listing of states and jurisdictions with their respective classifications according to the five groups defined above.

While Tables 5 and 6 assign all 54 states and jurisdictions to five groups with defined patterns of legislation and practice, there is considerable variation within each pattern with respect to the nature of laws and the extent of actual practice. Some of this is indicated by reference to exceptions (see footnotes to Table 5), and the full scope of differences emerges from the detailed descriptive information about each state and jurisdiction presented in Part III of this report.

Also, Tables 5 and 6 do not reflect changes which are currently in progress. For instance, in several states — Alaska, Minnesota, Mississippi, Nevada, North Carolina, South Dakota, Washington — new laws are under consideration for statutory recognition of nurse-midwifery. The impetus for bringing rules and regulations for nurse-midwifery under the responsibility of state Boards of Nursing has been the revision of nurse practice acts to provide for expanding roles of nurses. While states are considering statutory recognition of nurse-midwifery, this is the time to determine who should control standards of practice.

CONTROL OF PRACTICE

Responsibility for determining who shall practice nurse-midwifery, and how, is usually assigned by legislative statute to a public agency in the respective state or jurisdiction. Thus, those setting standards for professional practice are responsible to the state's taxpayers who, in effect, are also consumers. Also, private professional groups indirectly influence the ways in which statutory bodies determine standards for practice. For

TABLE 5. PATTERNS OF LEGISLATION AND ACTUAL PRACTICE OF NURSE-MIDWIFERY IN STATES AND JURISDICTIONS

I. States and jurisdictions with permissive laws and nurse-midwives practice fully

A. Specific recognition in legislative statutes, official regulations, or joint statements

Arizona
California
Connecticut
District of Columbia
Florida
Guam
Kentucky
Maine
Maryland
Mississippi
New Hampshire
New Jersey
New Mexico
New York
Ohio
Pennsylvania
Puerto Rico
South Carolina
Utah
Vermont
Virginia
Virgin Islands
West Virginia

B. No specific recognition in legislative statutes, official regulations, or joint statements

Georgia
Illinois
Louisiana
Minnesota
North Carolina
Oregon
Tennessee
Texas
Washington

II. States with permissive laws but nurse-midwives do not practice fully

A. Lay midwives practice fully

Alaska (a)
Arkansas
Hawaii
Oklahoma

B. Neither nurse-midwives nor lay midwives practice fully

Colorado (b)
Delaware
Idaho
Indiana
Iowa
Kansas
Montana (b)
Nebraska (a)
Nevada (a)
North Dakota
Rhode Island
South Dakota (a)(b)
Wyoming

III. States with restrictive interpretation of laws and no full practice by nurse-midwives

Alabama (a)
Massachusetts
Michigan (c)
Missouri (d)
Wisconsin

(a) Exception: Nurse-midwives practice fully in federal governmental hospitals.

(b) Specific recognition of nurse-midwifery practice appears in recent legislative statutes and official regulations.

(c) Exception: Nurse-midwives practice in Woman's Hospital of the University of Michigan Medical Center, Ann Arbor.

(d) Exception: Nurse-midwives practice in areas designated by the St. Louis Department of Hospitals and for which medical services are provided by St. Louis University, School of Medicine.

instance, state Boards of Nurse Examiners are usually interdisciplinary groups which include nurses registered in the respective states. Advisory committees appointed by these Boards consist of nurses qualified in various fields of nursing in their states, and Boards often choose to use standards developed by national professional organizations. In the case of nursing, many states use the national test pool and educational program accreditation procedures of the National League for Nursing.

The recent ACNM sponsored survey of legislation pertaining to nurse-midwifery practice revealed considerable variation in the control of midwifery practice throughout the country. Tables 7 and 8 show the nature and extent of variation by answering the following questions:

- What states and jurisdictions require licensure or other qualifications for the practice of nurse-midwifery?
- What statutory bodies are authorized to control standards for the practice of nurse-midwifery?

Two other tables show the extent to which the nurse-midwifery profession itself, represented by the ACNM, contributes to the control of nurse-midwifery practice. Thus, Tables 9 and 10 answer the following questions:

- Where do state laws, official regulations, binding statements, or similar public documents refer specifically to standards for practice defined by ACNM?
- Which of the ACNM standards for nurse-midwifery practice are specifically recognized in laws and official regulations?

The information in Tables 7-10 was obtained from a variety of documents relevant to the legal situation in the respective states (for complete references, see Part III of this report). Where reference is made to "licensure," "certification," and "accreditation," for the purposes of this survey, the following DHEW definitions pertain (1):

(1) Department of Health, Education and Welfare. *Licensure and Related Health Personnel Credentialing.* DHEW Publication No. (HSM) 72-11. Washington, GPO, 1971, p. 7.

TABLE 6. INDEX OF PATTERNS OF LEGISLATION AND ACTUAL PRACTICE OF NURSE MIDWIFERY, BY STATES AND JURISDICTIONS

	Classification (a)		Classification (a)
Alabama	III	Montana	IIB
Alaska	IIA	Nebraska	IIB
Arizona	IA	Nevada	IIB
Arkansas	IIA	New Hampshire	IA
California	IA	New Jersey	IA
Colorado	IIB	New Mexico	IA
Connecticut	IA	New York	IA
Delaware	IIB	North Carolina	IB
District of Columbia	IA	North Dakota	IIB
Florida	IA	Ohio	IA
Georgia	IB	Oklahoma	IIA
Guam	IA	Oregon	IB
Hawaii	IIA	Pennsylvania	IA
Idaho	IIB	Puerto Rico	IA
Illinois	IB	Rhode Island	IIB
Indiana	IIB	South Carolina	IA
Iowa	IIB	South Dakota	IIB
Kansas	IIB	Tennessee	IB
Kentucky	IA	Texas	IB
Louisiana	IB	Utah	IA
Maine	IA	Vermont	IA
Maryland	IA	Virginia	IA
Massachusetts	III	Virgin Islands	IA
Michigan	III	Washington	IB
Minnesota	IB	West Virginia	IA
Mississippi	IA	Wisconsin	III
Missouri	III	Wyoming	IIB

(a) See Table 5 for definition of each classification and for exceptions.

Licensure is the process by which an agency of government grants permission to persons to engage in a given profession or occupation by certifying that those licensed have attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected.

Certification is the process by which a nongovernmental agency or association grants recognition to an individual who has met qualifications specified by the group.

Accreditation is the process by which an agency or organization evaluates and recognizes an institution or program of study as meeting predetermined criteria or standards.

Two other terms which are not included above but appear in official documents require definition for purposes of this report. The term *approval* is considered synonymous with *accreditation*, as defined above, and *registration* is used as an approximate equivalent for *licensure*.

Table 7 — Licensure or Other Qualifications for the Practice of Nurse-Midwifery

Table 7 shows 40 states and jurisdictions where legislative statutes or official regulations require nurse-midwives to be licensed or meet specific qualifications in order to practice nurse-midwifery. Almost half (18) require licensure specifically for nurse-midwifery. In 11 others, licensure is not mandatory but official regulations define specific qualifications for nurse-midwives who want to practice. Although in 4 states nurse-midwives have the option to register in accordance with physician assistant laws, no nurse-midwives have sought to register for practice under these regulations. Nurse-midwives practicing in Connecticut have qualified in accordance

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TABLE 7. LICENSURE OR OTHER QUALIFICATIONS FOR THE PRACTICE OF NURSE-MIDWIFERY AS DEFINED BY STATES AND JURISDICTIONS

Licensure specific to nurse-midwifery

Arizona	Montana	Pennsylvania
California	New Hampshire	Puerto Rico
Connecticut (a)	New Jersey	Utah
Florida	New Mexico (b)	Virginia
Guam	New York	Virgin Islands
Kentucky	Ohio	West Virginia

Specific qualifications, other than state licensure, for nurse-midwifery

Colorado	Maine	South Carolina
District of Columbia	Maryland (c)	South Dakota
Georgia	Mississippi	Vermont
Illinois	Oregon	

Registration under laws for physician assistants

Arkansas (a)	Iowa
Connecticut (a)	Washington (a)

Legal provisions for lay midwives apply

Arkansas (a)	Louisiana	Texas (d)
Delaware	Maryland (c)	Washington (a)
Hawaii	Minnesota	Wyoming
Indiana	North Carolina	

(a) Nurse-midwives have a legal option to qualify for practice under statutes applicable to one or more other practitioners of midwifery
(b) In order to practice, nurse-midwives must be licensed by two separate statutory bodies
(c) Nurse-midwives must meet requirements of (1) lay midwife licensure laws, and (2) joint statement specific to nurse-midwifery
(d) Laws do not specify qualifications for practice

with the state's nurse practice act, while in Iowa no nurse-midwives are practicing.

Regarding the group of states where legal practice of nurse-midwifery is possible under lay midwife laws, the situation is ambiguous due to the varying, complex and often outdated legal bases for practice. First, the phrase "legal provisions" is used broadly to include (1) statutes scattered in various parts of the state codes which require midwives, inter alia, to carry out functions such as reporting births or instilling medications in the eyes of newborn babies; (2) local health regulations concerning permission to practice midwifery; (3) and state licensure laws. Among the states in this group, Texas has no midwifery licensure laws but does have various provisions with which midwives are specifically required to comply.

Second, in several states (Delaware, Hawaii, Minnesota, Washington) where midwifery licensure laws have not been repealed, they have not been applied to either lay midwives or nurse-midwives for many years. In two other states (Louisiana and North Carolina) currently licensing lay midwives, nurse-midwives have not applied for licensure. However, in four of the above states (Louisiana, Minnesota, North Carolina, Washington) nurse-midwives in the future will be practicing in accordance with rules and regulations under consideration by Boards of Nursing. In fact only three states (Indiana, Maryland, Wyoming) currently license nurse-midwives under the lay midwife laws, and in Maryland nurse-midwives actually function beyond the limitations of the midwife laws because as licensed professional nurses they can legally undertake responsibilities delegated by licensed physicians.

A trend in the country as a whole is the diminishing implementation of lay midwife licensure laws. Although 25 states and jurisdictions still have lay midwife licensure laws, 13 no longer implement them. Three other states have lay midwives who practice without licensure. In some situations, like Minnesota and Michigan, the licensure laws have been shelved because their specifications are no longer appropriate for modern professional nurse-midwives, while in other states, such as Tennessee, Virginia, and West Virginia, lay midwives are being phased out as more modern services are provided. Decision making in this respect varies from state to state but authority to control practice is always vested by legislative statute.

Table 8 — Statutory Agencies Authorized to Control Standards for Practice

Public agencies authorized by legislative statutes to control standards for the practice of nurse-midwifery are the focus of Table 8. Out of 49 states and jurisdictions with permissive laws, only 34 have specific laws which designate the group responsible for the control of midwifery practice. This number takes into consideration the fact that some states are listed under more than one category in Table 8. Explanations for this appear in the footnotes to the table. Three types of statutory agencies are most frequently designated by the states: (1) Boards of Health or, in some states, Health Departments or Departments of Human Resources; (2) Boards of Medical Examiners (or Boards of Medical Education and Licensure); and (3) Boards of Nurse Examiners (or Boards of Nursing).

California and the Virgin Islands are the only places where nurse-midwives have authority, under legislative statute, to participate in the control of their own practice. The Virgin Islands are unique in having the only statutory body responsible for nurse-midwifery which is so named. In the case of California, although the Board of Nursing Education and Nurse Registration is authorized to regulate the practice of nurse-midwifery, the Board is required by legislative statute to do so through a committee which includes nurse-midwives as well as obstetricians.

Two states (Colorado and New Hampshire) have created Joint Commissions representing the State Boards of Nursing and of Medicine which are authorized and active in developing, for joint promulgation, rules and regulations specific to the practice of nurse-midwifery. Idaho and Nebraska have similar mechanisms created by legislative statutes, which could be applied to the development of nurse-midwifery. In states where Joint Commissions set standards for nurse-midwifery practice, the state Boards of Nursing are the implementing agencies.

In 2 other states (Utah and Washington), general licensing bodies are responsible for implementing standards set by the state Board of Nursing or by a designated representative of the state's nursing profession.

Multiple authority for the control of practice exists in several states. In Arkansas, Connecticut, and Washington, nurse-midwives may practice under alternative sets of laws referring to lay midwifery, nursing, or physician assistants. In New Mexico, older laws require that nurse-midwives be licensed by the state's Department of Public Health while new laws provide for licensing by the Board of Nursing.

In 4 states and jurisdictions (District of Columbia, Maine, South Carolina, Vermont) which officially recognize nurse-midwifery in joint statements, no statutory agency has been specifically authorized to regulate the practice of nurse-midwifery.

Tables 9 and 10 — Recognition of ACNM Professional Standards

Table 9 shows 13 states which currently refer specifically to ACNM standards for the practice of nurse-midwifery in either legislative statutes or in regulations promulgated by statutory agencies. In several other states, there is official recognition of ACNM standards in the position statements of professional organizations, usually interdisciplinary, which influence standards for practice.

Table 10 lists 17 states which officially recognize ACNM certification and 14 states which recognize ACNM approved nurse-midwifery educational pro-

TABLE 8. STATUTORY AGENCIES AUTHORIZED TO CONTROL STANDARDS FOR THE PRACTICE OF NURSE-MIDWIFERY BY STATES AND JURISDICTIONS

State Board of Health (a)

Arkansas (b)
Connecticut (b)
Delaware
Florida
Florida
Hawaii
Kentucky
Maryland
New York
New Mexico
Virginia

State Board of Medical Examiners (a)

Arkansas (b) (c)
Connecticut (b) (c)
Guam
Indiana
Iowa (c)
Louisiana
New Jersey
Ohio
Pennsylvania
Puerto Rico
Washington (b)(c)
Wyoming

State Board of Nurse Examiners (a)

Alaska
Arizona
California
Connecticut (b)
Louisiana
Mississippi
Montana
Nevada
New Mexico
Oregon
South Dakota
Tennessee
Washington (b)
West Virginia

Joint Commission of State Boards

Colorado
Idaho
Nebraska
New Hampshire

Other agencies

Utah — Department of Business Regulation
Virgin Islands — Board of Nurse-Midwife Examiners
Washington (b) — Division of Professional Licensing

(a) Or equivalent
(b) Authority for control is ambiguous. Refer to Part III for specific instances.
(c) Authority for control is designated in the state's physician assistants act without specific recognition of nurse-midwifery

TABLE 9. EXTENT OF SPECIFIC RECOGNITION OF ACNM PROFESSIONAL STANDARDS FOR NURSE-MIDWIFERY PRACTICE BY STATES AND JURISDICTIONS

Legislative statutes or regulations by statutory agencies

Arizona
Connecticut
Florida
Kentucky
Montana
New Hampshire
New Jersey
New Mexico
New York
South Dakota
Utah (a)
Virginia
West Virginia

Statements by interdisciplinary professional groups

Colorado
District of Columbia
Maine
Maryland
Mississippi
South Carolina
Vermont

Other current official documents

Georgia — Joint statements of institutions which employ nurse-midwives
Guam — Affidavit of licensure to practice
Illinois — State Nurses' Association position statement
Louisiana — State Board of Nursing position statement
Maryland — State Department of Health policy
St. Louis, Missouri — Department of Health and Hospitals policy

(a) Legislative statute passed in 1971 was the first state law to require ACNM certification.

TABLE 10. ACNM STANDARDS FOR NURSE-MIDWIFERY PRACTICE OFFICIALLY RECOGNIZED BY STATES AND JURISDICTIONS

Certification by ACNM

Arizona
District of Columbia
Guam
Kentucky
Louisiana
Maryland
Mississippi
Montana
New Hampshire
New Jersey
New Mexico
New York
South Carolina
South Dakota
Utah
Vermont
West Virginia

Graduation from a nurse-midwifery educational program approved by ACNM

Arizona
Florida
Georgia
Illinois
Kentucky
Louisiana
Maine
Maryland
Mississippi
New Hampshire
New Mexico
South Carolina
Virginia
West Virginia

grams, the two ACNM standards for practice referred to most frequently. In the case of Maryland, ACNM certification is a qualification adopted by the State Health Department in licensing nurse-midwives under old lay midwife regulations. In the case of Georgia, graduation from an ACNM approved school of nurse-midwifery is the condition adopted by local institutions and agencies which employ nurse-midwives.

The trend toward use of ACNM standards in state control of nurse-midwifery practice is closely related to the recent development of ACNM mechanisms for conducting certification examinations for nurse-midwives and approval procedures for nurse-midwifery educational programs.

Additional and more recent information about regulations pertaining to the practice of nurse-midwifery in each of the states and jurisdictions listed in Tables 7 to 10 may be obtained directly from the respective statutory agencies. Their names and addresses, together with references for official documents, are given in Part III of this report. Included also are the names and addresses of ACNM members who serve as key sources for information on legislation and on activities of nurse-midwives involved with development of services in their respective states.

CONCLUSIONS

Nurse-midwifery in the United States today is, on the whole, a fairly open field. With few exceptions, laws of states and jurisdictions are not restrictive or clearly prohibitive of the development of nurse-midwifery. However, while there are indications that the trend is toward passage of enabling legislation in most states, it is also evident that in many of these states nurse-midwives are still not practicing and that in others, only one or two are employed. This situation raises questions which need to be answered with more information than our survey data provide. For instance:

- Are current laws too weak or ambiguous to provide sound legal bases for nurse-midwifery practice?
- What are the significant factors that prevent full practice by nurse-midwives? Are they conservative attitudes of doctors, hospital administrators, and nursing leaders, or restrictive third-party payment policies of health insurance companies, or unsuitable salaries and working conditions?
- Are people unaware of the professional competence, of the full scope of functions, and of the significant role of nurse-midwives in the health care system with respect to services and education for healthy child-bearing and family planning?

Infinite variation is as obvious a feature of legislation pertaining to nurse-midwifery as it is for other health matters. Whether this situation is more of a liability than an asset is debatable. However, nurse-midwives might be in a position to spearhead efforts toward development of sound legal bases for the practice of various types of new professional groups involved in health care. To do this, it is necessary to examine carefully the pros and cons of current legal bases relating to nurse-midwifery by answering two general questions:

- What are the implications of the different types of statutory recognition of nurse-midwifery, such as separate legislative statutes, separate rules and regulations?
- What is the real function of professional joint statements with respect to nurse-midwifery practice and what purpose do they serve in determining legality of practice?

Standards for nurse-midwifery practice, such as licensure and other qualifications, are currently set in most states by a variety of statutory agencies which may or may not have representation from nurse-midwifery. This means that those who are not members of the profession determine, in many situations, who shall practice and how. Thus, questions to be answered in planning for the future development of nurse-midwifery services are:

- How can existing statutory agencies in each state provide for effective participation of nurse-midwives in defining standards for their practice?
- What is a more effective alternative to the existing statutory agencies assigned to control nurse-midwifery?
- What should be the role of the ACNM in providing professional standards for use by state agencies concerned with nurse-midwifery practice?

While Part II of this report has outlined significant features in the picture of nurse-midwifery legislation and practice, Part III provides the individual characteristics of each state together with references to legislation and sources. This is an "open book" for those interested in establishing and promoting nurse-midwifery as a means of making more and better care accessible to families in need of child-bearing and family planning services.

PART III

DIRECTORY OF INFORMATION BY STATES AND JURISDICTIONS

ALABAMA

Legal Status

Nurse-midwives are practicing fully only in a U.S. Air Force hospital due to the ambiguity of the legal base for nurse-midwife practice. However, lay midwives practice under a midwife law (1), although no new permits have been issued since April 1973. Furthermore, whereas there are no clear prohibitions in either the Nurse Practice Act (2) or the Medical Practice Act (3), the state's Attorney General stated in a 1971 opinion that nurse-midwifery practice would be in "conflict" with the above-mentioned statutes (4). He further stated that new legislation would be necessary for full practice by nurse-midwives despite the existence of a physician assistants act (5) which would seem to cover their practice.

There is increasing interest in beginning nurse-midwifery practice in the state. The Alabama State Nurses' Association resolved at their Convention in November, 1974 to introduce legislation for nurse-midwifery (6).

Legislation and Sources

1. Code of Alabama 1940, Amended, Title 46, Professions and Occupations, Chapter 9, Midwives, Section 168 (1064) (711), Practice of Midwifery Regulated.

2. Code of Alabama 1940, Amended 1964, Title 46, Section 189 (34), Nurse Practice Act.

3. Code of Alabama 1940, Amended, Title 46, Professions and Occupations, Chapter 13, Medical Practice Act.

4. Opinion of the Attorney General, State of Alabama, in a letter from David W. Clark, Assistant Attorney General, to Charles E. Flowers, Jr., MD, November 5, 1971.

5. Code of Alabama 1940, amended 1971, Title 46, Professions and Occupations, Article 7, Assistants to Physicians, Section 297.

6. *The Alabama Nurse,* December 1974, pp. 3-4.

Qualifications for Practice

None.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

Maxwell Air Force Base Hospital
Montgomery, Alabama
Montgomery, Alabama 36112

ACNM Affiliation

Chapter 9, Region V

Key Source for Legislation Information

Elizabeth Richardson, CNM
406 Auburn St.
Tuskegee, Alabama 36083

ALASKA

Legal Status

Certified nurse-midwives are practicing fully only in U.S. government hospitals, but not in other institutions.

The medical practice act (1) does not prohibit midwifery practice, and lay midwives are known to be practicing, although there are no specific provisions for licensure of certified nurse-midwives or lay midwives. On the other hand, the nurse practice act (2) was amended during the 1972 legislative session. It allows nurses to perform acts of "medical diagnosis" and the "prescription of medical therapeutic or corrective measures" when authorized by regulations promulgated jointly by the State Medical Board and the State Board of Nursing and as implemented by the Board of Nursing. Regulations for nurse-midwifery practice under this statute are presently being developed.

Legislation and Sources

1. State Laws of Alaska, Chapter 08.64, Medicine, 1970.

2. State Laws of Alaska, Chapter 08.68, Nursing, 1973.

Qualifications for Practice

Under consideration by the State Boards of Nursing and Medicine.

Application for Licensure

Alaska Board of Nursing
Department of Commerce
Division of Occupational Licensing
Pouch 'D'
Juneau, Alaska 99801

Agencies Employing for Full Clinical Practice

USPHS Alaska Medical Center
Box 7-741
Anchorage, Alaska 99510

ACNM Affiliation

Chapter 26, Region VI

Key Source for Legislation Information

Ingeborg Rathke, CNM
Alaska Native Medical Center
Box 7-741
Anchorage, Alaska 99510

ARIZONA

Legal Status

Certified nurse-midwives are practicing fully under the Law Regulating the Practice of Nursing in Arizona, amended in 1973 to allow for the expanded role of the nurse (1). As a result of this change, the Rules and Regulations of the State Board of Nursing (2), and the lay midwife statutes (3) were revised. The new Rules and Regulations specifically delineate nurse-midwifery practice (4), and the lay midwife law prescribes that a qualified nurse-midwife certified by the Arizona State Board of Nursing is exempt from the lay midwifery licensing regulations. A small number of lay midwives continue to be licensed under this law.

Legislation and Sources

1. Law Regulating the Practice of Nursing in Arizona, Chapter 15, Article 1, Sections 32-1601.5. (e), September 1973.

2. Rules and Regulations of the State Board of Nursing, Supplement 1, New Rule Section IV, Part II, A. June 27, 1973, Arizona.

3. Arizona Revised Statutes, Licensing and Regulation of Midwifery, Title 36, Chapter 6, Article 7, Section 36-752.

4. Arizona State Board of Nursing information for applicants. "Requirements for Certification as a Nurse Practitioner in Extended Nursing Practice," August 1973.

Qualifications for Practice

1. Registration in Arizona as a professional nurse.

2. Successful completion of a course in midwifery approved by the American College of Nurse-Midwives.

3. Passing of the required examinations stipulated by the Board of Nursing. The Board may waive examinations for those nurses who have qualified and hold a certificate issued by the American College of Nurse-Midwives.

4. Membership in the American College of Nurse-Midwives.

Application for Licensure

Arizona State Board of Nursing
Occupational Licensing Building
1645 W. Jefferson Street, Room 254
Phoenix, Arizona 85007

Agencies Employing for Full Clinical Practice

Hospital
Davis-Monthan Air Force Base
Tucson, Arizona 85707

Maricopa County Hospital
2601 E. Roosevelt
Phoenix, Arizona 85006

Memorial Hospital
1201 S. 7th Avenue
Phoenix, Arizona 85007

USPHS Indian Hospital
P.O. Box 649
Fort Defiance, Arizona 86504

ACNM Affiliation

Chapter 21, Region VI

Key Source for Legislation Information

Nancy C. Bolles, CNM
Memorial Hospital
1201 S. 7th Avenue
Phoenix, Arizona 85007

ARKANSAS

Legal Status

Nurse-midwives are not practicing in Arkansas, even though the laws are not restrictive in this respect. Statutes and regulations (1) provide for the practice of lay midwives and continue to be implemented. Neither the state's Nurse Practice Act (2) nor the Medical Practices Acts (3) are clearly prohibitive. In fact, services rendered by physician assistants and registered nurses under the supervision of a licensed physician are permitted. An Attorney General's opinion of 1973 (4) stated that the physical presence of the physician is not required for this supervision.

Legislation and Sources

1. Arkansas Statutes of 1947, Act 1913, No. 96, Para. 82-110, and "Rules and Regulations Pertaining to the Practice of Midwives in Arkansas," Arkansas State Board of Health.

2. Arkansas Statutes, 1967, Act No. 315. Nurse Practice Act.

3. Arkansas Statutes, Act 65 of 1955, Act 198 of 1957 and Act 53 of 1971, Arkansas Medical Practices Acts.

4. Opinion No. 73-54, March 5, 1973, Letter to Senator W.D. Moore, Jr., from J.G. Tucker, Attorney General, Arkansas.

Qualifications for Practice

None specific to nurse-midwifery.

Application for Licensure

For specific information regarding practice under the lay midwife or physician assistants laws and regulations, write to:

Arkansas State Board of Health
4815 West Markham Street
Little Rock, Arkansas 72201

Arkansas State Medical Board
212 Jackson Street
Harrisburg, Arkansas 72432

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 20, Region V

Key Source for Legislation Information

Laura Mann, PHN
Consultant, Maternal and Child Health Division
Arkansas State Department of Health
4815 West Markham Street
Little Rock, Arkansas 72201

CALIFORNIA

Legal Status

A nurse-midwifery practice act (1) was signed into law on September 26, 1974. The California Board of Nursing Education and Nurse Registration is authorized under this act to define rules and regulations for the practice of nurse-midwifery through a committee which includes nurse-midwives and obstetricians. Until these regulations shall have been officially approved, nurse-midwifery practice is limited to specific educational institutions and community hospitals which are approved as experimental health manpower projects by the State Department of Public Health (2).

Legislation and Sources

1. California Business and Professions Code, Division 2, Chapter 6, Article 2.5, Nurse-Midwives; also, Section 2815.5, 1974.

2. California Health and Safety Code, Division 1, Part 1, Chapter 2, Article 18, Health Manpower Innovations, 1972.

Qualifications for Practice

Practitioners must meet the educational and professional standards established by the institutions which are approved for experimental health manpower projects by the state. Once rules and regulations of the Board of Nursing Education and Nurse Registration will have been approved, they will take precedence.

Application for Licensure

California Board of Nursing Education and Nurse Registration
Business and Professions Building
Room A-290
1021 O Street
Sacramento, California 95814

Agencies Employing for Full Clinical Practice

Los Angeles County — University of Southern California Medical Center
Women's Hospital
Los Angeles, California 90033

Martin Luther King Jr. General Hospital
Los Angeles, California 90059

St. Luke's Hospital
San Francisco, California 94110

Watts Health Foundation
Los Angeles, California 90059

ACNM Affiliation

Chapters 24 (Northern California) and 25 (Southern California), Region VI

Key Source for Legislation Information

Irene Matousek, CNM
Assistant Professor of Obstetrics
University of Southern California/L.A. County Hospital
442 Garfield Avenue
South Pasadena, California 91030

COLORADO

Legal Status

Certified nurse-midwives are not practicing fully at this time, but it is anticipated that they will do so in the near future under the state's 1973 Nurse Practice Act, which provides for expanded roles of nurses (1). Rules and regulations for practice are to be promulgated by the Boards of Nursing and of Medical Examiners. Guidelines for the practice of nurse-midwifery, as proposed by the Joint Practice Committee of the state's medical and nursing associations (2), have been adopted by the two Boards.

The practice of nurse-midwifery was limited due to the restrictive interpretation of the state's Medical Practice Act, which includes midwifery in its definition of the practice of medicine (3). However, certified nurse-midwives have been responsible for prenatal and postnatal care in public health settings. Also, since 1972, the University of Colorado Medical Center School of Medicine has been conducting a program to train physician assistants (obstetrical associates), whose functions are essentially the same as those of nurse-midwives.

Legislation and Sources

1. Colorado Revised Statutes of 1973, Chapter 97, Article 1, Professional Nursing Practice Act. Effective date January 1, 1974.

2. Proposed Guidelines for the Practice of Nurse-Midwifery, The Joint Practice Committee of the Colorado Medical Society and the Colorado Nurses Association, July 1974.

3. Colorado Revised Statutes, Chapter 91, Medical Practice Act, Section 91-1-6, 1963.

Qualifications for Practice

Being developed by the State of Colorado Boards of Nursing and of Medical Examiners.

Application for Licensure

None at present.

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 22, Region VI

Key Source for Legislation Information

Clyda M. Jensen, R.N.
Nurse Consultant
Maternity and Family Planning
Colorado Department of Health
4210 East 10th Avenue
Denver, Colorado 80220

CONNECTICUT

Legal Status

Certified nurse-midwives are practicing fully in clinical midwifery under the state's nursing statutes (1,2) and/or the Physician Assistants Act (3). Both legal bases are supported by an Attorney General's ruling. Licensure specific to nurse-midwifery practice is not required by either act.

In 1972, a position statement by the Connecticut Nurses Association defined nurse-midwifery as an added dimension of professional nursing (4). The practice of nurse-midwifery will be included in new provisions of the above nursing statutes, which are being revised to cover nurses in expanded roles.

The lay midwife laws, which were revised in 1971 to recognize some of the ACNM standards, still contain lay midwifery restrictions and the requirement of a state examination administered by the State Health Department (5,6,7). No nurse-midwives have applied for licensure under this revised law.

Legislation and Sources

1. General Statutes of Connecticut, Revision of 1968, Chapter 378 — Nursing. Section 20-87.

2. Letter of August 1, 1973 from Director, Community Health Division, State Health Department, Connecticut.

3. Substitute Senate Bill No. 1224, Public Act No. 717. An Act concerning Assistants to Physicians and Surgeons, approved July 8, 1971, Connecticut.

4. Connecticut Nurses Association, *Position on Nurse-Midwifery,* approved by Board of Directors of CNA, June 1972.

5. House Bill No. 7675, Public Act No. 410. An Act concerning the Abolition of the Connecticut Board of Examiners of Midwives and the Transfer of its Powers, approved June 9, 1971.

6. Memorandum of October 27, 1971, signed by the Commissioner, State Department of Health, Connecticut.

7. Public Health Code, Chapter 3, Midwifery, Sections 19-13-C1 to 19-13-C3, revised September 24, 1971, Connecticut.

Qualifications for Practice

Under the nursing statutes:

1. Licensure as a professional nurse registered in Connecticut.

2. Nurse-midwifery qualifications as defined by employing agency, usually requiring current ACNM certification.

Under the Public Health Code for Midwifery:

1. Passing of an examination as required by the State Board of Health (fee of $25.00).

2. Good moral character.

3. Connecticut residence.

4. Successful completion of a program approved by the Commissioner of Health or completion of an approved refresher course or internship, if applicant has been inactive for 5 years.

Limitations to Practice

Under lay midwife laws, no midwife shall use any instrument, or assist labor by any artificial, forcible, or mechanical means . . . or attempt to remove adherent placenta.

Application for Licensure

Under the Public Health Code for Midwifery:

Carol A. Christoffers, RN
Public Health Nursing Consultant
Maternal and Child Health Section
State Department of Health
79 Elm Street
Hartford, Connecticut 06115

Agencies Employing for Full Clinical Practice

Drs. Borelli, Foye, McGrade, and DeGrazia
Route 7, Professional Building
Brookfield, Connecticut 06804

Community Health Care Plan
150 Sargent Drive
New Haven, Connecticut 06511

Drs. I. Friedman, P. Molumphy and L. Olson
860 Howard Avenue
New Haven, Connecticut

Hill Health Center
428 Columbus Avenue
New Haven, Connecticut 06519

Yale Health Plan
17 Hillhouse Avenue
New Haven, Connecticut 06511

Yale New Haven Hospital
789 Howard Avenue
New Haven, Connecticut 06510

Yale University School of Nursing
Graduate Program in Maternal and Newborn Nursing and Nurse-Midwifery
38 South Street
New Haven, Connecticut 06510

ACNM Affiliation

Chapter 2, Region I

Key Source for Legislation Information

Linda P. Vieira, CNM
310 Willow Street
New Haven, Connecticut 06511

DELAWARE

Legal Status

Certified nurse-midwives are not functioning fully in clinical midwifery services. Although a 1943 health code pertaining to midwifery is still in effect, no lay midwives are presently licensed under it (1), nor have certified nurse-midwives been licensed under this code. The medical practice act does not prohibit the practice of midwifery(2).

Legislation and Sources

1. Delaware State Board of Health, Rules and Regulations Pertaining to Midwives, Article I, Chapter 25, 745, Section 2(i), September 28, 1943.

2. Delaware Code, Chapter 17, Medicine, Surgery and Osteopathy, 1964.

Qualifications for Practice

Under the health code, applicants must:

1. Be at least 21 years of age;

2. Possess sufficient experience in the practice of midwifery;

3. Be recommended by the Deputy State Health Officer of the county in which the midwife resides;

4. Pass a physical examination by a physician designated by the Executive Secretary of the State Board of Health;

5. Renew license annually on August 1.

Application for Licensure

Bureau of Licensure
Department of Health and Social Services
Division of Physical Health
State Health Building
Dover, Delaware 19901

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 6, Region III

Key Source for Legislation Information

Edith Wonnell, CNM
106 Wayland Road
Sedgely Farms
Wilmington, Delaware 19807

DISTRICT OF COLUMBIA

Legal Status

Certified nurse-midwives function fully under provisions of the Joint Statement by the District of Columbia Medical Society and the District of Columbia Nurses' Association, accepted in May 1973 (1). This statement enables nurse-midwives to practice in hospitals, with health agencies, and in private obstetricians' offices. In the Healing Art Practice Act of the District of Columbia (2), sections referring to the licensure and practice of midwifery do not apply to nurse-midwives, and the licensure procedures are also no longer operative for lay-midwives.

Legislation and Sources

1. Joint Statement by the District of Columbia Medical Society and the District of Columbia Nurses' Association Concerning Nurse-Midwife Practice, accepted May 1973.

2. Healing Art Practice Act, District of Columbia Code, 1967 Edition, Title 2, Chapter 1, Sections 2-113, 2-120, and 2-122.

Qualifications for Practice

1. Registration in the District of Columbia as a registered nurse;

2. Completion of an organized program of study and clinical experience in nurse-midwifery;

3. Certification by the American College of Nurse-Midwives.

Agencies Employing for Full Clinical Practice

D.C. Department of Human Resources
1875 Connecticut Avenue, N.W.
Washington, D.C. 20009

D.C. General Hospital
19th Street & Mass. Avenue, S.E.
Washington, D.C. 20003

Georgetown University School of Nursing
Nurse-Midwifery Program
Washington, D.C. 20007

Group Health Association
2121 Pennsylvania Avenue, N.W.
Washington, D.C. 20037

ACNM Affiliation

Chapter 6, Region III

Key Source for Legislation Information

Margaret Gallen, CNM
2800 Woodley Road, N.W.
Washington, D.C. 20008

FLORIDA

Legal Status

Certified nurse-midwives are functioning fully in clinical midwifery services. The Medical Practice Act, as amended in 1970, recognizes nurse-midwifery under "exemptions" in the definition of the practice of medicine (1). This statute empowers the State Department of Health to regulate the practice of both lay midwifery and of nurse-midwifery (2). Lay midwives are currently licensed to practice, and the state's physician assistants act also provides legal coverage for the practice of midwifery (3).

Legislation and Sources

1. Florida Statutes, Chapter 458, Medical Practice Act, Section 458.13(4), 1970.

2. Rules, State of Florida, Department of Health and Rehabilitative Services, Division of Health Services-Medical and Related Fields, Chapter 10D-36, Part I, Lay-midwifery, Part II, Nurse-midwifery, 1971.

3. Florida Statutes, Chapter 458, Medical Practice Act, Section 458.135, Physician's Assistant, 1970.

Qualifications for Practice

1. Licensure as a professional nurse in Florida.

2. Successful completion of a nurse-midwifery educational program approved by the American College of Nurse-Midwives.

3. Registration with the Division of Health as a nurse-midwife. (Annual renewal is required.)

Application for Licensure

Division of Health
Department of Health and Rehabilitative Services
P.O. Box 210
Jacksonville, Florida 32201

Agencies Employing for Full Clinical Practice

Bethesda Memorial Hospital
Boynton Beach, Florida

R.B. Cuthbert, Jr., MD, FACP
Mortan F. Plant Hospital
323 Jeffords Street
Clearwater, Florida 33516

Elgin Air Force Base Hospital
Valparaiso, Florida 32542

MacDill Air Force Base Hospital
Tampa, Florida 33608

L. Radkin, MD, and D. Juba, CNM
Live Oak, Florida

University Hospital
655 W. 8th Street
Jacksonville, Florida 32209

ACNM Affiliation

Chapter 8, Region V

Key Source for Legislation Information

Ethel J. Kirkland, CNM
Box 12006
Carver Station
Jacksonville, Florida 32209

GEORGIA

Legal Status

Nurse-midwives are functioning fully in several selected areas of the state, where the legal base for their practice is considered to lie in the state's nurse practice act (1), in conjunction with joint statements on nurse-midwifery developed locally by interdisciplinary professional groups responsible for nurse-midwifery services (2). Although lay midwives are permitted to practice under the midwifery practice act (3), the number of lay midwives applying for certification is diminishing rapidly, and the State Department of Human Resources is no longer offering training in lay midwifery.

A centralized listing system for certified nurse-midwives in the state is being explored with the Georgia Department of Human Resources.

Legislation and Sources

1. State of Georgia Code for Professions, Businesses and Trades, Chapter 84-10, Nurses.

2. Joint Statement on Nurse-Midwifery, Grady Memorial Hospital, Atlanta, Georgia, accepted March 5, 1971.

3. Georgia State Public Health Code, Chapter 88-14, Practice of Midwifery, 1964.

Qualifications for Practice

Although no statewide licensure requirements exist, the joint statements accepted by local professional groups define similar qualifications for nurse-midwives to practice. At Grady Memorial Hospital minimum qualifications are:

1. Licensure as a registered nurse in the state of Georgia;

2. Possession of a Certificate in Nurse-Midwifery from a program approved by the American College of Nurse-Midwives;

3. Currency in nurse-midwifery practice assessed according to criteria developed by the Grady Memorial Hospital Nurse-Midwifery Service.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

Archibald Memorial Hospital
with Thomas County
Thomasville, Georgia

Dr. S. Gatewood
Americus, Georgia

Glynn-Brunswick Memorial Hospital
Brunswick, Georgia 31520

Grady Memorial Hospital
80 Butler Street, S.W.
Atlanta, Georgia 30303

ACNM Affiliation

Chapter 9A, Region V

Key Source for Legislation Information

June Sangala, CNM
Nurse-Midwifery Service
Grady Memorial Hospital
80 Butler Street
Atlanta, Georgia 30303

GUAM

Legal Status

Nurse-midwives are employed for clinical midwifery services and are beginning to perform deliveries. They are licensed under the Medical Practices Code (1), and the Government of Guam Commission on Licensure to Practice the Healing Art has established standards for licensure (2), which include certification by the American College of Nurse-Midwives, in addition to those specified for midwives in the Code (3).

The Medical Practices Code is being revised and its provisions for midwifery practice (3) may be altered. At the same time, the Nurse Practice Act (4) is also being revised to include provisions for nurse-midwifery practice.

Legislation and Sources

1. Government Code of Guam for Medical Practices, Title 28, Chapter I, Definitions, Chapter II, General Provisions, 1952.

2. Memorandum from Guam Memorial Hospital Administrator to Director of Public Health and Social Services, Guam, September 7, 1973.

3. Government Code of Guam for Medical Practices, Title 28, Chapter IV, Midwives, 1952.

4. Government Code of Guam Medical Practices, Title 28, Chapter III, Nurse Practice Act, amended 1964.

Qualifications for Practice

1. Qualification as a graduate nurse.

2. Qualifications as established by the Commission on Licensure (currently using ACNM standards).

Application for Licensure

Commission on Licensure to Practice the Healing Art
Attention: Mr. Robert Taylor
Guam Memorial Hospital
P.O. Box AX
Agana, Guam 96910

Agencies Employing for Full Clinical Practice

Naval Regional Medical Center

Seventh Day Adventist Clinic (affiliated with Guam Memorial Hospital)

ACNM Affiliation

Region VI

Key Source for Legislation Information

J. Tiffany Coleman, CNM
P.O. Box B.T.
Agana, Guam 96910

HAWAII

Legal Status

Nurse-midwives may legally practice in Hawaii, although none are currently known to do so. The legal basis for practice is provided in lay midwife regulations of the Department of Health (1).

Although these regulations were prepared for the lay midwife, they do not impose excessive restrictions on nurse-midwifery practice. There has been some interest in the Department of Health in using ACNM certification as a criterion for granting licensure (2).

Legislation and Sources

1. Public Health Regulation, Department of Health, State of Hawaii, Chapter 6, Midwives, 1960. Authorization: Revised Laws of Hawaii, 1955, Sections 46-15 and 46-15.1.

2. Letter of October 11, 1973 to the ACNM from L.S. Childs, MD, Chief, Maternal and Child Health Branch, State of Hawaii Department of Health.

Qualifications for Practice

1. Be free from infectious and communicable disease, of sound mind and body, of good moral character, at least 21 years of age;

2. Have a physical examination, including a chest x-ray and serology, within 3 months prior to application;

3. Be graduates from a school of midwifery recognized by the Department of Health or a satisfactory equivalent;

4. Register annually with the Department of Health and pay a $2.00 fee.

Limitations to Practice

Under the Public Health Regulations of the State of Hawaii, a midwife shall only practice in cases of normal uncomplicated pregnancy, labor, and delivery and during the puerperium. She shall only attend cases which have been approved for home delivery by a physician in writing. Also, a midwife shall not attend any woman either during pregnancy or the puerperium who has any medical, surgical or obstetrical complication or who has any infectious or communicable disease or who is premature in labor.

Application for Licensure

Maternal and Child Health Branch
Department of Health
State of Hawaii
P.O. Box 3378
Honolulu, Hawaii 96801

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Region VI

Key Source for Legislation Information

Ruth Yoshioka
Maternity Nursing Consultant
State of Hawaii
Department of Health
P.O. Box 3378
Honolulu, Hawaii 96801

IDAHO

Legal Status

Certified nurse-midwives are not functioning fully, although there is an approval mechanism for full clinical practice. The state's Nurse Practice Act was amended in 1971 (1) to allow for the expanded role of the nurse, as authorized by rules and regulations jointly promulgated by the Idaho State Board of Medicine and the Idaho State Board of Nursing and implemented by the Idaho Board of Nursing (2). These rules and regulations do not specifically refer to nurse-midwifery but allow for practice. There are no laws regulating or prohibiting lay midwifery.

Legislation and Sources

1. Idaho Code, Chapter 84, Nurse Practice Act, Section 54-1413(e), 1971.

2. State of Idaho, Administrative Procedure Act, Minimum Standards, Rules and Regulations for the Expanding Role of the Registered Professional Nurse. June 1972.

Qualifications for Practice

1. Licensure as a registered nurse in Idaho.

2. Documentary evidence to the employer and the Boards of Medicine and Nursing of successful completion of special education or training for area of practice.

Application for Licensure

Chairman
Standards of Practice Committee
Idaho Nurses Association
2404 Bank Drive
Boise, Idaho 83705

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 23, Region VI

Key Source for Legislation Information

Marie Mohler, CNM
Idaho State University
School of Nursing
Pocatello. Idaho 83201

ILLINOIS

Legal Status

Nurse-midwives are practicing fully under the state's Nursing Act (1), as recognized in an official statement issued by the Illinois Nurses' Association (INA) (2). This statement recognizes the nurse-midwife as a specialist in advanced maternity nursing practice in the care of the uncomplicated maternity cycle, as prescribed by the licensed physician responsible for the patient's obstetric care.

A lay midwife statute within the Illinois Medical Practice Act (3) provides for licensure, but the authority to issue new licenses was repealed in an amendment to the Act (4).

Legislation and Sources

1. Illinois Revised Statutes 1967, Chapter 91, The Illinois Nursing Act, Sections 35.32-35.56.

2. "Specialization in Advanced Maternity Nursing," Illinois Nurses Association (INA). Approved by the INA Board of Directors, February 27, 1970.

3. Illinois Revised Statutes 1967, Chapter 91, The Illinois Medical Practice Act, Secions 1-39.

4. Illinois Revised Statutes 1967, Chapter 91, The Illinois Medical Practice Act, Section 5.3, Midwifery.

Qualifications for Practice

The INA statement requires that a nurse-midwife be:

1. Graduated from an approved school of professional nursing;

2. Licensed to practice as a registered nurse in Illinois;

3. Graduated from a nurse-midwifery program approved by the American College of Nurse-Midwives or accredited by the National League for Nursing.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

Chicago Board of Health
and Illinois Masonic Medical Center
Coordinated Nurse-Midwifery Service
834 W. Wellington
Chicago, Illinois 60657

Health and Hospitals Governing Commission of Cook County
Cook County Hospital
1835 West Harrison Street
Chicago, Illinois 60612

The University of Illinois at the Medical Center
College of Nursing, Department of Maternal-Child Nursing
Nurse-Midwifery Program
P.O. Box 6998
Chicago, Illinois 60680

ACNM Affiliation

Chapter 15, Region IV

Key Source for Legislation Information

Phyllis Burosh, CNM
2619 165th Street
Hammond, Indiana 46323

INDIANA

Legal Status

Certified nurse-midwives are permitted to practice fully under the state's lay midwifery statutes (1). Four nurse-midwives are currently licensed, but no lay midwives. However, it is not known whether any of the nurse-midwives are actually practicing.

Legislation and Sources

1. Indiana Medical Law of 1897 with Amendments through 1927, Indiana Statutes, Chapter 80, Section 6, Midwifery (as amended March 3, 1899, Acts 1899, p. 252).

Qualifications for Practice

1. Diploma from an "obstetrical school" recognized by the State Board of Medical Registration and Examination (Payment of a fee of $5.00 at the time of making application).

2. Alternatively, passing of an examination in midwifery as the Board shall require and payment of a fee of $10.00.

Application for Licensure

Board of Medical Registration and Examination of Indiana
1330 West Michigan Street
Room A412
Indianapolis, Indiana 46206

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 14, Region IV

Key Source for Legislation Information

Magdalena Hennel, CNM
R.R. 4, Box 292-C
Newburgh, Indiana 47630

IOWA

Legal Status

No certified nurse-midwives are currently practicing, although there are no specific prohibitions in the state's medical (1) or nurse practice (2) acts, whose definitions of medicine and professional nursing appear open to permissive interpretation regarding the legal practice of nurse-midwifery. Provisions in the laws pertaining to physician assistants (3) would cover nurse-midwifery practice, according to recent opinions of the state's Attorney General (4).

There is a desire for change in order to remove the ambiguity in the legal status of nurse-midwifery practice. The state's Board of Nursing has proposed revisions to the nurse practice act to cover expanded roles of nurses.

Legislation and Sources

1. 1973 Code of Iowa, Chapter 148, Practice of Medicine and Surgery.

2. 1973 Code of Iowa, Chapter 152, Practice of Nursing.

3. 1973 Code of Iowa, Chapter 148B, Physician Assistants.

4. Letter to Senator M. Doderes from F. M. Haskins, Assistant Attorney General, Des Moines, Iowa, January 4, 1974.

Qualifications for Practice

Under the physician assistants act:

1. Completion of a program approved by the Department of Health or affirmation of other qualifications by the Board of Medical Examiners of Iowa.

2. Approval of the applicant and of the supervising physician, as required by the Board of Medical Examiners of Iowa.

Application for Licensure

Under the physician assistants act:

Executive Secretary
Board of Medical Examiners
503 Empire Bldg.
Des Moines, Iowa 50309

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 17, Region IV

Key Source for Legislation Information

Mildred Dixon Hipwood
Educational Director
Cedarloo Hospital Council
Russell Lamson Building, 800
Waterloo, Iowa 50701

KANSAS

Legal Status

No nurse-midwives are practicing in Kansas, although there are no specific prohibitions in either the nursing practice acts (1) or the medical practice acts (2). The definitions therein of medicine and professional nursing appear open to permissive interpretation regarding the legal practice of nurse-midwifery. Midwifery as such is not mentioned in the Kansas statutes, and there is no evidence of interest in beginning nurse-midwifery services in the state, despite the absence of any serious opposition (3).

Legislation and Sources

1. Laws Relating to Registration of Nurses and Nursing Education, Laws of Kansas, Revised Edition 1973, Sections 65-1113 to 65-1126, and 74-1106 to 74-1108.

2. Kansas Healing Arts Act, 1957 Supplement to the 1970 General Session of Kansas, Sections 65-2801 to 65-2890.

3. Hawver, M., "Trained Midwife Taboo in Kansas," *Topeka Daily Capital*, December 14, 1972.

Qualifications for Practice

None.

Limitations to Practice

The state's Healing Arts Act restricts the performance of "any surgical operation of whatever nature . . ." to the practice of medicine. It is uncertain whether this would be interpreted as a limitation on nurse-midwifery performance, such as repair of episiotomies.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 19, Region IV

Key Source for Legislation Information

Karen Stolte, CNM
313 East 15th Place
Lawrence, Kansas 66044

KENTUCKY

Legal Status

Certified nurse-midwives are practicing fully under the state's revised rules and regulations for the practice of midwifery, effective in April 1975 (1). These regulations distinguish between the nurse-midwife and the lay midwife, and recognize the increasing role of the nurse-midwife in the delivery of midwifery services. Regarding lay midwifery, the new regulations authorize renewal of existing permits to practice, but the issuance of new permits to lay midwives is not authorized.

Specific nurse-midwife practice standards and lay midwife practice standards are separately defined by the Bureau of Health Services in the state's Department of Human Resources, which is authorized by statute to regulate the practice of midwifery in Kentucky (2).

Legislation and Sources

1. Kentucky Department for Human Resources, Bureau of Health Services (902 KAR 4:010) adopted February 13, 1975. Effective April 9, 1975.

2. Kentucky Revised Statutes 211.090, 211.180.

Qualifications for Practice

1. Licensure as a registered nurse in Kentucky.

2. Graduation from a program in nurse-midwifery approved by the American College of Nurse-Midwives.

3. Certification by the American College of Nurse-Midwives.

4. Annual renewal of licenses.

Application for Licensure

Department for Human Resources
Bureau of Health Services
275 East Main Street
Frankfort, Kentucky 40601

Agencies Employing for Full Clinical Practice

Appalachian Regional Hospital
Hazard, Kentucky 41701

D.G. Barker, MD
Hindman, Kentucky (Knott County) 41822

Buckhorn Clinic
Perry County, Kentucky
(Write to: National Health Service Corps
U.S. Department of Health, Education and Welfare
Health Services and Mental Health Administration
Rockville, Maryland 20852)

Frontier Nursing Service
Wendover, Kentucky 41775

Ireland Army Hospital
Fort Knox, Kentucky 40121

Lake Cumberland District Health Department
Somerset, Kentucky 42501

Lend-a-Hand Center
Walker, Kentucky (Knox County) 40997

J. Myron Lord, MD
Frankfort, Kentucky 40601

Morehead Clinic
Morehead, Kentucky 40351

University of Kentucky Medical Center
Lexington, Kentucky 40506

ACNM Affiliation

Chapter 10, Region III

Key Source for Legislation Information

Helen E. Browne, CNM
Director
Frontier Nursing Service
Wendover, Leslie County, Kentucky 41775

LOUISIANA

Legal Status

Certified nurse-midwives are practicing fully in the state under the state's nurse practice act (1). The Louisiana State Board of Nursing has stated that nurse-midwifery as practiced by a certified nurse-midwife is viewed as an extension of nursing practice (2).

Lay midwives practice in the state under two separate authorities empowered to regulate midwifery practice. The state's medical practice act provides for control of midwifery practice through the Board of Medical Examiners (3), except for Orleans Parish, where, according to a separate statute of 1950 (4), standards for practice are determined by the State Board of Health. The provisions of that statute supersede the general statute for the state (5). Lay midwives currently practicing in the state are supervised by public health nurses.

Legislation and Sources

1. Louisiana Revised Statutes of 1950, as amended by Act 166, Chapter 11, Nurses, 1966.

2. Letters from the Louisiana State Board of Nurse Examiners to M. Meglen, CNM, Director, Nurse-Midwifery Programs, The University of Mississippi Medical Center, Jackson, dated April 17, 1973 and January 21, 1974.

3. Louisiana Revised Statutes, Professions and Occupations, Chapter 15, Physicians and Surgeons, Section 37: 1277-78, Midwifery: Examination: License, 1975.

4. Louisiana Revised Statutes, Professions and Occupations, Chapter 15, Part III, Midwifery in Orleans Parish, Section 37:1331-1339, 1950.

5. Reporter's notes following Louisiana Revised Statutes, Chapter 15, 37-1276.

Qualifications for Practice

None specified in state statutes, but licensure as professional nurse in Louisiana and ACNM certification are required.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

Louisiana Health and Social and Rehabilitation Services
Division of Health
P.O. Box 60630
New Orleans, Louisiana 70160

University of Mississippi Medical Center
Nurse-Midwifery Education Program
265 Woodland Hills Building
Jackson, Mississippi 39216
(Affiliated with the Earl K. Long Hospital, Baton Rouge, Louisiana)

ACNM Affiliation

Chapter 9, Region V

Key Source for Legislation Information

Sue Bennett, CNM
3608 Bon Air Drive
Monroe, Louisiana 70201

MAINE

Legal Status

Nurse-midwives are practicing fully under the state's recently amended nurse practice act (1). This statute now provides that a registered professional nurse may diagnose "illness" or prescribe therapeutic and corrective measures when such services are delegated by a physician and the nurse has completed the additional educational program required for the performance of such services. Practice of nurse-midwifery is endorsed by a joint statement of the Maine Medical Association, Maine Nurses' Association, and Maine Hospital Association, which recognizes the practice of nurse-midwifery by registered nurses meeting specified standards (2). There are no specific statutes pertaining to midwifery practice in the state.

Legislation and Sources

1. Maine Revised Statutes 1964, Amended 1974, Title 32, Chapter 31, Nurses and Nursing, Sections 2101 to 2108.

2. Joint Statement of Policy on Nurse-Midwifery, Maine. Revised October 1971.

Qualifications for Practice

1. Licensure as a Registered Nurse in Maine.

2. Certification in nurse-midwifery from a program approved by the American College of Nurse-Midwives.

3. Fulfillment of criteria for nurse-midwifery practice as defined by the employing hospital.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

Maine Medical Center
22 Bramhall Street
Portland, Maine 04102

ACNM Affiliation

Chapter 1, Region I

Key Source for Legislation Information

Phyllis Tryon, CNM
Clinical Director
Nurse-Midwifery Service
22 Bramhall Street
Portland, Maine 04102

MARYLAND

Legal Status

Certified nurse-midwives are practicing fully under the state's lay midwife laws (1) and under the state's Nurses Licensing Act (2). The definition of nursing in the latter was amended in 1974 to provide for the expanded role of the nurse (3). In addition, a joint statement of policy by the Maryland Nurses' Association and the Medical and Chirurgical Faculty of the State of Maryland sets standards and requirements for practice (4).

Nurse-midwives must continue to apply for licensure under the old lay midwife regulations (1,5), although these contain inappropriate provisions for nurse-midwives.

Legislation and Sources

1. Annotated Code of Maryland (1957 Edition), "Midwives," Article 43, Sections 82 to 94 (Enacted 1924).

2. Annotated Code of Maryland (1965 Replacement Volume), Nurses Licensing Act, Article 43, Sections 290 to 302. As amended by Chapter 77 of the Acts of the General Assembly of Maryland, 1969.

3. Definition of the Practice of Registered Nursing as amended by the General Assembly of Maryland, 1974.

4. Nurses Protocol Regulating the Practice of Nurse-Midwifery in Maryland, adopted 1970, amended 1973.

5. Regulations of the State Board of Health Governing Licensing of Midwives, adopted February 1, 1957.

Qualifications for Practice

Under the lay midwife laws, applicants shall:

1. Be 21 years of age, of good moral character, and have a clean appearance;

2. Be able to read and write English;

3. Have a medical examination by the health officer of the county of residence, including serology and chest x-ray;

4. Take a course of instruction from specified public health nursing personnel in the state, or show a diploma from a school of nurse-midwifery;

5. Pass an examination in midwifery given by two physicians named by the State Department of Health and practicing in the city or town of applicant's residence, *or* submit proof of being licensed by another state or country in which the requirements for licensure are equal to those in this state;

6. Renew license biennually.

Application for Licensure

Maryland State Department of Health
Bureau of Preventive Medicine
2411 North Charles Street
Baltimore, Maryland 21218

Agencies Employing for Full Clinical Practice

Baltimore City Hospital
Baltimore, Maryland 21224

Johns Hopkins Hospital
Department of Obstetrics and Gynecology
600 North Broadway
Baltimore, Maryland 21205

Johns Hopkins University
School of Hygiene and Public Health
Department of Maternal and Child Health
615 North Wolfe Street
Baltimore, Maryland 21205

Mercy Hospital
Department of Obstetrics and Gynecology
301 St. Paul Place
Baltimore, Maryland 21202

Peninsula General Hospital
Department of Obstetrics and Gynecology
Salisbury, Maryland 21801

Provident Hospital
Department of Obstetrics and Gynecology
2600 Liberty Heights Avenue
Baltimore, Maryland

United States Air Force
Nurse-Midwifery Program
Malcolm Grow USAF Medical Center
Andrews Air Force Base, Maryland 20031

ACNM Affiliation

Chapter 6, Region III

Key Source for Legislation Information

Frances Damratowski, CNM
31 Cardor Court
Perry Hall, Maryland 21236

MASSACHUSETTS

Legal Status

Nurse-midwives are not permitted to practice fully in Massachusetts. Although the state's medical practice act does not define the practice of medicine or surgery (1), the courts have held that the practice of midwifery constitutes the practice of medicine, which is the exclusive area of the licensed physician. In a precedent involving prosecution of a midwife (Commonwealth vs. Porn, 1907), the Massachusetts Supreme Court held that "Both medical and popular lexicographers define midwife as a female obstetrician and midwifery as the practice of obstetrics" (2). The court also stated that the legislature could "separate by a line of statutory demarcation, the work of the midwife from the practitioner of medicine" (2). This has not been accomplished despite several legislative efforts during the past several years.

A bill (3) introduced in the 1975 legislative session would provide for licensure of nurse-midwives by the State Board of Registration in Nursing. The act would authorize the Board to adopt and, with the approval of the State Department of Public Health, to promulgate rules and regulations for the practice of nurse-midwifery. One requirement for practice in the bill is graduation from a school for nurse-midwives approved by the American College of Nurse-Midwives.

Legislation and Sources

1. The Commonwealth of Massachusetts, Board of Registration in Medicine, Laws Pertaining to the Registration of Qualified Physicians, General Laws, Chapter 13, June 10, 1966.

2. Commonwealth vs. Porn (1907), 82 N.E. 31, 196 Massachusetts 326 17 L.R.A., N.S. 94, 13 Ann. Cas. 569.

3. Massachusetts House Bill No. 1686 (1975) introduced by Mr. Louis Bertonazzi of Milford, Massachusetts to amend General Laws, Chapter 112, to add Section 74C (1) and (2).

Qualifications for Practice

None.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 1, Region I

MISSISSIPPI

Legal Status

Fully functioning certified nurse-midwives are employed throughout the state. The state's Medical Practice Acts exempt "females engaged solely in the practice of midwifery" from the statutes governing practice of medicine (1). In addition to nurse-midwives, over 200 lay midwives are practicing in accordance with rules and regulations defined by the State Board of Health.

On several occasions, the state's Attorney General has ruled that the practice of nurse-midwifery does not violate the state's nurse practice act (2), which was amended in 1974 to provide for the expanded roles of nurses (3). As a result, rules and regulations for the practice of nurse-midwifery are now being developed by the State Board of Nursing in consultation with the state's nurse-midwives. Currently, qualifications for nurse-midwifery practice are set by a joint statement (4) which has been accepted by the Mississippi State Board of Health and the State Board of Nursing, the Mississippi Nurses Association and the Mississippi State Medical Association. This statement endorses midwifery as extended nursing practice and sets qualifications for practice in the state.

Legislation and Sources

1. Mississippi Code of 1942, Recompiled, Professions and Callings, Medical Practice Acts, Title 32, Chapter 10, Section 8887.

2. State of Mississippi, Attorney General's opinion in letter to Nurses Board of Examination and Regist ation, July 14, 1969, and Attorney General's opinion in letter to University of Mississippi Medical Center, August 2, 1972.

3. Law Regulating the Practice of Nursing in Mississippi, Sections 73-15-1 to 73-15-35. Issued by Mississippi Board of Nursing, Jackson, Mississippi, 1974.

4. Joint Statement on the Practice of Nurse-Midwifery in Mississippi, Accepted by the State Board of Health, the State Board of Nursing, the Mississippi Nurses Association and the Mississippi State Medical Association. Effective July 1972.

Qualifications for Practice

1. Licensure in the State of Mississippi as a registered nurse.

2. Graduation from a nurse-midwifery basic education or refresher program approved or recognized by the American College of Nurse-Midwives.

3. Certification in nurse-midwifery from the American College of Nurse-Midwives signifying successful passage of the national written and clinical examinations.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

Delta Community Hospital and Health Center
Mound Bayou, Mississippi 38762

Mississippi State Board of Health
Bureau of Family Health Services
P.O. Box 1700
Jackson, Mississippi 39205

South Washington County Hospital
Hollandale, Mississippi 38748

University of Mississippi Medical Center
2500 North State Street
Jackson, Mississippi 39216

ACNM Affiliation

Chapter 9, Region V

Key Source for Legislation Information

Sister Dinah White, CNM
Faculty, Nurse-Midwifery Education Program
Department of Obstetrics and Gynecology
University of Mississippi Medical Center
265 Woodland Hills Building
Jackson, Mississippi 39216

MISSOURI

Legal Status

The provisions of the state's medical practice act permitting the issuance of licenses to practice midwifery were repealed in 1959, although a few lay midwives still practice in rural areas under a "grandfather clause" (1). Also, on March 9, 1972 the Attorney General for the state of Missouri issued an opinion to the effect that the state's Nursing Practice Act (2) did not cover midwifery practice by registered nurses (3).

At present, certified nurse-midwives are practicing fully in designated areas under the supervision of the Department of Obstetrics and Gynecology, Saint Louis University School of Medicine. Designated areas include those assigned by the Saint Louis Department of Health and Hospitals and for which medical service is provided by the School of Medicine, Saint Louis University. Responsibility for delegating nurse-midwifery functions rests with the Medical Directors of these services (4).

Legislation designed to broaden the scope of the Nursing Practice Act (2) has been introduced.

Legislation and Sources

1. Missouri Revised Statutes 1959 and Supplement to RSMo 1963, Occupations and Professions, Title 22, Chapter 334, Physicians and Surgeons Section 334.190 to 334.220, Practice of Midwifery Limited.

2. Missouri Revised Statutes 1953, Occupations and Professions, Chapter 335, Nursing Practice Act.

3. Letter to H. Domke, MD, Director, Division of Health, Missouri State Department of Public Health and Welfare, from J.C. Danforth, Missouri State Attorney General. Opinion No. 79, March 9, 1972.

4. Memorandum from the Hospital Commissioner, Department of Health and Hospitals, City of St. Louis to Medical Director, St. Louis City Hospital, Missouri, July 7, 1971.

Qualifications for Practice

Nurse-midwives currently practicing in designated areas under the supervision of St. Louis University and St. Louis Department of Health and Hospitals must be:

1. Licensed as a registered nurse in Missouri.

2. Certified by the American College of Nurse-Midwives.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

St. Louis Department of Health and Hospitals
1515 Lafayette
St. Louis, Missouri 63104

St. Louis University
School of Nursing and Allied Health Professions
1401 South Grand Boulevard
St. Louis, Missouri 63104

ACNM Affiliation

Chapter 19, Region IV

Key Source for Legislation Information

Sister Christopher Brockman, CNM
Staff Nurse-Midwife, Instructor
St. Louis University
School of Nursing and Allied Health Professions
1401 South Grand Boulevard
St. Louis, Missouri 63104

MONTANA

Legal Status

Nurse-midwives are permitted to practice fully under a 1974 addition to the state's Nursing Practice Act (1), and pertaining specifically to nurse-midwives. The state's Medical Practice Act was likewise amended by including nurse-midwives in the list of exemptions (2).

The licensing procedure for nurse-midwives includes an "amendment" to the state's nursing license, granting a "certificate of nurse-midwifery" (1).

Legislation and Sources

1. Revised Code of Montana 1947, Nursing Practice Act, Section 66-1246, "Licensing of Midwives," 1974.

2. Revised Code of Montana 1947, Medical Practice Act, Section 66-1012 (2) (j), 1974.

Qualifications for Practice

1. Licensure as a registered nurse in Montana.

2. Certification by the American College of Nurse-Midwives. Temporary approval to practice pending receipt of results of certification is limited to four months.

3. Fulfillment of any other requirements set by the Montana Board of Professional Nursing Administration.

4. Payment of a $25.00 fee, with annual license renewal ($5.00 fee).

Application for Licensure

Montana State Board of Professional Nursing
Administration
Lalonde Building
Helena, Montana 59601

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 23, Region VI

Key Source for Legislation Information

Gertrude Malone, RN, MN
Executive Secretary
Montana State Board of Nursing
Helena, Montana 59601

NEBRASKA

Legal Status

Certified nurse-midwives are not practicing fully except at Offatt Air Force Base Hospital. Full nurse-midwifery practice in the state is limited by ambiguous legal provisions. The state's medical practice act defines medical practice as "the practice of medicine, surgery or obstetrics, or any of their branches" (1). However, midwives are specifically exempted from requirements of the Basic Sciences Licensing acts (2), and are referred to in other statutes of the state (3). Furthermore, the nurse practice

act is not restrictive with respect to nurse-midwifery practice (4).

Legislation and Sources

1. Revised Statutes Nebraska 1969, relating to Practice of Medicine and Surgery, Section 71-1, 102.

2. Nebraska Laws of 1927, C.S. 1929, Public Health and Welfare, Article 4, Basic Sciences: Licensing, Section 71-416, Act: Scope.

3. Nebraska Laws of 1937 C.S. Supplement 1941, Public Health and Welfare, Article 14, Crippled Children, Section 71-1404.

4. Revised Statutes Nebraska 1975, Practice of Nursing, Section 71-1, 132.05 (3), (4).

Qualifications for Practice

None.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

Ehrling Berquist Hospital
Offatt Air Force Base
Omaha, Nebraska 68113

ACNM Affiliation

Chapter 17, Region IV

Key Source for Legislation Information

Catherine Corboy, CNM
3063 South 42nd Street
Omaha, Nebraska 68105

NEVADA

Legal Status

Although certified nurse-midwives do not practice fully in the state except at a U.S. Air Force Base, nurse-midwives may legally do so under the state's nurse practice act, which provides for the expanded role of the nurse (1). To implement this act, the State Board of Nursing is developing rules and regulations to assist nurses in multiple kinds of practitioner settings. The intent of the Board is to make it possible for nurse-midwives to practice under the nurse practice act without separate nurse-midwife licensure.

Legislation and Sources

1. Nevada Revised Statutes, Laws Relating to Nursing, Chapter 632, Sections 632.000 to 632.500, July 1, 1973.

Qualifications for Practice

Being developed by the State Board of Nursing.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

Nellis Air Force Base Hospital
Las Vegas, Nevada 89101

ACNM Affiliation

Chapter 22, Region VI

Key Source for Legislation Information

M. Sandra Bourbon, CNM
Assistant Professor
Orvis School of Nursing
University of Nevada
Reno, Nevada 89507

NEW HAMPSHIRE

Legal Status

Certified nurse-midwives are able to function fully and practice under the state's nurse practice act (1) as amended in 1971 and 1973 to cover the expanded roles of nurses. Requirements for practice are defined in rules and regulations jointly promulgated by the state's Boards of Medicine and of Nursing (2). The legal title for the qualified nurse-midwife is Advanced Registered Nurse Practitioner (ARNP).

Legislation and Sources

1. New Hampshire Revised Statutes, The Laws Relating to Registered Nurses et al, Annotated 326-A:2, Sections 1-12, as amended by Chapter 392, 1973.

2. Rules and Regulations for the Advanced Registered Nurse Practitioners, Part B, Section 3.1, Nurse-Midwifery, January 1, 1974, New Hampshire.

Qualifications for Practice

1. Licensure as a registered nurse in New Hampshire.

2. Completion of a course in midwifery approved by the American College of Nurse-Midwives.

3. Passing of the examinations required for certification by the American College of Nurse-Midwives.

Application for Licensure

New Hampshire Board of Nursing Education and Nurse Registration
105 Loudon Road
Concord, New Hampshire 03301

Agencies Employing for Full Clinical Practice

Strafford County MIC Program
791 Central Avenue
Dover, New Hampshire 03820
Affiliated with
Wentworth Douglas Hospital
Dover, New Hampshire 03820

ACNM Affiliation

Chapter 1, Region I

Key Source for Legislation Information

Judy Edwards, CNM
Strafford County MIC Program
791 Central Avenue
Dover, New Hampshire 03820

NEW JERSEY

Legal Status

Certified nurse-midwives are practicing fully under provisions of the state's lay midwife act (1) and subsequent rules and regulations of the Board of Medical Examiners which pertain specifically to nurse-midwives (2). These rules allow the Board to waive the required examination for those nurse-midwives who hold certification by the American College of Nurse-Midwives. New licenses are not being issued to lay midwives.

Legislation and Sources

1. New Jersey Statutes Annotated, "Midwifery," Chapter 10, Sections 45:10-1 to 45:10-16.

2. Rules of New Jersey State Board of Medical Examiners, 13:35-9-8. Licensure by endorsement of midwives. Effective January 19, 1973.

Qualifications for Practice

1. Passing of an examination given by the State Board of Medical Examiners or proof of certification by the American College of Nurse-Midwives.

2. Licensure as a registered nurse in New Jersey (not mandatory).

3. Certificate or diploma from a school of midwifery and other requirements listed for lay midwives.

$5.00 fee for registration (issued every 2 years).

Application for Licensure

Secretary, New Jersey State Board of Medical Examiners
28 West State Street
Trenton, New Jersey 08625

Agencies Employing for Full Clinical Practice

Atlantic City Medical Center
1925 Pacific Avenue
Atlantic City, New Jersey 08401

Jersey City Medical Center
(previously Margaret Hague Maternity Hospital)
Clifton Place
Jersey City, New Jersey 07304

New Jersey College of Medicine and Dentistry
Martland Hospital
Department of Obstetrics and Gynecology
Division of Midwifery
65 Bergen Street
Newark, New Jersey 07101

North Hudson Hospital
Weehawken, New Jersey 07087

ACNM Affiliation

Chapter 4, Region II

Key Source for Legislation Information

Evelyn Hart, CNM
40 Jonesdale Avenue
Metuchen, New Jersey 08840

NEW MEXICO

Legal Status

Nurse-midwives are practicing fully under rules and regulations of the state's Department of Health and Social Services (1). The Department, which is empowered by a general statute (2) to regulate midwifery practice, has defined regulations for licensure and practice of nurse-midwifery separately from those for the practice of lay midwifery. On the other hand, the state's Nursing Practice Act of 1968 exempts the practice of midwifery other than by a registered nurse (3). This provision includes authorization for new rules and regulations pertaining to nurse-midwives, issued by the State Board of Nursing on April 15, 1973 (4).

The confusing situation created by these overlapping authorities was presented to the state's Attorney General's office by the state's Board of Nursing for clarification. In an opinion issued July 23, 1974, the state's Assis-

tant Attorney General ruled that the situation could be reconciled in the following way (5):

1. All persons who wish to practice midwifery must be licensed by the Health and Social Services Department.
2. All persons who wish to imply that they are nurses must be licensed as a registered nurse.
3. All persons who are licensed as registered nurses, who also meet the qualifications of the Board of Nursing as nurse-midwives, may be so designated on their nursing licenses.

In effect, these regulations mean that practicing nurse-midwives are licensed by two state authorities. However, licensure requirements of the two are essentially the same (1,3).

Legislation and Sources

1. Nurse-Midwife Regulations for New Mexico, adopted by the State Board of Health, August 11, 1967.

2. New Mexico Statutes Annotated, 1953 compilation (1973 P.S.) Section 12-34, Powers and Authority of Department (Health and Social Services).

3. New Mexico Statutes Annotated, Nursing Practice Act, 1953 compilation, amended 1968 (1973 P.S.) Sections 67-2-1 to 67-2-28.

4. New Mexico Board of Nursing, Manual #1, *Rules and Regulations of the New Mexico Board of Nursing,* Volume III, Chapter 1-3, Definitions, Section C(3), Registered Nurse-Midwife-CNM (Certified Nurse-Midwife), April 15, 1973.

5. Advisory letter from J.E. Pendleton, Assistant Attorney General of New Mexico, to R. Dilts, Director, New Mexico Board of Nursing, July 23, 1974.

Qualifications for Practice

To obtain a license for nurse-midwifery practice from the Health and Social Services Department:

1. Licensure or eligibility for licensure as a registered nurse in New Mexico.

2. Successful completion of a program in nurse-midwifery approved by the American College of Nurse-Midwives.

3. Compliance with physical requirements defined by the state's Department of Public Health.

To be designated "Registered Nurse-Midwife" by the state's Board of Nursing:

1. Licensure as a registered professional nurse in New Mexico.

2. Successful completion of an approved educational program of a school of nurse-midwifery.

3. Passing of the "National Qualifying Examinations as directed by the American College of Nurse-Midwives."

4. Any person holding a valid nurse-midwifery permit from the Health and Social Services Department as of April 15, 1973 is automatically considered licensed under these provisions.

Application for Licensure

District Health Officer
Department of Health and Social Services
Box 2348
Santa Fe, New Mexico 87501
and
New Mexico Board of Nursing
505 Marquette Avenue, N.W.
Albuquerque, New Mexico 87101

Agencies Employing for Full Clinical Practice

Kirtland Air Force Base Hospital
Albuquerque, New Mexico 87110

Indian Health Service Hospital
Shiprock, New Mexico 87420

ACNM Affiliation

Chapter 21, Region VI

Key Source for Legislation Information

Suzanne Dahlmann
220 Nishoni, #44
Gallup, New Mexico 87301

NEW YORK

Legal Status

Certified nurse-midwives are practicing fully as provided in the State of New York's amended midwifery act (1) which specifies that only physicians and nurse-midwives may practice midwifery. The state's Sanitary Code Regulations, set by the Public Health Council (2), list requirements for approval to practice nurse-midwifery specifically.

Until 1971, New York City was exempt from state health code requirements which restricted nurse-midwifery practice in the state. The City Health Department pioneered nurse-midwifery legislation by amending the city's lay midwife code to provide specific nurse-midwife regulations in 1959 (3).

According to the state's amended midwifery act, the practice of lay midwifery is no longer legal anywhere in the State of New York.

Legislation and Sources

1. State of New York Public Health Law, Title III, Control of Midwifery, Section 2560, June 1972.

2. New York State Official Compilation of Codes, Rules, and Regulations, Title 10 (Health), Chapter I (State Sani-

tary Code), Part II, Sections 11.190 et seq., Nurse-Midwives. Adopted by the Public Health Council, January 31, 1975. Effective on February 21, 1975.

3. New York City Health Code, Article 43, Nurse-Midwifery, Sections 43.01 to 43.13, 1959.

Qualifications for Practice

1. Certification as a nurse-midwife by the American College of Nurse-Midwives. Pending results of certification examination, temporary approval to practice is granted up to one year.

2. Registration as a professional nurse in New York State.

3. (a) Graduation from an approved education program in nurse-midwifery within the past 5 years; *or* (b) practice as a nurse-midwife within the past 5 years, including performance of 10 deliveries, 2 of them within the past year; *or* (c) completion, within the past 5 years, of a refresher course approved by the State Department of Health.

Application for Licensure

Dorothy C. Cox
Health Manpower Group
New York State Department of Health
ESP Office Tower Building
Albany, New York 12237

Agencies Employing for Full Clinical Practice

Albany Medical Center
Department of Obstetrics
Albany, New York 12208

Beth-Israel Medical Center
10 N.D. Perlman Place
New York, New York 10003

Brookdale Hospital Center*
Linden Blvd. and Rockaway Pkwy.
Brooklyn, New York 11202

Brooklyn-Cumberland Medical Center*
39 Auburn Place
Brooklyn, New York 11205

Brooklyn Jewish Hospital*
667 Eastern Parkway
Brooklyn, New York 11213

Child Bearing Center
50 East 92nd Street
New York, New York 10028

Columbia-Presbyterian Medical Center
Nurse-Midwifery Service and
Graduate Program in Nurse-Midwifery
168th Street and Broadway
New York, New York 10032

Downstate Medical Center
State University of New York
450 Clarkson Avenue
Brooklyn, New York 11213

Elmhurst Hospital
Queens, New York 11203

Flower-Fifth Avenue Hospital*
5th Avenue and 106th Street
New York, New York 10029

Gouverneur Hospital
9 Gouverneur Slip
New York, New York 10002

Harlem Hospital Center
Lenox Avenue and 135th Street
New York, New York 10037

Jacobi Hospital
Pelham Pkwy. and Eastchester Road
Bronx, New York 10461

King's County Hospital
451 Clarkson Avenue
Brooklyn, New York 11203

Lenox Hill Hospital
New York, New York 10021

Lincoln Hospital*
Concord Avenue and 141st Street
Bronx, New York 10454

Morrisania Hospital*
168th Street and Gerard Avenue
Bronx, New York 10452

Mount Sinai Medical Center
5th Avenue and 100th Street
New York, New York 10029

Maternity, Infant Care - Family Planning Projects
New York City Department of Health
377 Broadway
Suite 718
New York, New York 10013

New York Hospital
525 E. 68th Street
New York, New York 10021

Roosevelt Hospital
58th Street and 9th Avenue
New York, New York 10019

*Employment information can be obtained from:
Director, Midwifery Service Program
Maternity, Infant Care - Family Planning Projects
New York City Department of Health
377 Broadway, Suite 718
New York, New York 10013

*Employment information can be obtained from:
Director, Midwifery Service Program
Maternity, Infant Care - Family Planning Projects
New York City Department of Health
377 Broadway, Suite 718
New York, New York 10013

St. Luke's Hospital
New York, New York 10025

St. Mary's Hospital*
1298 St. Mark's Avenue
Brooklyn, New York 11213

University of Rochester Medical Center
Rochester, New York 14627

ACNM Affiliation

Chapter 4, Region II

Key Source for Legislation Information

Elizabeth M. Cooper, CNM
3 Woodridge Trail
Henrietta, New York 14467

NORTH CAROLINA

Legal Status

Certified nurse-midwives are functioning fully in North Carolina in connection with a nurse-midwifery service developed through joint efforts of the School of Nursing and the School of Medicine at the University of North Carolina in Chapel Hill.

The state's Medical Practice (1) and Nurse Practice (2) Acts were amended in 1973 to allow nurses to perform delegated medical tasks including diagnosis and treatment, and rules and regulations pertaining to the practice of nurse-midwifery are being developed. Current licensure laws for lay midwives are not thought to be applicable to nurse-midwives.

Approximately 30 lay midwives are licensed to conduct home deliveries under the supervision of public health nurses. State laws require lay midwives to secure a permit to practice midwifery from the state's Department of Human Resources or a local board of health (3). These agencies are also authorized to promulgate rules and regulations governing the practice of lay midwifery (3).

Legislation and Sources

1. State of North Carolina General Statutes, Medical Practice Act, Article 1, Sections 90-1 to 90-21, with amendments through 1973.

2. State of North Carolina General Statutes, Nurse Practice Act, Article 9, Sections 90-158 to 90-172, with amendments through 1973.

*Employment information can be obtained from:
Director, Midwifery Service Program
Maternity, Infant Care — Family Planning Projects
New York City Department of Health
377 Broadway, Suite 718
New York, New York 10013

of Midwives, Section 130 to 167, 1973. (1967, [illegible]
1973, C 475, S.128.)

Qualifications for Practice

Licensure as professional nurse in the state and other qualifications as specified by the employing agency.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

University of North Carolina
School of Nursing and School of Medicine
Department of Obstetrics and Gynecology
Chapel Hill, North Carolina 27514

ACNM Affiliation

Chapter 7, Region V

Key Source for Legislation Information

Sandra J. Regenié, CNM
Director of Nurse-Midwifery
School of Nursing
University of North Carolina
Box 93, Carrington Hall
Chapel Hill, North Carolina 27514

NORTH DAKOTA

Legal Status

Certified nurse-midwives are not currently practicing, as the state's medical practice act, which defines the practice of medicine as "the practice of medicine, surgery and obstetrics" (1), is open to restrictive interpretation. The state's Nurse Practice Acts, however, are permissive, having been amended in 1971 to delete the section prohibiting diagnosis and treatment (2). There are no provisions for midwifery in the state laws and no lay midwives are practicing. Also, there is no provision in the state's laws for practice by physician assistants.

Legislation and Sources

1. North Dakota Century Code, Physicians and Surgeons, Chapter 43-17-01 (2), 1957.

2. North Dakota Century Code, Nurse Practice Acts, Chapter 43-12, 1971.

Qualifications for Practice

None.

Qualifications for Practice

None.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 20, Region V

Key Source for Legislation Information

Cecilia Buser, CNM
3142 N.W. Expressway, Apt. 141
Oklahoma City, Oklahoma 73112

OREGON

Legal Status

Certified nurse-midwives are functioning fully in Oregon. They practice under the state's nurse practice act, which was revised in 1973 to provide for the expanded roles of nurses (1) and authorizes the state's Board of Nursing to set administrative rules pertaining to the practices of all nurse-practitioners, including nurse-midwives. Specific qualifications and standards of practice are under consideration.

In some rural areas, a few lay midwives are practicing without licenses because no licensure regulations exist.

Legislation and Sources

1. Oregon Revised Statutes, Chapter 678, Law Regulating the Practice of Professional Nursing as amended in 1973.

Qualifications for Practice

Until qualifications for nurse-midwifery practice have been promulgated by the Board of Nursing, nurse-midwives must meet the requirements of the employing agency. Currently, after review of the applicant's educational background and professional experience, the Board of Nursing may issue a "letter of endorsement."

Application for Licensure

Oregon State Board of Nursing
1400 S.W. Fifth Street, Room 574
Portland, Oregon 97201

Agencies Employing for Full Clinical Practice

Dr. D.F. Woomer
750 Eleventh Avenue, East
Eugene, Oregon 97401

ACNM Affiliation

Chapter 23, Region VI

Key Source for Legislation Information

Carolyn Stadter, CNM
1005 S.E. 136th Avenue
Vancouver, Washington 98664

PENNSYLVANIA

Legal Status

Nurse-midwives are practicing fully under the state's midwife law, which vests regulatory powers in the State Board of Medical Education and Licensure (1). Current regulations of this Board restrict licensure to nurse-midwives (2,3). Under study is a proposal to amend the regulations to require certification by the American College of Nurse-Midwives as a prerequisite for practice, instead of the examination administered by the Board.

The Board authorizes the Department of Health to supervise licensed midwives and to issue periodic instructions outlining techniques and procedures for midwives.

Legislation and Sources

1. Pennsylvania Act No. 155, Sections 1-4. An Act to provide for the better protection of the lives, bodies and health of newborn children and parturient women by providing for the licensing and revocation of midwives, etc., 1911.

2. Commonwealth of Pennsylvania, Department of State Commissioner of Professional and Occupational Affairs, State Board of Medical Education and Licensure, Rules and Regulations. Amended 1972.

3. Pennsylvania Bulletin, Doc. No. 22-1877. Filed September 22, 1972.

Qualifications for Practice

1. Licensure as a professional nurse.

2. Completion of a course in midwifery approved by the State Board of Medical Education and Licensure.

3. United States citizenship, or a Declaration of Intent to become a citizen; 21 years of age, good moral character; not addicted to alcohol or narcotics.

4. Successful completion (75%) of a licensing examination administered by the Board.

or

Satisfaction of all requirements of the Board and a valid license in another state or territory of the United States, provided the requirements are substantially equal to those required by the Board.

5. Payment of a $25.00 fee, as well as a $5.00 fee for biennial renewal of license.

Application for Licensure

Secretary
State Board of Medical Education and Licensure
279 Boas Street
Harrisburg, Pennsylvania 17120

Agencies Employing for Full Clinical Practice

Booth Maternity Center
6051 Overbrook Avenue
Philadelphia, Pennsylvania 19131

McKeesport Hospital
1500 Fifth Avenue
McKeesport, Pennsylvania 15132

Temple University Hospital
Department of Obstetrics and Gynecology
3401 North Broad
Philadelphia, Pennsylvania 19140

ACNM Affiliation

Chapter 5, Region III

Key Source for Legislation Information

Eunice Ernst, CNM
R.D. 1
Perkiomenville, Pennsylvania 18074

PUERTO RICO

Legal Status

Nurse-midwives are practicing fully in hospitals and health centers, with over 450 professional nurse-midwives currently licensed in Puerto Rico. The Board of Medical Examiners of Puerto Rico is authorized by the Commonwealth medical practice act to regulate the practice of professional nurse-midwifery (1).

Over 100 lay midwives are licensed to practice by the Puerto Rico Board of Health, which is also responsible for supervision of their work (2).

Legislation and Sources

1. Ley Tribunal Examinador de Medicos de Puerto Rico, Ley Num. 22, Articulo 20, Aprobada el 22 de Abril 1931, segun has sido enmiendad hasta 1970. (Law on the Puerto Rico Board of Medical Examiners, Law No. 22, Article 20, Approved April 22, 1931, as amended through 1970.)

2. Regulamento para Comadronas Auxiliares, Departamento de Salud, Mar. 20, 1961. (Regulations for lay midwives, Department of Health, March 20, 1961.)

Qualifications for Practice

1. License to practice nursing in Puerto Rico.

2. Graduation from a school of nurse-midwifery recognized by the Board of Medical Examiners of Puerto Rico.

3. Passing of an examination by the Board of Medical Examiners of Puerto Rico.

Application for Licensure

Puerto Rico Board of Medical Examiners
261 Tanca Street
Box 3271
San Juan, Puerto Rico 00907

Agencies Employing for Full Clinical Practice

Puerto Rico Department of Health
1306 Ponce de Leon Avenue
Santurce, Puerto Rico 00908

School of Nurse-Midwifery
University Hospitals
Caparra Terrace
Rio Piedras, Puerto Rico 00924

ACNM Affiliation

Chapter 27, Region II

Key Source for Legislation Information

Cecilia Fonseca de Colon, CNM
Nurse-Midwife Consultant
Julio C. Artega 674
Villa Prades
Rio Piedras, Puerto Rico 00924

RHODE ISLAND

Legal Status

Despite the lack of any restriction on practice, no certified nurse-midwives are practicing in Rhode Island. Although there are no statutory provisions for the licensure of lay midwives or nurse-midwives, both the state's medical practice act (1) and the state's nurse practice act (2) are open to permissive interpretation.

Legislation and Sources

1. Rhode Island General Laws 1956 Amended, Physicians and Surgeons, Chapter 5-37.

2. Rhode Island General Laws 1956 Amended, Nurses, Chapter 5-34.

Qualifications for Practice

None.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 2, Region I

Key Source for Legislation Information

Nancy Mularczyk, CNM
85 Bluefield Street
New Bedford, Massachusetts 02740

SOUTH CAROLINA

Legal Status

Nurse-midwives are currently employed in a nurse-midwifery service and also for teaching and supervision of lay midwives whose practice is controlled by the State Board of Health. The state's Attorney General advised that nurse-midwives can practice legally under provisions of the state's laws governing nursing (1) and the medical practice laws (2), but are not governed by the rules and regulations for lay midwives. Accordingly, the Joint Practice Commission of the South Carolina Medical Association and the South Carolina Nurses' Association, in January, 1973, formulated a Joint Statement on the Practice of Nurse-Midwifery in South Carolina (3) which is currently in effect.

Although there are no legislative statutes regarding the practice of midwifery, the 169 lay midwives who are practicing must comply with rules and regulations for midwives defined by the State Board of Health (4) . Under their provisions a midwife is required to secure a Certificate of Registration from the County Health Department.

Legislation and Sources

1. Code of Laws of South Carolina, Title 56, Chapter 17, Nurses, Section 56-951 to 56-1018, 1962 and 1969.

2. Code of Laws of South Carolina, Title 56, Chapter 24 (as amended), Physicians and Surgeons, Section 56-1351 to 56-1385, 1962.

3. Joint Statement on the Practice of Nurse-Midwifery in South Carolina. J.S. Practice Commission of the South Carolina Medical Association and the South Carolina Nurses' Association, January 1973.

4. Rules and Regulations Governing Midwives in the State of South Carolina, Executive Committee of the State Board of Health, Approved effective October 21, 1970.

Qualifications for Practice

1. Licensure as a registered nurse in South Carolina.

2. Graduation from a nurse-midwifery basic education program approved or recognized by the American College of Nurse-Midwives.

3. Certification in nurse-midwifery by the American College of Nurse-Midwives signifying successful passage of the national written and clinical examinations.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

Nurse-Midwifery Program
Medical University of South Carolina
80 Barre Street
Charleston, South Carolina 29401

M. Wells, CNM, S.L. Collins, MD, and A.J. Villani, MD, PA
1501 Ninth Avenue
Conway, South Carolina 29526

ACNM Affiliation

Chapter 7, Region V

Key Source for Legislation Information

Margaret Ann Corbett, CNM
Nurse-Midwifery Program
College of Nursing
Medical University of South Carolina
80 Barre Street
Charleston, South Carolina 29401

SOUTH DAKOTA

Legal Status

Nurse-midwives may practice fully under the state's Nurse Practice Act, which permits nurses with "appropriate training" to perform "special acts delegated by a physician . . . or by the medical staff of an employing

medical facility" (1). Rules and regulations of the State Board of Nursing adopted in January 1975 (2) implement this law by requiring certification by the American College of Nurse-Midwives as a prerequisite for practice.

Currently, two nurse-midwives are practicing in the state, both employed by the Indian Health Service.

Legislation and Sources

1. South Dakota Code of Laws, Nurse Practice Act, Section 36-9-3 (1) as amended 1972.

2. Rules and Regulations of the State Board of Nursing, Chapter 20:48:04:02 (3), "Nurse-Midwife," January 1975.

Qualifications for Practice

1. Licensure as a professional nurse.

2. Current certification by the American College of Nurse-Midwives.

Application for Licensure

South Dakota Board of Nursing
Room 210, Johnson Building
P.O. Box 836
Mitchell, South Dakota 57301

Agencies Employing for Full Clinical Practice

Public Health Service Hospital
Pine Ridge, South Dakota 57770

ACNM Affiliation

Chapter 16, Region V

Key Source for Legislation Information

Barbara Criss, CNM
Public Health Service Hospital
Pine Ridge, South Dakota 57770

TENNESSEE

Legal Status

Certified nurse-midwives are practicing fully under an addition to rules and regulations of the Tennessee Board of Nursing, which allows for expanded roles of nurses (1). Neither the state's medical practice act (2), which specifically exempts midwives, nor the nurse practice act (3) is restrictive. A joint committee of the Tennessee Medical Association and Tennessee Nurses' Association is developing a statement on nurse-midwifery practice.

Lay midwives are practicing in the state under supervision of the State Health Department, although no statutory provisions for their licensure exist. Physician assistants practice under an exemption to the Medical Practice Act, which also exempts registered nurses (4).

Legislation and Sources

1. Addition to Nursing RN 32, Responsibility of Rules and Regulations of the Tennessee Board of Nursing Concerning the Licensure and Education of Registered Nurses, April 19, 1974.

2. Tennessee Code Annotated, Title 63, Chapter 1, State Licensing Board for the Healing Arts, 1953.

3. Tennessee Code Annotated, Title 63, Chapter 7, Professional Nurses, amended in 1972.

4. Public Chapter No. 166 of Medical Practice Act of Tennessee, 1973.

Qualifications for Practice

Currently being developed.

Application for Licensure

Tennessee Board of Nursing
301 7th Avenue North
Nashville, Tennessee 37219

Agencies Employing for Full Clinical Practice

Halston Valley Community Hospital
Kingsport, Tennessee 37662

Nurse-Midwifery Program
Department of Nursing Education
Meharry Medical College
Nashville, Tennessee 37208

Nurse-Midwifery Service
Maternal and Infant Care Project
Woodlawn Extended
Dyersburg, Tennessee 38024

ACNM Affiliation

Chapter 10, Region V

Key Source for Legislation Information

Betty Y. Garbutt, CNM
Assistant Director for Nurse-Midwifery
Division of Family Health Services
Tennessee Department of Public Health
409 Capitol Towers
510 Gay Street
Nashville, Tennessee 37216

TEXAS

Legal Status

Nurse-midwives are employed for full clinical midwifery functions without being licensed for midwifery because such licensure is not required by state law. Although the State Board of Health is empowered by law to promulgate rules and regulations in areas of public health, it has not formulated any specific rules and regulations pertaining to nurse-midwifery. Also, there are no restrictions in either the medical practice (1) or the nurse practice (2) acts. Interested physicians and nurses are exploring the possibility of new legislation specific to nurse-midwifery.

Lay midwives are also permitted to practice without licensure and in accordance with public health laws relating to specific procedures in their practice (3). The legal basis for midwifery practice is an Appelate Court decision in 1956 which ruled that childbirth is not considered a disease or disorder. Thus, the practice of midwifery is not included in the practice of medicine, as it was then and is currently defined (4). However, it has been pointed out that one engaging in this practice (midwifery) must not go so far as to practice medicine without a license (5). It is considered that an essential element is that such person (a medical practitioner) receive directly or indirectly compensation for a diagnosis, or treatment of a disease, disorder or injury (6).

Legislation and Sources

1. Laws of Texas, Title 71, Public Health, Chapter 6, Medicine, 1953.

2. Laws of Texas, Title 71, Public Health, Chapter 7, Nurses, 1959.

3. Public Health Laws in Texas Penal Code (Title 12, Art. 746) and in Civil Statutes (Title 71, Art. 4441, 4442, 4445, 4445a, 4447, Rules 34 to 49a and Art. 4447e).

4. *Banti v. State*, Court of Criminal Appeals of Texas, 1956, (Cite: 289 South Western Reporter 2d Series 244).

5. State of Texas Department of Health, Memorandum from the Legal Consultant to the Nurse Consultant in Family Planning, MCH Division, July 2, 1973.

6. The Attorney General of Texas, Opinion No. WW-1278, March 13, 1962, directed to Angelina County Attorney.

Qualifications for Practice

None specified.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

Bexar County Hospital District
(Robert B. Green Hospital)
527 N. Leona
San Antonio, Texas 78207

Sheppard Air Force Base Hospital
Wichita Falls, Texas 76306

Su Clinica Familiar
152 South 6th Street
Raymondville, Texas 78580

ACNM Affiliation

Chapter 20 (North Texas), 32 (South Texas), Region V

Key Source for Legislation Information

Sister Angela Murdaugh, CNM
Director, Nurse-Midwifery Service
Su Clinica Familiar
152 South 6th Street
Raymondville, Texas 78580

UTAH

Legal Status

Prior to June 1971, nurse-midwives were practicing fully only in connection with the educational program at the University of Utah. Since that time, an Act for the Licensing of Nurse-Midwives (1) has permitted them to function fully anywhere in the state. This act provides that individuals meeting its requirements shall have their professional nursing licenses also designate them as a certified nurse-midwife, and that licensed nurse-midwives function within standards of practice set by the American College of Nurse-Midwives.

Legislation and Sources

1. Utah Senate Bill No. 158. An Act Relating to Nursing and Providing for the Licensing of Nurse-Midwives, Section 58-31-9, 1971.

Qualifications for Practice

1. Licensure as a registered nurse in Utah.

2. Certificate in nurse-midwifery from the American College of Nurse-Midwives. Temporary approval to practice nurse-midwifery for a period not to exceed 4 months may be granted pending receipt of official notification of passing the examination.

3. Written verification of certification as a nurse-midwife by the American College of Nurse-Midwives, submitted to the Department of Business Regulation.

UTAH (continued)

Application for Licensure

Nursing Consultant
Department of Business Regulation
330 East 4th Street, South
Salt Lake City, Utah 84111

Agencies Employing for Full Clinical Practice

Family Practice Clinic, Holy Cross Hospital
1045 E. 1st Street
Salt Lake City, Utah

Hospital
Hill Air Force Base
Ogden, Utah 84406

Uintah County Hospital
Vernal, Utah 84078

University of Utah
College of Nursing
25 South Medical Drive
Salt Lake City, Utah 84112

Utah State Department of Health
45 Fort Douglas Boulevard
Salt Lake City, Utah 84112

ACNM Affiliation

Chapter 22, Region VI

Key Source for Legislation Information

Joyce Cameron, CNM
Associate Professor
College of Nursing
University of Utah
25 South Medical Drive
Salt Lake City, Utah 84112

VERMONT

Legal Status

Nurse-midwives are practicing fully in all areas of the maternity cycle and of family planning. General authorization for their practice is provided by the state's Nurse Practice Act which was amended in March 1974 (1) to permit practice by specially prepared nurses in extended nursing roles, delegated by a responsible physician. The practice of nurse-midwifery is included within this legal framework.

A joint statement of policy specific to the practice of nurse-midwifery in Vermont was approved by the Vermont State Nurses Association, the Vermont State Medical Society, and the Vermont Hospital Association in 1974 (2). The statement's qualifications, functions, and standards for nurse-midwifery practice in the state are in keeping with those of the American College of Nurse-Midwives. The statement also provides for a Joint Committee comprised of representatives from the above three state professional groups. Of the nine committee members, two must be nurse-midwives certified by the American College of Nurse-Midwives, and two must be obstetricians certified by the American Board of Obstetrics and Gynecology.

Because the state's Nurse Practice Act broadly recognizes nurse specialists without defining their roles or specific preparation and requirements, the Vermont State Nurses Association and the Vermont State Medical Society have appointed a Joint Commission on Practice. One member of this Commission is a nurse-midwife. The main purpose of the Commission is to develop a statement on the scope of practice for nurses in extended roles. Included will be subsections relating to the preparation and roles of nurse-midwives, as well as each of the various types of nurse practitioners.

Legislation and Sources

1. Vermont Statutes Amended, July 1974, Title 26, Chapter 24, An Act to Provide for the Regulation of the Practice of Nursing, Section 1552, Definitions.

2. Statement of Policy, Vermont State Nurses Association, Vermont State Medical Society, Vermont Hospital Association. Signed by president of VSMS February 15, 1974, by President of VSNA March 2, 1974 and by President of VHA March 5, 1974.

Qualifications for Practice

1. Registration as a professional nurse with the Vermont State Department of Nurses.

2. Certification by the American College of Nurse-Midwives.

3. Other requirements as specified by the employing institutions or agencies.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

Associates in Obstetrics and Gynecology
40 Colchester Avenue
Burlington, Vermont 05401

University of Vermont
College of Medicine
Department of Obstetrics and Gynecology
Given Medical Building
Burlington, Vermont 05401

ACNM Affiliation

Chapter 1, Region I

Key Source for Legislation Information

Mary Lee Mantz, CNM
Director, Nurse-Midwifery
The University of Vermont
College of Medicine
Department of Obstetrics and Gynecology
Given Medical Building
Burlington, Vermont 05401

VIRGINIA

Legal Status

Nurse-midwives are practicing fully under the recently amended Rules and Regulations of the Board of Health of Virginia (1). The Board is empowered by a midwife act (1) to issue permits and adopt rules and regulations governing the practice of midwifery. According to the revised regulations, applicants for new permits must be nurse-midwives. However, they are also required to comply with regulations for practice established for lay midwives.

Currently, over 100 lay midwives are licensed and practicing under the supervision of local health departments. Their permits to practice may be renewed annually.

Legislation and Sources

1. Rules and Regulations of the Board of Health, Commonwealth of Virginia, Governing the Practice of Midwifery, effective July 1, 1974. Statutory Authority: Code of Virginia, Sections 32-16.1 through 32.167.6.

Qualifications for Practice

1. Registration as a professional nurse in Virginia.

2. Graduation from a school of midwifery approved by the American College of Nurse-Midwives.

3. Age 18-65.

4. Previous experience, i.e., observation of and assistance with 10 or more deliveries in hospital.

5. Passing of a physical examination by the Local Health Director or a practicing physician, including specific laboratory tests.

6. Letters of reference from each of two local practicing physicians.

7. Renewal of permit every two years.

Application for Licensure

Director
Bureau of Maternal Health
600 Madison Building
109 Governor Street
Richmond, Virginia 23219

Agencies Employing for Full Clinical Practice

Hospital
Langley Air Force Base
Virginia 23365

St. Mary's Hospital
910 Virginia Avenue
Norton, Virginia 24273

ACNM Affiliation

Chapter 6, Region III

Key Source for Legislation Information

Marguerite Hydorn, CNM
Associate Professor
Maternity-Child Nursing
Virginia Commonwealth University
School of Nursing, Box 638
MCV Station
Richmond, Virginia 23298

VIRGIN ISLANDS

Legal Status

Nurse-midwives are employed for clinical midwifery services by the Virgin Islands Health Department, which owns and operates all public health facilities in the territory. The nurse-midwifery practice act (1) set requirements for practice and established the Board of Nurse-Midwife Examiners (2).

Lay midwives are prohibited from practice by the nurse-midwifery practice act.

Legislation and Sources

1. Virgin Islands Code, Title 27, Chapter 1, Sub-chapter V, Nurse-Midwifery, 1960, amended in 1969.

2. Virgin Islands Code, Title 3, The Board of Nurse-Midwife Examiners, Section 415(a)5 and 415(b)5, 1960.

Qualifications for Practice

1. High school education or equivalency.

2. Graduation from both an accredited school of professional nursing and of midwifery.

3. Good character and good physical and mental health.

4. Payment of a $10.00 fee.

Licensure through reciprocity is available to those with proof of licensure in another state or foreign country, if in the Board's opinion, Virgin Islands requirements are satisfied.

Application for Licensure

Executive Director
Board of Nurse-Midwife Examiners
U.S. Virgin Islands
c/o Charles Harwood Memorial Hospital
Christiansted, St. Croix, U.S. Virgin Islands 00802

Agencies Employing for Full Clinical Practice

Virgin Islands Health Department at:

Charles Harwood Memorial Hospital
Christiansted, St. Croix, U.S. Virgin Islands 00802

Knud Hausen Memorial Hospital
Charlotte Amalie, St. Thomas
U.S. Virgin Islands 00801

ACNM Affiliation

Chapter 28, Region II

Key Source for Legislation Information

Theolinda Hewitt, CNM
P.O. Box 305
Christiansted, St. Croix
U.S. Virgin Islands 00802

WASHINGTON

Legal Status

Although there are no legal restrictions to the practice of nurse-midwifery, only one nurse-midwife is practicing fully in the state of Washington. A 1917 lay midwife act (1) is still in effect despite attempts at repeal since 1971.

The state's nurse practice act (2), revised in 1973, provides for extended nursing practice in areas recognized jointly by the nursing and medical professions and regulated by the State Board of Nursing. Rules and regulations for advanced registered nurses and specialized registered nurses have recently been promulgated by the Board (3). Also, the physician assistants act (4) would appear to cover the practice of nurse-midwifery.

Legislation and Sources

1. Revised Code of Washington, Chapter 18.50, Midwifery, Sections 50.010 to 50.900. 1917.

2. Revised Code of Washington, Laws of 1973, Law Regulating the Practice of Registered Nursing, Chapter 133, Sections 18.88.010 to 18.88.285.

3. Board of Nursing Rules and Regulations, WAC 308-120-190 to 250. February, 1975.

4. Revised Code of Washington, Chapter 18.71A, Physicians' Assistants, Sections 18.71A.010 to 18.71A.0o0. 1971.

Qualifications for Practice

Under the nurse practice act:

1. Licensure as a professional nurse;

2. Others as determined by the Board of Nursing.

Under the lay midwife act:

1. Passing of an examination and payment of a $15.00 fee.

2. Certificate or diploma from a school of midwifery having an approved program;

or

3. Certificate or diploma from a foreign institution of equal requirement, conferring the right to practice in that country;

4. Endorsement by a physician licensed in the state of Washington.

The physician assistants act does not provide for licensure. The State Board of Medical Examiners is authorized to adopt rules and regulations fixing the qualifications for persons who may be employed as physician assistants.

Limitations to Practice

Licensure under the lay midwife act prohibits the nurse-midwife from prescribing any drug or medicine, except some household remedy, after the birth of the infant.

Physician assistants may practice only after authorization by the Board of Medical Examiners and only to the extent permitted by the Board.

Application for Licensure

Under the Nurse Practice Act:
Executive Secretary
Washington State Board of Nursing
Department 77180
P.O. Box 649
Olympia, Washington 98501

Under the lay midwife act:
Administrator
Division of Professional Licensing
Fifth and Sylvester
71000 Capital Center Building
P.O. Box 649
Olympia, Washington 98501

Under the physician assistants act:
Division of Professional Licensing
Fifth and Sylvester
71000 Capital Center Building
P.O. Box 649
Olympia, Washington 98501

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 23, Region VI

Key Source for Legislation Information

Tamara Cyr Baker, CNM
205C North 63rd Avenue
Yakima, Washington 98902

WEST VIRGINIA

Legal Status

Certified nurse-midwives are practicing fully and are licensed under a recently enacted nurse-midwifery practice act (1) which is derived from a 1931 lay midwife law. Under the new act, the few lay midwives holding licenses on July 1, 1973 were permitted to continue practicing in accordance with the former law, but authority for licensing midwives was transferred from the state's Board of Health to the Board of Examiners for Registered Nurses.

Legislation and Sources

1. Code of West Virginia, Chapter 30, Article 15, Midwives, Sections 30-15-1 to 30-15-8, 1973.

Qualifications for Practice

1. Registration as a professional nurse in West Virginia.

2. Graduation from a school of midwifery approved by the American College of Nurse-Midwives.

3. Certification by the American College of Nurse-Midwives.

Application for Licensure

West Virginia Board of Examiners for Registered Nurses
Building 3, Room 416
1800 Washington Street, East
Charleston, West Virginia 25305

Agencies Employing for Full Clinical Practice

A.R. Jacobson, MD
P.O. Box 50
Beckley, West Virginia 25801

ACNM Affiliation

Chapter 11, Region III

Key Source for Legislation Information

Nancy Schnell, CNM
1250 Dorsey Avenue
Morgantown, West Virginia 26505

WISCONSIN

Legal Status

Nurse-midwives are not permitted to practice fully in the state at this time, according to the 1973 Wisconsin Attorney General's interpretation of statutes concerning midwifery and medical practice (1). However, the state's nurse practice act (2) does not specify any conditions which would prohibit the practice of midwifery.

In 1953, sections of the state's statutes referring to licensure of midwives were repealed, but a "grandfather clause" included in statutes pertaining to the state's Medical Examining Board permitted lay midwives already licensed to continue practicing under the old laws and subject to "other provisions" in the Board Statutes (3). In 1955, the state's Attorney General had interpreted that statute to mean that in effect no person other than a licensed physician could practice midwifery, although according to the more recent interpretation, it is not clear from the law that the legislature intended to exclude all persons except physicians from practicing midwifery, and therefore new legislation would be required (1).

Legislation and Sources

1. Letter from the Attorney General of the State of Wisconsin directed to the Secretary, Medical Examining Board, March 5, 1973, referring to 44-0-AG-94 (1955).

2. Wisconsin Statutes, Chapter 441, Division of Nurses.

3. Wisconsin Statutes, Chapter 448, Medical Examining Board, Section 448.20, 1953.

Qualifications for Practice

None.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 16, Region IV

Key Source for Legislation Information

Anita H. Grand, CNM
Maternal and Child Health Consultant
State Division of Health
P.O. Box 309
Madison, Wisconsin 53701

WYOMING

Legal Status

One nurse-midwife is licensed to practice midwifery in accordance with the state's medical practice act (1). Although the law was not designed for nurse-midwifery practice, it is not restrictive, and the state's Nursing Practice Act is likewise permissive (2). Although no nurse-midwives are practicing fully, some physicians in the state have expressed interest in starting nurse-midwifery services.

Legislation and Sources

1. Wyoming Statutes-1957, Chapter 33, Physicians and Surgeons, Section 33-339, Practitioners of Obstetrics and Midwifery.

2. State of Wyoming Nursing Practice Act, Sections 33-280 through 33-291, Wyoming Statutes, 1957.

Qualifications for Practice

1. Graduation from a midwifery program.
2. Passing of an examination by the state's Board of Medical Examiners.

Application for Licensure

Executive Secretary
Board of Medical Examiners
State Office Building West
Cheyenne, Wyoming 82001

Agencies Employing for Full Clinical Practice

None at present.

ACNM Affiliation

Chapter 22, Region VI

Key Source for Legislation Information

Karol A. McRorie, CNM
1202 East Fifth Avenue
Cheyenne, Wyoming 82001

APPENDIX A

PHILOSOPHY OF THE AMERICAN COLLEGE OF NURSE-MIDWIVES

The Philosophy of the American College of Nurse-Midwives is based on the belief that

- Every childbearing family has a right to a safe, satisfying experience with respect for human dignity and worth; for variety in cultural forms; and for the parents' right to self-determination.
- Comprehensive maternity care, including educational and emotional support as well as management of physical care throughout the childbearing years, is a major means for intercession into, and improvement and maintenance of, the health of the nation's families. Comprehensive maternity care is most effectively and efficiently delivered by interdependent health disciplines.
- Nurse-midwifery is an interdependent health discipline focusing on the family and exhibiting responsibility for insuring that its practitioners are provided with excellence in preparation and that those practitioners demonstrate professional behavior in keeping with these stated beliefs.

Adopted 1972

APPENDIX B

ACNM STATEMENT OF QUALIFICATIONS, STANDARDS, AND FUNCTIONS

Qualifications for the Practice of Nurse-Midwifery

1. Certification by the American College of Nurse-Midwives.
   a. Active licensure as a registered nurse in one of the 50 states or Territories including the District of Columbia.
   b. Completion of a nurse-midwifery educational program approved by the American College of Nurse-Midwives.
2. Compliance with legal requirements of the jurisdiction in which nurse-midwifery practice will occur.

Standards for the Practice of Nurse-Midwifery

Nurse-midwifery practice

1. Strives to provide continuity of care to the woman and her family during the maternity cycle, continuing interconceptionally throughout the childbearing years;
2. Fosters the delivery of safe and satisfying care;
3. Recognizes that childbearing is a family experience and encourages the active involvement of family members in care;
4. Upholds the right to self-determination of consumers within the boundaries of safe care;
5. Focuses on health and growth as developmental processes during the reproductive years;
6. Stimulates community awareness and responsiveness to the needs for delivery of quality family-centered care;
7. Occurs interdependently within a health care delivery system;
8. Occurs within a formal written alliance with an obstetrician, or another physician, or a group of physicians, who has/have a formal consultative arrangement with an obstetrician-gynecologist;
9. Exists within a framework of medically approved protocols;
10. Occurs within the realm of professional competence;
11. Requires opportunities for continuing professional growth and development;
12. Includes an on-going process of evaluation.

Functions for the Practice of Nurse-Midwifery

The nurse-midwife

1. Assumes responsibility for the management and complete care of the essentially healthy woman and newborn related to the childbearing processes;
2. Develops with the woman an appropriate plan of care attentive to her interrelated needs;
3. Participates in individual and group counseling and teaching throughout the childbearing processes;
4. Manages, through mutual agreement and collaboration with the physician, that part of care of medically complicated women which is appropriate to the skills and knowledge of nurse-midwives.
5. Collaborates with other health professionals in the delivery and evaluation of health care;
6. Assesses own professional abilities and functions within identified capabilities;
7. Assumes responsibility for own self-determination within the boundaries of professional practice;
8. Maintains and promotes professional practice in concert with current trends;
9. Utilizes Standards for Evaluation of Nurse-Midwifery Procedural Functions in development and evaluation of practice (Addendum 1).
10. Promotes the preparation of nurse-midwifery students;
11. Assists with the education of other health care personnel;
12. Supports the philosophy and official policies of the American College of Nurse-Midwives.

Accepted 1975

ADDENDUM 1

Standards for Evaluation of Nurse-Midwifery Procedural Functions

The following guidelines were adopted by the Executive Board of the American College of Nurse-Midwives as a way of approaching the clinical practice of the nurse-midwife. Practice is continually evolving and it varies depending upon the institution and the demands for service within each setting. Because of this, the nurse-midwife may frequently be in a position of having to evaluate a new function for possible inclusion into her practice. This need for evaluation may be stimulated by the obstetrician, the demands of the patient or community, pressure from other groups, or desires of the nurse-midwife herself. In any case, the answer as to the worth and safety of a new procedure for inclusion into nurse-midwifery may not be clear.

No one of these guidelines can stand alone. It is only by employing each of them and then surveying the whole that an accurate feeling for the safety and suitability of the procedure for nurse-midwifery practice can be obtained. Guidelines help to direct but they do not necessarily guarantee that the direction will be completely clear. Systematic review of new procedures will help to assure that the statements on qualifications, standards and functions are up to date.

1. The procedure assists the nurse-midwife in managing the care of the normal childbearing woman and infant.
   a. It does not conflict with the basic philosophy of nurse-midwifery as outlined by the ACNM and with that outlined by the nurse-midwifery service.
   b. The procedure can be done competently by the nurse-midwife, i.e., the practitioner has obtained sound theory and supervised clinical experience from qualified faculty.
   c. The nurse-midwife is prepared to handle possible complications from the procedure until help arrives.

2. The procedure is within accepted obstetrical practice within the institution.
   a. It is presently an established procedure.
   b. It is a new procedure that is being instituted by the obstetric service.

3. The procedure fills a demonstrated need.
   a. There is consumer demand.
   b. Within the obstetric team it is appropriate that the nurse-midwife carry out the procedure.
   c. The nurse-midwife feels the procedure will contribute to the provision of optimal care.

4. The procedure is evaluated in the literature and/or in practice.
   a. The literature has been reviewed with both indications and contraindications identified.
   b. There is consideration of what other institutions and other nurse-midwives are doing.

5. The procedure is within legal limits.

6. There is an on-going plan for the evaluation of the procedure.
   a. The plan is filed with the Clinical Practice Committee at the time of initiation of the procedure.
   b. Progress reports are periodically submitted to the Clinical Practice Committee.

The Committee requests that if a nurse-midwifery service or a nurse-midwife intends to initiate a new procedure, the Clinical Practice Committee be notified. This will enable the Committee to record changes in practice throughout the United States and will also facilitate the dissemination of information of nurse-midwifery practice. It is hoped that periodic reports to the Committee will be made which are evaluative and in summary form. The collection of this type of data is important to the development of nurse-midwifery and will provide a resource for other services which may be considering the initiation of the same procedures.

Accepted January 27, 1972

APPENDIX C

ACNM POSITION STATEMENT ON NURSE-MIDWIFERY LEGISLATION

Preamble

The patterns of health laws in the United States vary widely and are changing rapidly. The complexity of this situation presents a barrier to the optimal growth and development of nurse-midwifery due to serious ambiguities in the legal base for practice. The American College of Nurse-Midwives (ACNM) has received increasing demands from the public and from professional organizations for recommendations on legislation. The following position statement is a result of the desire of ACNM to respond to these demands.

Beliefs

The ACNM believes that accessibility to comprehensive care is the right of all persons. Certified nurse-midwives have demonstrated that they are capable of making significant contributions in provision of this care. The ACNM believes that legislation which regulates the practice of the profession of nurse-midwifery should be so designed that it promotes and protects the health and welfare of the public. To achieve these objectives nurse-midwives must collaborate with other groups which share their primary concern of quality maternal and infant health care for all population groups.

Statement

A nurse-midwife who is currently certified by ACNM is qualified to practice nurse-midwifery throughout the United States and its jurisdictions.

The American College of Nurse-Midwives, as the recognized authority governing nurse-midwifery practice, is responsible for

- Certification of nurse-midwives;
- Establishment of qualifications, standards, and functions for the practice of nurse-midwifery;
- Approval of nurse-midwifery educational programs;
- Development of guidelines for nurse-midwifery services;
- Development of guidelines for continuing education of nurse-midwives.

Separate statutory recognition is recommended as the basis for nurse-midwifery practice. To the extent possible, this legislation should be uniform throughout the United States and its jurisdictions. Until such legislation is enacted, nurse-midwives may practice under a variety of legal arrangements.

Nurse-midwives should be involved in the policy making process of those regulatory bodies which administer and/or influence the practice of nurse-midwifery. Nurse-midwives who act in these capacities should be representative of and accountable to the practicing nurse-midwives within their respective areas.

Information and consultation on legislation pertaining to nurse-midwifery is available through the American College of Nurse-Midwives.

This statement was prepared by the ACNM Legislation Committee based upon recommendations from participants in the ACNM Workshop on the Legal Status of Nurse-Midwifery, held in Cincinnati, Ohio, June 14-15, 1974. Approved by Board of Directors, July 30, 1974.

APPENDIX D

ACNM LEGISLATION COMMITTEE GUIDELINES FOR ESTABLISHING NURSE-MIDWIFERY PRACTICE

Step I.

Send for and read the actual documents which pertain to nurse-midwifery practice in your state. These are

1. Nurse Practice Act;
2. Medical Practice Act;
3. Legislation specifically mentioning midwifery or nurse-midwifery;
4. Existing joint policy statements of groups such as American Nurses Association, American College of Obstetricians and Gynecologists, medical societies, etc. relating to the practice of nurse-midwifery;
5. Existing statement by the Attorney General or by any single professional organization;
6. Any other documents felt to be relevant by the Department of Health.

Step II.

If there is no specific statement prohibiting the practice of nurse-midwifery in the medical practice act, nurse-midwifery practice may be established according to the guidelines set up by the American College of Nurse-Midwives.

Step iii.

Any specific parts of nurse-midwifery which are forbidden by the law (Example: Only a doctor may perform minor surgical procedures, e.g., episiotomies) should be written up as a clinical practice experiment and formally studied. Statistics should be carefully kept.

Step IV.

When a body of practice has been established with accurate statistics as a visible reflection of its existence, a statement may be sought from the Attorney General concerning the limits and extent of this practice. Such a statement should be sought via joint participation of official groups. (This statement does not have the force of law but is increasing evidence in favor of nurse-midwifery practice.)

Step V.

A joint policy statement on nurse-midwifery practice may be sought from the state nurses association, state hospital association and the state medical society. This would also provide guidelines and a visible approval of practice.

At this time the Legislation Committee does not suggest any changes in the laws unless they are completely restrictive to the practice of nurse-midwifery.

Note: These guidelines were developed by the Legislation Committee in 1971. They are in the process of revision.
Further information may be obtained from the American College of Nurse-Midwives.

APPENDIX E

UPDATE OF TABLE 5 ON PAGE 13

PATTERNS OF LEGISLATION AND ACTUAL PRACTICE OF NURSE-MIDWIFERY IN THE UNITED STATES

I. States and jurisdictions with specific recognition of nurse-midwifery in legislative statutes or official regulations:

A. CNM's practicing fully:

Alabama	Florida	Massachusetts	North Carolina	South Carolina
Alaska	Guam	Mississippi	Ohio	Utah
Arizona	Hawaii	New Hampshire	Oregon	Virgin Islands
California	Indiana	New Jersey	Pennsylvania	Virginia
Colorado	Kentucky	New Mexico	Puerto Rico	Washington
Connecticut	Maryland	New York	Rhode Island	West Virginia
				Wisconsin

B. CNM's not practicing fully:

Delaware	Idaho	Michigan	Montana*	South Dakota*

II. States with permissive laws, but no specific recognition of nurse-midwifery:

A. CNM's practicing fully:

Arkansas	Illinois	Minnesota	Texas
District of Columbia	Louisiana	Missouri	Vermont
Georgia	Maine	Tennessee	Wyoming

B. CNM's not practicing fully:

Iowa	North Dakota*	Oklahoma
Nebraska	Nevada	

III. States with restrictive interpretation of laws and no CNM's practicing fully:

Kansas

* Exception: Nurse-Midwives practice in federal governmental hospitals

Prepared by the Legislation Committee of the American College of Nurse-Midwives

July, 1980

APPENDIX F

UPDATE OF TABLE 7 ON PAGE 15

LICENSURE OR OTHER QUALIFICATIONS FOR THE PRACTICE OF NURSE-MIDWIFERY AS DEFINED BY STATES AND JURISDICTIONS

Licensure Specific to Nurse-Midwifery

Alabama	Maryland	Oregon
Alaska	Massachusetts	Pennsylvania
Arizona	Michigan	Puerto Rico
California	Mississippi	Rhode Island
Connecticut (a)	Montana	South Carolina
Delaware	New Hampshire	South Dakota
Florida	New Jersey	Utah
Guam	New Mexico	Virginia
Hawaii	New York	Virgin Islands
Indiana	North Carolina	Washington
Kentucky	Ohio	West Virginia

Specific Qualifications, other than State Licensure, for Nurse-Midwifery

District of Columbia	Maine
Georgia	Vermont
Illinois	

Legal Provisions for Lay Midwives May Apply

Louisiana	Minnesota	Texas (b)

Legal Provisions for Physician Assistants May Apply

Connecticut (a)	Iowa

(a) Nurse-Midwives have a legal option to qualify for practice under statutes applicable to one or more practitioners of midwifery.
(b) Laws do not specify qualifications for practice.

April, 1980

APPENDIX G

UPDATE OF TABLE 8 ON PAGE 17

REGULATORY AUTHORITY FOR NURSE-MIDWIFERY BY STATES AND JURISDICTIONS

State Board of Health (or equivalent)

Connecticut (a)
Delaware
Florida (b)
Hawaii
New York
New Mexico
Rhode Island

State Board of Medicine (or equivalent)

Guam
Indiana
New Jersey
Ohio
Pennsylvania
Puerto Rico

State Board of Nursing (or equivalent)

Alabama
Alaska
Arizona
California
Florida
Kentucky
Maryland
Massachusetts
Michigan
Mississippi
Montana
Oregon
South Carolina
South Dakota
Washington
West Virginia

Joint Commission of State Boards

Idaho
New Hampshire
North Carolina
Virginia

Other Agencies

Utah — Department of Business Regulation, Committee of Certified Nurse-Midwifery
Virgin Islands — Board of Nurse-Midwife Examiners

(a) Authority for control is ambiguous.
(b) Registration required.

April, 1980

APPENDIX H

SPECIFIC RECOGNITION OF CERTIFIED NURSE-MIDWIVES IN LAWS OF STATES AND JURISDICTIONS

Statutory Recognition with or without Regulatory Recognition

Alabama
California
Colorado
Kentucky
Maryland
Massachusetts
Michigan
Montana
New York
Ohio
Utah
Virginia
West Virginia

Regulatory Recognition Only

Alaska
Arizona
Connecticut
Delaware
Florida
Hawaii
Idaho
Indiana
Mississippi
New Hampshire
New Jersey
New Mexico
North Carolina
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Washington

Prepared by the Legislation Committee of the American College of Nurse-Midwives.

January, 1980

MIDWIFERY OUTSIDE OF THE NURSING PROFESSION: THE CURRENT DEBATE IN WASHINGTON

HEALTH POLICY ANALYSIS PROGRAM
SCHOOL OF PUBLIC HEALTH AND COMMUNITY MEDICINE
UNIVERSITY OF WASHINGTON

MIDWIFERY OUTSIDE OF THE NURSING PROFESSION:

THE CURRENT DEBATE IN WASHINGTON

Health Policy Analysis Program
RD-37
School of Public Health and Community Medicine
University of Washington
Seattle, Washington 98195
(206) 543-3522

October, 1980

Other publications:

Health Maintenance Organizations: An Analysis of Policy Issues for Washington State, 1974

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The Next Step . . . Designation of a Washington "State Agency" Under P.L. 93-641,* 1975

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PREFACE

The Health Policy Analysis Program (HPAP) is a cooperative undertaking of the executive and legislative branches of Washington State and the University of Washington's School of Public Health and Community Medicine.

The purpose of the Program is to provide independent research and analysis services to the State's public decision-makers who have responsibility for health care policies and programs.

Assignments undertaken by the Program represent the priorities and concerns of the public officials. The selection process for work assignments is the responsibility of the HPAP Advisory Committee which includes representatives of the

- Washington State House of Representatives
- Washington State Senate
- Department of Social and Health Services
- Washington State Hospital Commission
- School of Public Health and Community Medicine

The Program is funded by Washington State and is housed in the Department of Health Services of the School of Public Health and Community Medicine.

During the period of this report the staff of the Health Policy Analysis Program included:

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SUMMARY OBSERVATIONS

1. Concern over the adequacy of the state's 1917 midwifery statute is a product of (1) the recent appearance of candidates who have successfully fulfilled the requirements for licensure, (2) activities of midwifery advocates in the areas of legislation and education, and (3) a small, but noticable increase in out-of-hospital births.

2. Since 1975, sixteen individuals have been licensed as midwives in this state. Nine of them were trained abroad (see pp. 5-6).

3. In 1978, a midwifery school was established in Seattle. Five of its graduates have been licensed as midwives (see pp. 9-10).

4. Between 1970 and 1979, the percentage of out-of-hospital births in Washington rose from 0.6 percent to 2.6 percent. The absolute numbers, however, are relatively small--approximateiy 1,600 out of 50,000 births in 1978. The great majority of these births (approximately 80 percent) are attended by licensed practitioners, including licensed midwives (see pp. 11-16).

5. Midwifery is an integral component of maternity services in Europe. It is viewed in terms of (1) normal pregnancy, (2) a broad scope of practice, (3) a variety of practice settings, and (4) a profession distinct from nursing (see pp. 19-22).

6. The European consensus seems to be that while some nursing skills are necessary to the practice of midwifery, one need not first be a nurse in order to be a competent midwife (see p. 22).

13. In framing a new statute, the membership of the designated credentialing authority will be crucial to establishing the credibility of the midwifery regulatory process (and midwifery itself) in the minds of the public and the professional community (see pp. 67-69).

14. Of the various duties usually assigned to an occupational credentialing body, the determination of educational requirements and the approval of training programs will be the most important under a new midwifery statute (see p. 69).

15. In the absence of a general consensus on midwifery and professional organizations that could be entrusted to develop reasonable educational standards, the task of approving programs may best be performed by the credentialing body constituted under a new statute (see pp. 57,69).

16. Whether a midwifery credentialing body should have ultimate decision-making authority or should be advisory to state government depends on the perceived need for public accountability (see pp. 70-73).

17. Continuing education, re-examination, and peer review are mechanisms for promoting continued competence over the course of a practitioner's career. Since the relationship between these activities and quality of care is unclear, discretion is important in devising a reasonable set of requirements (see pp. 73-76).

18. In deciding how dependent or independent midwives should be in their association with physicians, important considerations are the level of training and the scope of practice (see pp. 77-81).

19. Midwives may be allowed to use certain basic obstetrical medications without being granted prescriptive authority. At issue is the difference between the "dispensing" and the "administering" of legend drugs (see pp. 83-85).

7. While the European experience can offer useful guidelines, caution must be exercised in applying European standards to midwifery practice in this country. Because midwifery is neither well established nor well accepted in the United States, a flexible policy perspective would appear desirable (see pp. 24-25).

8. While midwifery, in general, is very limited and highly controversial, nurse-midwives have, to date, received the greatest degree of recognition (see pp. 29-32).

9. Outside of nursing, midwifery has been limited by the lack of (1) organized leadership and educational activities, (2) favorable state regulatory policy, and (3) clear relationships with, and acceptance by, other health professionals (see pp. 32-36).

10. In revising the current statute, the legislature may wish to consider three approaches: (1) deferring action, (2) revising the existing statute, and(3) combining in a single statute a regulatory program for nurse-midwives and midwives independent of nursing (see pp. 41-45).

11. The critical elements of any new midwifery statute will be (1) the scope of practice, (2) training requirements, (3) the credentialing process, and (4) the degree of independence vis-a-vis other practitioners. The definition of scope of practice will largely govern decisions regarding the other three factors. In general, the broader the scope of practice, the more rigorous should be the other requirements (see pp. 45-47).

12. In view of current developments in occupational regulation, the state may wish to consider certification or registration as an alternative to licensure. All three can be used to require the same standards of education and practice (see pp. 61-66).

INTRODUCTION

Toward the latter part of 1979, the Health Policy Analysis Program Advisory Committee requested that a study be undertaken on the subject of midwifery and, in particular, midwifery outside of the nursing profession. Specifically, HPAP was asked to examine the principal issues that will have to be resolved in developing new legislation that would supplant the state's existing midwifery statute enacted in 1917. This law does not require nurse training as a prerequisite to licensure as a midwife.

As will be discussed more fully in Chapter 1, there are essentially three developments that have prompted public officials in this state to take an interest in devising a new midwifery statute. The first is the reactivation of the 1917 provisions which had lain dormant for decades. This was brought on by the recent appearance of a number of individuals whose credentials enabled them to fulfill the requirements for licensure under the existing law. Second, midwifery advocates have raised the visibility of this issue through legislative activity and the establishment of a midwifery school, the graduates of which are eligible to sit for the state licensing examination. Finally, there has been concern over the rise in out-of-hospital births, especially those attended by unlicensed or otherwise unqualified individuals. As a result, the legislature has made some preliminary efforts to assess the adequacy of the existing midwifery statute and its relevance to maternity services in this state.

Underscoring these local developments, however, is what appears to be a widespread and growing interest in midwifery generally as a valuable resource in the delivery of obstetric services. An integral and predominant feature of maternity care in most developed countries, indeed throughout the world, midwifery virtually disappeared in the United States following the emergence of hospital-based, medical obstetrics in the mid-1900s. That midwives are once again becoming active is a consequence of many factors. Important among these are the women's movement, the professional and political activities of midwives, and the ongoing controversy surrounding the efficacy of standard birth practices and their relationship to psychological needs as well as physical safety. To the extent that it has occurred, the revival of midwifery has been helped greatly by the willingness of many individuals and organizations to overcome fear, prejudice, and inertia in order to give expression to a branch of maternal and child care long considered taboo in this country.

Modern midwifery has been marked by the emergence of several groups of practitioners. First there are nurse-midwives, registered nurses who have undertaken advanced training and have passed a uniform, national certifying examination administered by the American College of Nurse Midwives. The practice of these "certified nurse-midwives" (CNMs) is governed in almost all states either by statute or by regulation issued by established professional licensing bodies, generally boards of nursing or medical examiners. While nurse-midwives have gained the high regard of the professional community and the public wherever they have been allowed to apply their skills, their acceptance by the medical community is by no means universal, nor has it been quickly and easily forthcoming.

In addition to nurse-midwives, many other persons have begun to attend births. Because these individuals vary widely in their training, experience, and competence, meaningful categorization is difficult. In the debate over maternity services, however, they are commonly referred to as "lay" or "empirical" midwives. They appear to be educated, urban, middle class women serving their peers. They contrast greatly with the "granny" midwives of earlier generations, who were largely the uneducated poor practicing among the uneducated poor in rural areas and in the immigrant communities of the larger metropolitan centers.

Unlike the nurse-midwives, these other practitioners are viewed by many in the health establishment generally, and the medical profession in particular, as not having a place in modern maternity care. Also unlike nurse-midwives, whose training standards and codes of professional practice are well established, midwifery outside of nursing does not yet have a strong professional and educational foundation. Moreover, few states have attempted to provide a regulatory framework for this group of practitioners. Most states either have no statutes relating to midwives or--as is the case in Washington--have laws enacted in the early 1900s that have little relevance to modern standards of obstetrical care. Only a few states have taken steps to recognize and regulate the activities of those persons providing birth services outside of the established health professions.

This inquiry is intended to examine the major policy questions that will have to be addressed by the legislature in any deliberations on the regulation of midwives outside of the nursing profession. In the politics of maternity care, this issue is often highly charged with emotion and divisiveness, and it is for this reason that the HPAP Advisory Committee thought that a dispassionate and practical analysis would be especially useful.

Chapter I will focus on the specific concerns that have given rise to the current interest in midwifery on the part of public officials in this state. The second chapter provides an overview of midwifery in the United States and in other developed countries, addressing such issues as its history, training requirements, and regulation. Chapters III-VIII will examine the major policy questions. Our concluding remarks and general observations are set out in Chapter IX.

Chapter I

THE STATE'S INTEREST IN MIDWIFERY

The discussion of midwifery legislation that is currently taking place in Washington is a consequence of recent activity under the state's current licensure statute, the strategies adopted by midwifery proponents, and the increase in out-of-hospital births. This chapter provides an overview of these developments.

Washington's Midwifery Statute

At the present time, state law provides for the licensure of midwives under the terms of legislation enacted in 1917 (see Appendix A). In general, the law requires that examinations be administered by the state Department of Licensing. Applicants for licensure must be graduates of legally recognized schools of midwifery, domestic or foreign, in which the program of training is of at least fourteen months' duration. The regulations indicate the subject areas to be covered by the initial licensing examination and permit examination on other topics to be required from time to time as circumstances warrant. Presumably, this latter provision was intended to allow midwives to be tested on new developments in maternity care that are relevant to their practice. The law requires midwives to secure the services of a physician when abnormal symptoms appear in mother or infant and to conform to state public health and vital statistics reporting requirements. Midwives are prohibited from prescribing medications and are limited to the use of "household remedy" after birth.

Prior to 1975 there is no record of anyone having been licensed under the midwifery provisions. This is hardly surprising given the short lived fate of the one or two midwifery schools that existed in this country during the first half of the century.[1] In the latter months of 1974, however, a Danish midwife applied for licensure. With no precedent or experience to go on, the Department of Licensing--with some hesitation--activated the administrative machinery and prepared an examination with the assistance of an outside medical consultant. In March of 1975, the first license was granted under the state's midwifery statute. Since then, fifteen other persons have obtained licenses. Eight have been foreign-trained midwives, most of whom had undergone basic nurse training. Five were graduates of the recently established Seattle Midwifery School (see p. 10). Two others, a physician's assistant and a registered nurse, did not undergo midwifery training per se. However, they were deemed eligible by the Department to sit for the examination on the basis of their having special education and clinical experience in maternal and child health care. As of this writing (August 1980) two persons have applied to take the licensing examination to be given in January 1981. Six students midway through the training program at the Seattle Midwifery School will be eligible for licensure upon graduation.

Since activating the midwifery regulatory process in 1975, the Department of Licensing has adopted several practices in an attempt to reconcile the provisions of an outdated statute with contemporary circumstances and expectations. Between 1975 and 1979, for example, the Department used a single medical consultant to devise examination on a one-by-one basis as applicants presented themselves. Examinations are presently held in January and July. Their format and content are determined by an informally constituted professional advisory group consisting of physicians, certified nurse-midwives, and licensed

midwives. Whereas the earlier applicants for licensure had strong midwifery credentials from abroad, the eligibility of some of the more recent applicants has not been quite so clear-cut. When in doubt, therefore, the Department now seeks legal advice on whether an applicant is properly qualified. There is also some discussion in the Department on including the professional advisory group (mentioned above) in revising applications for licensure.[2]

It appears that the Department of Licensing has acted cautiously and with good judgment in administering the provisions of the midwifery statute.

Pressure for Change from Midwifery Advocates

The trend toward out-of-hospital births, the presence of licensed midwives, and the status of the current midwifery statute are well known to those whose business or inclination it is to keep abreast of such matters. That midwifery licensure has become a public policy issue is, in part, a consequence of the active steps taken in recent years by the supporters of midwifery in the areas of legislation and training.

In mid-1977, the Washington State Midwifery Council (WSMC) approached the Committee on Social and Health Services of the state House of Representatives with a view toward revising the 1917 statute. Formed in 1977, the WSMC represents persons interested in midwifery, home birth, and other childbirth alternatives. Between November 1977 and March 1979 there were several public hearings on various legislative proposals favored by the WSMC. The provisions of these early proposals were extremely controversial. They included such topics as prescriptive drug authority, hospital admitting privileges, mandatory insurance coverage, and apprenticeship training.

A "compromise bill" was put before the House committee in late 1979. Under House Bill #2713 (see Appendix B), the Director of Licensing was empowered to promulgate standards for accrediting training programs (Section 6), develop and administer licensing examinations (Sections 6 and 7), provide for the maintenance of continued professional competence (Section 4), take disciplinary measures, and to act in other matters relating to professional licensure. The Director was to be assisted in these duties by a Midwifery Advisory Committee (Section 3) composed of professionals and consumers. With respect to scope of practice issues, the bill did not provide for the more general prescriptive drug authority as did the earlier proposals. It did, however, grant midwives the authority to "acquire and administer" three categories of drugs deemed necessary to basic midwifery practice--eye prophylaxis, anti-hemorrhagics, and local anesthetics (Section 7). The use of anesthetics implied the authority to suture or to perform and repair episiotomies, or both, although these functions were not explicitly mentioned in the bill.

Following a public hearing in January 1980, H.B. #2713 failed to win enough support to be moved out of committee for consideration by the House. Supporters of the bill emphasized its advantages in terms of greater freedom of choice for parents, more competition in the health industry which would probably lower the costs of care to consumers and third-party insurers, and a lessening of the amount of inappropriate medical intervention which would both lower costs and improve the quality of maternity services. The bill was opposed by the medical community, in general, and the obstetricians, in particular, who argued against the necessity for a midwifery licensure law and expressed a definite preference for nurse-midwives. The physicians contended that the health sector had made much progress in responding to demands for modified birth practice and that there was now sufficient diversity among practitioners and settings to

meet the needs of most individuals. The nursing profession, including nurse-midwives, took a neutral stance, stating that should the legislature see fit to continue the practice of midwifery, the standards for education and training should be consistent with standards recognized in the developed countries of Europe (see p. 22).

Concern was expressed about the bill's vagueness on scope of practice, accreditation of training programs, measurement of continued competence, and membership of the midwifery advisory committee. It is thought that another licensure proposal will be developed for consideration during the 1981 legislative session.

In addition to working through legislative channels, midwifery advocates have pursued other courses in pressing for a favorable reappraisal of the state's licensure statute. About the time the WSMC began discussions with state lawmakers in 1977, it was also decided that several useful purposes would be served by establishing a midwifery training program. Without a formal program, it would be extremely difficult for in-state residents wishing to become midwives to satisfy the educational requirements under the current or any future licensure statute. Indeed, several lay midwives who were active at the Fremont Women's Clinic Birth Collective in 1977 were denied permission to take a licensing exam as they had not undergone an organized course of instruction. As we have seen, the first seven persons to obtain licenses in this state between 1975 and 1979 had all received their training abroad. Moreover, since the approximately ten midwifery programs in the U.S. are not standardized, there was no assurance that any of them would meet the standards of present or future licensure laws in Washington.

A second objective of establishing an educational program was to demonstrate the potential for competence, an issue that

would surely surface in any legislative deliberations on midwifery licensure.

Finally, it was hoped that the existence of a school would add visibility and momentum to the efforts to re-establish midwifery as an option in childbirth in Washington.[4]

Following some fruitless discussions with representatives of one of Seattle's community colleges, the lay midwives from the Fremont Birth Collective mentioned above decided to develop a training program on their own initiative. The Seattle Midwifery School began operation in May, 1978. The present course of study includes approximately 350 hours of classroom instruction and a clinical component drawing mainly on the School's home birth services and its relationships with several of Seattle's publicly funded community clinics. To date, the School has not been able to negotiate supervised clinical rotations for its students in area hospitals. However, preceptorships with private physicians are being established, and current admission policies give preference to applicants who are able to arrange supervised preceptorships prior to starting the course of study at the school. In general, the period of training lasts from two to three years, depending on the time taken to complete the clinical requirements.[5]

Out-of-Hospital Births and Birth Attendants

In recent years, modern obstetrical care, as practiced in hospitals, has come under increasing scrutiny as both parents and professionals have raised serious questions as to the necessity, efficacy, safety, dignity, and cost of institutional maternity care. Critics charge that hospital obstetrics have become highly impersonal, that many of the routine practices are more for the convenience of medical and hospital staffs than for the health and safety of mothers and infants, and that some of these practices may even be harmful. At issue here are such items as the separation of mothers and babies, exclusion of family members from the birth environment, routine enemas, shaving, and IV's, multiple and unsupportive attendants, use of

analgesics, the predominance of the lithotomy position for birth (back flat with knees drawn up), restriction on food intake and mobility, and routine episiotomy.[6] Advocates for change contend that parents can and should have more control over these more discretionary aspects of maternity care.

Parents and a growing number of professionals are also voicing serious concern over aspects of medical obstetrical management of labor and delivery. The emphasis here is on aggressive management and excessive intervention. Many are particularly alarmed about the routine application of high technology in the absence of medical indication or in situations where its benefits have not been firmly established through rigorous scientific experimentation. There is presently much controversy centering on the long term effects of obstetric medications, electronic fetal monitoring, elective induction of labor, the cesarean section rate (which doubled between 1971 and 1976), the routine use of forceps, oxytocin challenge tests (a prenatal screening test), and other practices.[7]

A result of this controversy is that hospital obstetrics has come to be viewed by many as insensitive to human and personal needs and overly obsessed with pathology and the use of sophisticated equipment. Since the early 1970s, a small but growing number of parents have sought and received maternity care outside of hospitals---in the home, in practitioner offices and clinics, and more recently, in specially designed free-standing birth centers. After steadily falling over the past several decades, the percentage of U.S. births occurring outside of hospitals has risen from a low point of 0.6% in 1970 to 1.5% in 1977, as can be seen in Table 1. The trend in Washington has been somewhat more pronounced than in the nation (see Table 2) with out-of-hospital births rising from 0.6% to 2.5% during the same period. Again, it must be emphasized that the absolute number of these births is still quite small compared with total births. In 1979, for example, the figures were approximately 1,600 and 60,000 respectively.

Table 1

Percent Distribution of Live Births by Attendant and by Place of Delivery: United States Selected Years 1940-1977

Year	Physician in hospital	Not in hospital	
		Physician	Midwife, other, and not specified
1940	55.8	35.0	9.3
1950	88.0	7.1	5.0
1960	96.6	1.2	2.2
1970	99.4	0.1	0.5
1971	99.1	0.3	0.6
1972	99.2	0.2	0.5
1973	99.3	0.2	0.5
1974	99.2	0.3	0.5
1975	98.7	0.4	0.9
1976	98.6	0.4	1.0
1977	98.5	0.4	1.1

Source: Vital Statistics of the United States, Volume I, Natality. U.S. Department of Health and Human Services, National Center for Health Statistics. Published annually.

Table 2

Percentage of Live Births by Place of Occurrence Washington, 1970-79

Year	Hospital[1]	Maternity[2] home	Private residence	Other and not stated	Total not in hospital
1970	99.4	0.2	0.3	0.1	0.6
1971	99.1	0.1	0.6	0.2	0.9
1972	99.0	-	0.7	0.3	1.0
1973	98.2	-	0.8	1.0	1.8
1974	98.8	-	0.8	0.4	1.2
1975	98.4	-	0.8	0.8	1.6
1976	97.0	-	1.0	1.0	2.0
1977	97.5	-	1.2	1.3[3]	2.5
1978	97.3	-	1.2	1.5[3]	2.7
1979	97.4	-	1.2	1.4	2.6

1. Includes federal and non-federal facilities.
2. No longer in existence, these facilities (licensed under 18.46 RCW) served (a) unwed mothers and (b) rural areas. As of April 1980, childbirth centers are licensed under 18.46 RCW, as amended.
3. Includes a small number of births (less than 13) that were listed as "born on arrival" and that represent less than .05% of total live births.

Source: Vital Statistics Summary: Washington State, Department of Social and Health Services, Center for Health Statistics. Published annually.

To varying degrees, many hospitals have responded to demands for change by altering their policies and procedures. These modifications have ranged from simply permitting husbands into the delivery room to the creation of separate family-centered maternity units staffed by nurse-midwives where parents can have a substantial voice in how they wish their birth experience to proceed.[8] In this state, for example, a recent University of Washington survey indicated that in the near future approximately 65 percent of the state's hospitals intend to establish combined labor-delivery rooms or some other alternative birth arrangements within the hospital.[9] It is still much too early to assess the impact--if any--that these changes in hospital obstetrical practices will have on the prevalence of births outside of hospitals.

In the ongoing debate over the future of maternity services in this country, perhaps the most divisive issue is that of home birth. The rule rather than the exception at the beginning of this century, home birth became insignificant in the mid-1900s as the philosophy and practice of modern medical obstetrics moved childbirth into the hospital. There has been a small increase in home births in recent years. Despite a common perception that this occurred due to the activities of counter-culture types, religious sects, and other fringe groups, the available evidence indicates that the primary interest in birth at home is coming from urban, middle class individuals who are seeking greater flexibility and control of their birth experiences than are allowed in hospitals or other institutional settings.[10]

Since it represents a radical departure from the current norms of obstetrical practice and since there has been little substantive research on the subject, the controversy over home birth has been based as much on emotion and ideology as on reason and objectivity.

Our own assessment inclines us toward the view that home birth is neither safe nor hazardous in and of itself. Rather,

it appears more reasonable to suggest that the outcome of childbirth at home will be largely dependent on the conditions under which it takes place. While information is admittedly limited, the experience in this country and elsewhere indicates that home birth can be a viable option in maternity under certain conditions. These includes the careful selection of cases to include only low-risk pregnancies, a high level of parental responsibility and maturity, a suitable home environment, the management of the pregnancy by a skilled practitioner, and the ready availability of consultation and support services to handle the complications and emergencies that are bound to arise despite the best of selection procedures. If these principles are allowed to prevail, it is likely that planned home birth will be shown to be a childbirth alternative well within the bounds of acceptable standards of public health and safety.[11]

The interest of public officials in the rising number of out-of-hospital births in this state has had to do with the qualifications of those attending these births. There has been some concern that parents wanting to give birth outside of the hospital setting are turning to practitioners who may not have the knowledge and skills necessary to ensure a high standard of care. The available data, however, do not indicate a major problem. As portrayed in Table 3, birth certificate information supplied by the Department of Social and Health Services revealed that, in 1978, about 80 percent of births occurring outside of hospitals were attended by licensed practitioners. The 20 percent that were not took place mainly in the home, accounting for 41 percent of the births in that setting.

Describing the unlicensed attendant group is difficult owing to the substantial number of births in the "Father/Midwife" group. This designation was apparently used by fathers where the birth certificate asked for information as to the type of attendant.

Table 3

Out-of-Hospital Births By Place and By Attendant - Numbers (Percentages)

Washington, 1978

Attendants	Home	Birth Center	Chiro.-Naturo. Office	Misc. Other	En Route	Unknown	Attendant Totals
Licensed							
Physician	186 (23.4)	450 (63.1)		18 (66.7)	86 (81.9)	2 (40.0)	742
Osteopath	18 (2.3)	43 (6.0)		4 (14.8)	4 (3.8)	-	69
Naturopath	29 (3.6)	11 (1.5)	15 (93.7)	-	-	-	55
Cert.-Nurse Midwife	48 (6.0)	196 (27.5)	-	1 (3.7)	-	-	245
Licensed Midwife	182 (22.9)	11 (1.5)	-	-	-	-	193
Emergency Med. Team	5 (.6)	-	-	-	1 (1.0)	-	6
Subtotals	468 (58.8)	711 (99.7)	15 (93.7)	23 (85.2)	91 (86.7)	2 (40.0)	1,310 (79.0)
Unlicensed							
Father-Midwife	208 (26.1)	-	-	2 (7.4)	3 (2.8)	1 (20.0)	214
Father	21 (2.6)	-	-	1 (3.7)	-	-	22
Relative	26 (3.3)	-	-	1 (3.7)	-	2 (40.0)	29
Lay Midwife	61 (7.7)	2 (.3)	1 (6.3)	-	11 (10.5)	-	75
Unknown	12 (1.5)	-	-	-	-	-	12
Subtotals	328 (41.2)	2 (.3)	1 (6.3)	4 (14.8)	14 (13.3)	3 (60.0)	352 (21.0)
TOTALS	796 (100)	713 (100)	16 (100)	27 (100)	105 (100)	5 (100)	1,662 (100)

It is possible that this terminology was intended to mean "father acting as midwife." However, in view of the large number involved it seems plausible to suggest that lay midwives may have attended some of these births and that the fathers signed the birth certificates in order to protect their chosen practitioners from possible legal or other reprisals. This same rationale, of course, may also apply to the other categories of unlicensed attendants. If this is indeed the case, then the 75 births attributed to unlicensed lay midwives in Table 3 may be substantially understated.

It appears that in this state there are opportunities for parents wanting an out-of-hospital birth experience to receive the services of qualified practitioners. While physicians and nurse-midwives predominate in birth centers, the presence of licensed midwives has increased the availability of competent practitioners to those desiring home birth. Were it not for the availability in this state of a variety of properly licensed practitioners willing to respond to the demand for non-traditional maternity services, it is indeed likely that many more births would come under the care of persons who may not possess qualifications necessary for a high standard of service. For example, in Oregon where there is no regulatory provision for the practice of midwifery outside of nursing, only about 60 percent of non-hospital births are attended by licensed practitioners compared with 80 percent in Washington. With respect to home birth, the comparable figures are 43 percent and 60 percent respectively.[12]

The state can indeed be said to have an interest in the outcome of birth. The mismanagement of pregnancy can result--although this is a rare occurrence--in death. More significantly, inadequate or inappropriate supervision can have untoward effects which are not readily detectable at birth, but which can have serious

long term effects on growth and development. Efforts to safeguard mothers and infants against incompetent birth attendants, therefore, are a legitimate activity of government, and it is in this context that the current debate over midwifery must be viewed.

Chapter II

MIDWIFERY: AN OVERVIEW

Throughout history, every society has sought to provide assistance to mothers during childbirth. Traditionally, this task has fallen to the midwives, female birth attendants who, with little or no training, gave aid and comfort to women in labor. Even today in many parts of the world, particularly in undeveloped countries, these traditional midwives are the principal source of maternal care. It has been estimated that, worldwide, two-thirds of births occur without the assistance of a trained attendant.[13]

Modern times, however, have also witnessed the emergence of trained professional midwives capable of rendering a wide spectrum of services in keeping with generally accepted standards of obstetrical care. While professional midwifery, whether combined with or separate from nursing, is now being cautiously regarded in the U.S., it is a firmly established and well accepted component of maternal and child health services in most developed countries, particularly in Europe. This is an extremely important distinction that should be recognized when considering what should be the proper stance toward the regulation of midwifery in this country.

As policymakers in this state and elsewhere contemplate their response to public demands for changes in maternity care, perhaps the experience of other developed countries might hold some useful lessons. This chapter will focus on the perceptions and practices of professional midwifery in Europe.

An American perspective is also a necessary part of this discussion. Midwives, be they trained or untrained, their practice legal or illegal, have always been active in this country.

Widely practiced in the early 1900s, midwifery diminished sharply toward mid-century with the advent of modern medical obstetrics and is beginning to appear again, albeit for different reasons and in a different form. This evolution will also be discussed.

International Perspectives

The recognition and regulation of midwifery has a long history in the developed countries of Europe, dating back several hundred years in Great Britain and Sweden, for example.[14] Throughout much of Europe, the laws regulating midwifery, the educational system in which it was taught, and the professional associations that represented and governed it were largely in place at the turn of this century. As such, professional midwifery in Europe preceded the birth of modern obstetrics and was presented and incorporated into the health systems of the various nations. The respectability and acceptance which this chronology assured is conveyed in the opening paragraph of a recent report of the Council of Europe which stated:

> From time immemorial, the midwife has played an important part in obstetric care. In recent decades, others have come to work beside her in this field, such as the general practitioner and the specialist, the hospital nurse and the district nurse, the physiotherapist and the dietician.[15]

In addition to holding midwifery in high regard, international health agencies view its professional scope of responsibility in rather broad terms. In 1966 the World Health Organization declared:

> A midwife is a person who is qualified to practice midwifery. She is trained to give the necessary care and advice to women during pregnancy, labour and the postnatal period, and to conduct normal deliveries on her own responsibility, and to care for the newly born infant. At all times she must be able to recognize the warning signs of abnormal or potentially abnormal conditions which necessitate referral to a doctor, and to carry out emergency measures in the absence

> of medical help. She may practise in hospitals, health units or domiciliary services. In any one of these situations she has an important task in health education within the family and the community. In some countries, her work extends into the fields of gynaecology, family planning and child care.[16]

A similar definition of midwifery was adopted in 1972 by a joint working party of the International Federation of Gynecology and Obstetrics and the International Confederation of Midwives:

> A Midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and had acquired the requisite qualificiations to be registered and/or legally licensed to practise midwifery.
>
> She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period, to conduct deliveries on her own responsibility and to care for the new born and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help.
>
> She has an important task in health counselling and education, not only for patients but also within the family and community. The work should involve ante-natal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care.
>
> She may practice in hospitals, clinics, health units, domiciliary conditions or any other service.[17]

When examining the concept and practice of midwifery as they exist in Europe, several general impressions stand out.

First, <u>the primary focus of midwifery is the medically uncomplicated, or normal, pregnancy</u>. There is a recognition of the difference between the abnormal and the normal aspects of pregnancy and a belief that midwives are most appropriate in dealing with the latter. As the Council of Europe report stated:

> "The obstetrician is, because of his training, pre-eminently qualified in the pathological aspects of obstetrics, whereas the midwife is best equipped to deal with the physiological aspects, i.e., for normal obstetrics."[18]

A noted Dutch obstetrician put it another way when he said the midwife is the "specialist in normal obstetrics" and that "People who have studied for more than ten years at a university are not suited to sit down for hours watching a natural process taking place as a routine."[19]

A second observation is that in many European countries, the laws and regulations governing midwifery provide for a broad scope of practice. Midwives are allowed to perform prenatal screening, to manage normal deliveries on their own responsibility, including the use of certain medications and minor surgical procedures, to provide postnatal and neonatal care, and, more recently, to be involved in certain family planning activities and gynecological care.

The breadth of midwifery as it is perceived in Europe is illustrated by the recommendation of a joint working party of obstetricians and midwives and public officials that met in Copenhagen in 1969. With respect to the scope of practice, the working party agreed that:

> All midwives should receive training in every aspects of prenatal care and the recognition of abnormalities. Having received such training they should be permitted to conduct prenatal care on their own responsibility.
>
> The responsibility for the conduct of normal labour falls within the province of every midwife.
>
> A midwife should be responsible for the postnatal care of the mother for a minimum period of ten (10) days. In some countries this may be extended to the full postnatal period of six (6) to eight (8) weeks.
>
> A midwife should be responsible for the care of the newborn baby for a minimum period of ten (10) days. After this period further care would depend on the facilities available.

> A midwife should be taught the general principles of family planning. In some circumstances she may be encouraged to assist in clinics and can have a valuable role in motivating patients to seek advice on family planning.
>
> A midwife should be so trained that she can detect and differentiate between the normal and the abnormal. If any abnormality occurs, it is her responsibility to call medical aid.[20]

Third, midwives are considered capable of practicing in hospitals, in clinics, in maternity centers, and in the home. The presence of a midwife in these settings is well accepted by professionals and patients alike.

Fourth, midwifery is viewed as a profession separate and distinct from nursing. Even where midwifery education and nursing education are combined to one extent or another, midwifery is regulated under separate statutory and administrative authorities.

Finally, on the issue of educational preparation, the European consensus seems to be that while some nursing skills are useful and necessary in the practice of midwifery, one need not first be a nurse in order to be a competent midwife. For example, the joint working party mentioned above made the following recommendations which appear to encourage flexibility.

> A student should have 12 years' general education before starting midwifery training.
>
> The age for entry should be at least 18 years.
>
> The minimum period of midwifery training should be three years, one year of which should be allocated to nursing training. If a candidate is already a general trained nurse, she may take midwifery training in two years.
>
> The hours of theoretical instruction should occupy a minimum of 1/3 (one-third) of the total training time.
>
> In addition to teaching in obstetrics and neontal paediatrics, the syllabus should include some instruction in basic sciences,

> parentcraft, preparation for childbirth, community care, analgesia, epidemiology, certain aspects of gynaecology and family planning.
>
> During training a student midwife should undertake the care of not less than 50 women in the prenatal period, 50 women during the course of labour and 50 women in the early post-natal period.
>
> No specified number of domicilary confinements should be required but experience in the care of mother and baby at home is advisable.[21]

In practice, countries adopt a variety of approaches. In France, Denmark, and The Netherlands, midwifery training is entirely separate from nursing education. In others, there are two paths of entry into midwifery. Students can enter training directly (i.e., without a nursing background) or, in the case of qualified nurses, there is a specialized training course of lesser duration than the basic midwifery program. This dual pathway approach is found in Germany, England and Wales, and Belgium. Here again, nurse training is not a prerequisite to midwifery, though it is allowed for. In Norway, Sweden, and Scotland, only fully qualified nurses may enter into midwifery training programs.

Generally speaking, where midwifery education is independent of nursing, training programs are two or three (mostly three) years. Where nurses are allowed to take advanced training in midwifery, the programs last from one to two years. To be considered for entry into the training programs, applicants must generally possess a secondary school education, and the minimum age limits range from eighteen to twenty-one.[22]

While there may be valid arguments both for and against the combination of midwifery and nursing, the European experience suggests that both approaches can work well--either separately or side by side--and that each nation must decide which alternatives best meet its needs.[23]

While the principles which have been described here are generally accepted, countries must vary to take account of their political, economic, and cultural heritage. While the European Economic Community is presently trying to devise some minimum professional standards that would be applicable to all member countries, differences will clearly remain, and the need for them is recognized.[24]

Although the European experience offers useful guidelines and perspectives, some caution must be exercised in applying the European model to midwifery practice in America. As mentioned earlier, midwifery has a long history in Europe, reaching back several hundred years, and it is now an established profession. Midwives, furthermore, attend the great majority of births in Great Britain, Germany, Sweden, Denmark, and The Netherlands.[25]

Midwifery in Europe enjoys the high regard of government. In the Federal Republic of Germany, for example, a midwife is required by law to be present at every birth.[26] Many European midwifery schools are directly supported by government. Another factor to be borne in mind is that, in Europe, public policy decisions affecting midwifery are made at the national level. Therefore, any changes in educational requirements or practice patterns are implemented simultaneously and uniformly throughout any given country.

Finally, as regards the important matter of services financing, the various European national health insurance schemes pay for the services of midwives whether they are salaried employees (as most are) or independent practitioners working on a fee-for-service basis. In The Netherlands, for example, where about half of the births take place at home, national insurance pays the family for the cost of birth at home only if it is managed by a midwife. Families wanting a physician present must bear the costs themselves, unless they have private insurance which recognizes physician attendance in the home.[27]

In most of Europe, professional midwives--be they nurses or not--are a distinct and integral component of the medical care system. They account for the majority of births, have ready access to all specialty and back-up services, and enjoy the respect and support of the professional community, the public, and the government. There is little question of European physicians refusing to cooperative with midwives at any stage in the care of a pregnant woman. There is little question of hospitals refusing to accept midwives either as employees or as independent, community-based practitioners. And there is little question of health insurance programs, public or private, refusing to pay for the services of midwives.

As will be described below, these conditions do not apply in the United States, where midwifery practice--both in and outside of nursing--is extremely limited and highly controversial. Therefore, while the conditions that govern the practice of midwifery in Europe may provide useful direction to the current debate in Washington, it does not seem appropriate to apply them rigidly at this time. Modern European midwifery has evolved gradually over many decades, whereas its ultimate place in the United States will not be determined for many years. Under these circumstances, it may be prudent for state policymakers to allow a reasonable level of flexibility in the formulation of regulatory policy, so that midwifery develops in a manner that best responds to prevailing medical, societal, and political attitudes and conditions. To impose, without alteration, the European standards for the training and credentialing might be to insist on uniformity at a time when the public interest might be better served in the long run by permitting diversity and versatility.

Midwifery in the United States

In contrast to the European experience, midwifery has been largely excluded from modern maternity in this country. This occurred for the same reasons that ensured midwifery's success abroad. Whereas professional regulation was firmly established in Europe at the turn of the century, it was only beginning to develop here. Furthermore, while such activities were national in scope overseas, professional regulatory matters in the U.S. were left to the states to deal with individually as they deemed necessary. Consequently, about thirty-four states enacted laws for the control of midwives, all having varying provisions and levels of restrictiveness. Even local health departments adopted their own measures to govern the activities of midwives.[28] These early state and local measures constituted the "granny midwife laws" frequently referred to in the debate on midwifery outside of nursing.

Unlike in Europe, American midwives in the early 1900s had no professional associations or educational systems upon which to build and maintain professional standards and recognition. There were only three formal midwifery school in the U.S. in the early 1900s.[29] Training programs were mounted by many local health departments in certain parts of the country (with some support from the federal Children's Bureau during the 1920s). These efforts depended highly on local finances and initiatives which varied widely.[30]

That midwifery failed to mature in the early part of this century is also owing to ethnic considerations. In contrast to the common language and common heritage shared by midwives in foreign countries, midwives in America had tremendously diverse backgrounds. They were found largely among the poor black population in the South and the various immigrant groups that settled in the major metropolitan areas.[31]

These regulatory, professional, and demographic patterns were significant limitations on midwifery's ability to attain professional stature and respect. As one observer stated, "The

more localistic and diversified the system of legitimization and control of midwives, the less likely would there be internal visibility and a drive for professionalism and institutionalization, i.e., the less likely the development of midwifery as a viable institution."[32]

Of equal, if not greater, importance to the virtual disappearance of midwifery in the first half of this century were the unfavorable view of midwives on the part of the medical profession. The early medical literature gave much emphasis to the "midwife problem" although the term was never clearly defined.[33] Midwives were characterized as being "full of arrogance and superstition," "filthy and ignorant," "a relic of barbarism" and even "un-American."[34] It appears that many doctors viewed midwives as being largely responsible for this country's high maternal mortality rate in the early 1900s.

When the evidence was examined, however, the connection did not hold. In a 1933 report on maternal mortality in New York City, the New York Academy of Medicine concluded that:

> . . . contrary to the generally accepted opinion, the midwife is an acceptable attendant for properly selected cases of labor and delivery. . . and that her results are as good as those obtained by the physician under what are justly regarded as comparable circumstances and for comparable cases.[35]

The Academy also reported that the midwives more commonly attended, with "better than average" results, the poor and foreign born, ". . . a group of women whose childbearing as a group is more hazardous than average. . ."[36]

At about this time, a White House Conference on Child Health and Protection (presided over by prominent medical and obstetrical leaders) gathered information on maternal mortality and on the performance of midwives from various parts of the country. The Conference concluded that "The high maternal mortality rate in this country is a reflection on the training and education of

the personnel responsible for furnishing maternity care."[37] In other words, the high death rate was the product of a generally poor standard of obstetrical care and not the result of the activities of any particular group.

Referring to the reports on midwifery practice, the Conference report stated:

> . . . statistics show very favorable maternal mortality rates in the practice of midwives, in general, and remarkably low rates for the mothers attended by trained and supervised midwives.[38]

Despite these findings and the recognition given to the important contributions of European midwives, the medical leadership of the time saw no permanent role for midwives in the development of modern obsteric services. The prevailing view was that maternity services should be based in hospitals and should be supervised by qualified physicians assisted by trained nurses, a strategy which, in the words of the conference report, ". . . leaves the midwife out of the ultimate scheme." The hope was that physicians and nurses working together could " . . . supplant the European midwifery system to the advantage of both mother and infant, and to all concerned."[39]

In the short run, of course, the midwife had to be accepted and dealt with, as she was the only source of care in many parts of the country, ". . . where topography, race, social, and economic situations made it impossible to replace her at the present time or even in the immediate future."[40] The Conference, therefore, recommended that training opportunities be made available to midwives at the local level and that local health authorities develop standards for licensure and education.[41]

The scenario envisaged at the White House Conference is, in large part, an accurate portrayal of what took place in the first part of the century. Births moved from the home to the hospital maternity units staffed by physicians and nurses. Where state and local health authorities acted at all, they adopted widely

divergent measures for the control and supervision of midwives. The end result was that the proportion of births attended by midwives fell from about fifty percent in 1900[42] to about one percent in 1950 (see Table 1, p. 12).

In the latter half of this century, midwifery has begun to make a small but noticeable reappearance in the U.S. This has come about as a result of developments in the nursing profession, the women's movement, and the concerns of parents and professionals about the quality and costs of maternity services as presently organized.

Whereas midwifery once flourished mainly among the poor and the geographically isolated, it is now emerging among the urban middle classes. Among present-day midwives, some are nurses; others are not. In this latter group, some midwives have legal recognition in the states where they practice (as in Washington), while others practice outside of the law or where the law has been silent. In neither case do they play a major role in the delivery of maternity care as do their European counterparts.

Certified Nurse-Midwives

To date, the greatest degree of recognition has been given to certified nurse-midwives (CNM), registered nurses who have taken from eight months to two years of advanced training at one of the approximately twenty-four university-affiliated programs accredited by the American College of Nurse-Midwives.

Nurse-midwifery first appeared in this country in 1925 with the establishment of the Frontier Nursing Service, which employed British-trained nurse-midwives to serve poverty-stricken, rural areas in Kentucky.[43] In 1931, six years later, the Maternity Center Association initiated the first nurse-midwifery education program in New York City in order to meet the needs of families that did not have access to basic maternity care.[44]

Nurse-midwifery has developed slowly but steadily. The American College of Nurse-Midwives was founded in 1955. Nurse-midwives achieved a large measure of professional recognition in 1971, when the College issued a joint statement on maternity care, together with the American College of Obstetricians and Gynecologists and the Nurses Association of the American College of Obstricians and Gynecologists. The statement declared that as part of a ". . . health team . . . directed by a qualified obstrician," nurse-midwives ". . . may assume responsibility for the complete care and management of uncomplicated maternity patients."[45] The team concept is interpreted broadly so as to allow a variety of working arrangements and either direct or indirect medical supervision. In all cases, however, the understanding is that obstetrical consultation must be available and that there must be a written signed agreement (or protocol) defining the nurse-midwife's scope of activities and referral and consultation policies.[46]

While there has been much activity around the country in support of nurse-midwifery, it is as yet only a very small element in American maternity care. A 1976 survey indicated that there were about one thousand nurse-midwives in the United States, slightly more than half of whom were involved in clinical practice. Of this latter group, eighty-four percent managed deliveries. In 1976, it was estimated that nurse-midwives accounted for only one percent of the births in this country.[47]

Nurse-midwives in clinical practice work in a variety of settings. The largest single group (about forty-six percent) work in hospitals. Public health agencies account for fourteen percent and another thirteen percent are in private practice with physicians. Nurse-midwives also practice in the U.S. military and in prepaid health plans. About ten percent practice in maternity services operated predominantly by nurse-midwives; these services are mostly in hospitals but may be organized by nurse-midwives in private practice outside of hospitals.[48]

Few nurse-midwives are, in fact, active clinically in community-based practice. Of the 548 who managed deliveries in 1976-77, only 43 (about 8 percent) did so in non-hospital settings.[49]

While the training and orientation of nurse-midwives are geared toward the exercise of independent judgment, there are limits on their level of independence. Not only are they closely bound to physicians in a professional sense, as illustrated by the "team concept" and "written protocols" mentioned above, but also many state laws and regulations describe the relationship between the physician and the nurse-midwife as supervisory.[50]

The association with physicians, both at the official level and in clinical practice situations, has unquestionably served nurse-midwifery well in terms of professional status and work opportunities. Indeed, given the medical community's historical opposition to midwives, the formal ties to physicians were probably a reasonable and necessary step toward securing a foothold in the health system. Increasingly, however, there is some concern among nurse-midwives that their dependence on medical approval, together with their hospital-based training, prevents them from responding to the growing demand for non-traditional maternity services.[51]

Clearly, the development of nurse-midwifery will depend largely on prevailing medical attitudes and preferences at the local level. Although nurse-midwives have consistently demonstrated their ability to deliver a high standard of care since the early days of the Frontier Nursing Service,[52] their acceptance by physicians varies widely from state to state. In Washington, for example, nurse-midwives provide a full range of clinical services both in and out of hospitals under the regulatory authority of the State Board of Nursing. To date, there has been no major conflict with organized medicine. In New Jersey, regulations governing nurse midwifery practice have been the subject of a prolonged dispute between the Board

of Nursing and the Board of Medical Examiners. At issue have been such questions as whether nurse-midwives should be allowed to perform episiotomies (something for which they are trained) and whether they should be allowed to practice outside of hospitals (something for which there is growing precedent around the country).[53]

In general, the level of harmony and cooperation between physicians and nurse-midwives will be heavily influenced by the potential for economic and professional rivalry between the two groups. It is clear that the early physician supporters of nurse-midwifery envisaged it as appropriate in a hospital setting, requiring medical supervision, and occurring in circumstances that did not permit competition for patients.[54] To the extent that nurse-midwives demand and obtain more autonomy, the potential for conflict with physicians will increase.

The ultimate impact of nurse-midwifery on maternity services will depend not only on physician attitudes but will also be a function of consumer demand, the reimbursement policies of third-party insurers (public and private), the legislative and administrative decisions of state and federal government, and the pressure brought to bear by nurse-midwives themselves.

Midwifery Outside of Nursing

That nurse-midwifery has made noticeable advances over the past ten years is a consequence of effective leadership, organization, educational and professional status, patient acceptance, government support, and--from time to time--spirited debate and political activism. The same cannot be said for midwifery outside of the nursing profession.

In one sense, the two branches of midwifery can be said to share a common history in that both have their origins in unconventional attempts to meet perceived gaps in the provision of maternity care. In the case of nurse-midwifery, the focus

was on the economically disadvantaged and geographically isolated. Outside of nursing, midwifery has grown in response to recent demands for alternatives to obstetrical services as provided by physicians in hospitals. Furthermore, our inquiries among the two groups in this state and elsewhere have revealed frequent expressions of a common purpose and philosophy and an interest in forming closer working relationships. Along these lines, within the American College of Nurse-Midwives there has been ongoing debate over the possibility of an alliance with non-nurse-midwives.[55] Nevertheless, there are several important differences between these groups of practitioners.

Whereas the acceptance of nurse-midwives has grown steadily, those wishing to offer maternity services outside of nursing have experienced considerable difficulty in obtaining recognition and legitimacy. These individuals have had no educational or professional base from which they could achieve respectability and status. Although there are about ten training programs in the country, the limited information that could be gathered suggests that, for the most part, they are loosely organized and vary widely in their sponsorship, structure, teaching orientation, and stability. Moreover, none is accredited or otherwise endorsed by a public or private body that could speak authoritatively on the quality of instruction provided. As to an organized leadership component, no such element exists. At present, there are independent advocacy groups (the Washington State Midwifery Council, for example) that have formed in some states to disseminate information and press for favorable legislation and regulatory policies. Should midwifery outside of nursing gain momentum in the states, it is probable that a nationally-based association will be formed. Perhaps at some point nurse-midwives and their non-nurse counterparts will combine under one umbrella organization as they did overseas with the creation of the International Confederation of Midwives. In the near future, however, the forces advocating the practice of midwifery independent of nursing are likely to retain a local focus.

Another factor hindering the development of midwifery separate from nursing is that few states have taken positive steps to respond to this recent phenomenon. Most states have either repealed or administratively deactivated the midwifery laws of the early 1900s. At one point, approximately thirty-four states had explicit provisions. A 1976 survey indicated that this number had fallen to sixteen.[56] Since then, more states have discontinued midwifery regulatory authorities. At present, only eleven states have statutes or regulations permitting the practice of midwifery independent of nurse-midwifery. These states are Arizona, Connecticut, Florida, Minnesota, Missisippi, New Jersey, New Mexico, Rhode Island, Tennessee, Texas, and Washington.

In addition to explicit regulatory provisions, the legitimacy of midwifery has been established by different means in other states. In Oregon, a recent opinion of the state attorney general held that midwifery independent of nursing is within the scope of the law so long as it excludes the performance of episiotomies or the use of medications.[57] In some states the courts have recognized midwifery as separate from nursing. In others, they have concluded that childbirth is a natural function and hence that midwifery does not constitute the practice of medicine.[58]

While the majority of state midwifery provisions are remnants of the early 1900s, in three instances (Arizona, New Mexico, and Rhode Island) they represent recent attempts by state governments to deal with the reality of midwifery outside of the established maternity care system. In each case, action was initiated by a state health department and involves a qualifying examination, case reports by midwives, and oversight by a professional advisory committee (see Appendixes C, D, and E). Arizona's program was the first to be established--in February, 1978--and state officials have reported a generally favorable experience in terms of safety factors and workability of the program.[59]

In addition to states in which definitive action has been taken, there have been varying degrees of activity in other states--as in Washington--directed toward developing a contemporary policy toward midwifery. In 1979, for example, the Texas legislature passed a bill (H.S. 635) that provided for the training and registration of midwives. The bill, however, was vetoed by the governor.[60] A bill introduced into the California legislature in 1978 addressed a variety of issues pertaining to professional midwives, including training, licensure, reimbursement, and others. Although the bill (A.B. 1896), as ultimately enacted, made no reference to midwifery, the legislature recommended that training programs be mounted as demonstration projects under an existing authority.[61] At present, the rules and standards governing these projects are proceeding slowly through the state's administrative machinery.

The absence of a recognized and credible professional structure in terms of educational requirements, leadership organization, and governmental recognition has meant that midwifery outside of nursing has come to be viewed in some quarters as not having a part in the health system. Some--particularly within the medical profession--view its appearance as a step backwards to the days of the granny midwives. This negative opinion is further compounded by the issue of home birth, for it is in the home setting that most midwives offer their services. As mentioned in the previous chapter, home birth is an extremely emotional subject. Many are strongly opposed to it despite the mounting body of evidence that it can be a safe option for properly selected cases.

Because there has been little attempt to regulate or otherwise monitor the practice of midwifery outside of nursing, it is impossible to estimate the number of midwives, their backgrounds, or the characteristics of their practice with a high degree of accuracy. As for numbers, the only statement that we

can make at this time with any sense of confidence is that in the U.S. today the number of midwives is at least equal to, and probably greater than, the number of nurse-midwives--that is, one thousand or more.

The characteristics and practice patterns of midwives vary. Some are entirely self-taught, having done little more than attending births periodically (with or without an experienced partner) and reading a book or two on the birth process. These are the real "lay midwives." At the other end of the spectrum are those who have undergone several years of specialized training, including structured theoretical preparation and supervised clinical instruction. Washington's licensed midwives are generally among the latter group. In between lies a variety of backgrounds and skills. Practice patterns also differ. While some midwives conduct their activities completely separated from other established maternity care resources, others have developed working relationships with local providers (physicians, hospitals, and clinics) that enable them to provide a higher standard of care.

As we mentioned at the beginning of this report, it is precisely because of this great variance in preparation and practice that we have rejected the blanket reference of "lay midwife" in describing all midwives other than nurse-midwives. There are many, primarily the self-taught, to whom the term is properly applied. In discussing those who must undergo rigorous training and licensure requirements, however, the term can be misleading, inappropriate, and prejudicial.

In the following chapters, the focus will be on those broad policy issues which the legislature will have to address in reviewing the state's existing midwifery statute.

Chapter III

MIDWIFERY: THE POLICY QUESTIONS

General Perspective

This inquiry was undertaken to assist in the current legislative deliberations over the present state law which recognizes the practice of midwives other than nurse-midwives. It should be stated that our understanding was that the existing statutory authority would be continued in one form or another. This report has been based on that premise.

That midwives can be trained to deliver a high standard of maternity care without the prerequisite of a nursing education has been amply demonstrated over many years in Europe and elsewhere. Moreover it is a reality that has been recognized in the leadership circles of American nurse-midwives.[62] Regardless of the type of educational preparation, however, the key element is that midwives are accepted by the health community and have ready access to all of the services necessary to the proper care of pregnant women and infants. Otherwise, the standard of service provided by midwives will be less than optimal no matter how excellent their training may be. This point bears special emphasis. In our view, the underlying issues in the current midwifery debate have more to do with psychological acceptance than with the feasibility of establishing a regulatory program that will produce competent midwives.

As stated above, this inquiry was conducted on the assumption that the state would continue to recognize the practice of midwives outside of nursing. Nevertheless, some believe that to do so is neither necessary nor relevant to the maternity needs of the population. Their views are not without merit. The main argument is that the conditions which gave rise to the midwifery statutes of the early 1900s--that is, the paucity

of qualified practitioners and other medical resources--no longer exist. This is undeniably true. Further, in the context of the controversy over obstetrical policies and practices, those who advocate repeal of the 1917 statute state that the health system is responding to the various demands for change. Hospitals are adopting more flexible and permissive policies, for example, birthing rooms, early discharge, family participating, and allowance for natural childbirth. The appearance of birth centers has increased opportunities for out-of-hospital birth. Indeed, the development of nurse-midwifery itself has expanded the choices available to prospective parents both in and outside of hospitals. It can be reasonably argued, therefore, that the established health care system is capable of meeting both the medical and personal needs of most families. To permit the practice of a second category of midwife, some contend, would fragment the delivery of maternity services and confuse the public.

On the other hand, should the existing statute be repealed or midwifery (other than nurse-midwifery) held to be illegal, persons active in the provision of non-traditional birth services may "go underground" and practice outside the law. Such persons would thus be lost to any attempts to ensure an acceptable level of competence. This is a very real concern to public officials in states where there is an active alternative childbirth movement.

The basic issues have to do with public safety and enforcement. As suggested in the discussion of home birth, it is fairly clear that--regardless of state law or medical custom--people will, if they so choose, seek and obtain unconventional birth services. Some fear that, without the regulatory mechanism for midwives, expectant mothers wishing to depart from traditional practices will be at a disadvantage in assessing the qualifications of those offering to assist them. The danger is that such women could fall victim to incompetent or unscrupulous practitioners with potentially disastrous consequences. As shown previously in Table 3 (see p. 15), approximately 20 percent of births occurring outside of hospitals were attended by unlicensed individuals. Had there not been licensed midwives active in this

state, it is probable that this percentage would have been higher.

On the question of enforcement, no matter what stance the legislature ultimately takes on midwifery, the state will never be able to effectively bar the provision of birth services by persons acting outside of the law. This is due to the relative infrequency of life-threatening complications and the fact that birth can take place in the privacy of a home. As one observer of childbirth and the law has noted, "The law is outcome oriented. Unless something goes wrong, the law is not likely to affect anything that people do in our society."[63] Moreover, the experience of the alternative childbirth movement suggests that parents who select home birth or non-traditional birth attendants will not bring suit in the event of an undesirable, or even tragic outcome. When prosecution does take place, it appears to be initiated at the urging of the local medical profession.[64] In view of this inability to effectively police the activities of birth attendants operating outside of the law, some argue that the state--by allowing for the practice of licensed midwives--would provide greater access to properly trained practitioners. The advantage seen here is to reduce the necessity for some parents to seek out individuals with uncertain credentials in order to have a birth experience that cannot be accommodated by the established health system.

In addition to the issues of public safety and enforcement, there are some who would urge the continuation and expansion of midwifery practice on the grounds that it could reduce the costs of maternity care. It is argued that midwives, by reason of their degree of training, income expectations, non-interventionist orientation, and willingness to practice in non-traditional settings, would offer a less costly alternative to hospital-based medical obstetrics. This view, for example, is held in some quarters of the third-party insurance industry in Washington. Others contend that the lower charges of midwives will introduce a competitive force that may exert a moderating influence on physician and hospital charges.

At present, it is not possible to determine clearly the impact of midwifery on the cost of maternity care. In the Seattle area, licensed midwives are currently charging approximately $500 for complete maternity care. This compared with combined, average physician and hospital charges of around $1,600 for normal maternity care.[65] These figures, however, do not tell the whole story. For one thing, a certain proportion of clients handled by midwives will develop complications that require referral to physicians or hospitals, or both, depending on the nature of the condition. The extent of such referrals is not known. Second, if third-party insurance coverage of midwifery services becomes generally available, it is probable that the fees of midwives will rise to some extent, since the incentive to restrain fee increases will be lessened when clients no longer have to bear the full economic costs of care. The product of both these factors will be to lessen the differential between the costs of midwifery services and the costs of maternity care offered by other providers.

Turning to the task of presenting strategies aimed at preserving the practice of midwives other than nurse-midwives, three alternatives may be considered. These are: (1) to take no action, (2) to amend the current statute maintaining its focus independent of nursing, and (3) combine in a single statute the regulatory provisions governing the practice of nurse-midwives and their counterparts outside of nursing.

Maintaining the Current Licensing Authority

There may be some benefit in delaying--for a time--any substantive change in the present licensing authority. There has been, after all, a great deal of activity without the assistance of legislative direction.

The provisions of 18.50 RCW are clearly outdated. Nevertheless, the Department of Licensing appears to have proceeded cautiously and prudently in the development of examinations that reflect modern obstetrical knowledge and standards and in the selection of suitable candidates for licensure. The Department has also secured professional consultation and assistance in various aspects of policy determination. In addition, there has been no evidence of incompetence or harmful practices by midwives licensed under the existing law. Hence, it seems that the existing statute has not presented a threat to public safety, the protection of which is the main purpose of all occupational credentialing provisions.

Apart from the operational aspects of the law itself, there has been movement in other areas that will influence the direction of public policy on midwifery. With varying degrees of success, licensed midwives have attempted to forge lines of communication and establish relationships with other groups with a role in maternity care: physicians, nurse-midwives, hospitals, third-party insurers and others. The Seattle Midwifery School, established in 1978, has been continually assessing and revising its curriculum and admission policies in order to promote high standards of performance among its graduates. The several legislative hearings on the subject of midwifery licensure have broadened the scope of the public debate in Washington. Finally, the actions of other states will no doubt add understanding and insight into an area of social policy in which there has been little precedent in this country.

The main advantage of delaying any specific ation is to capitalize on events in this state and elsewhere that will facilitate the development of a public consensus of midwifery independent of nursing. The principal disadvantage of maintaining the current law is that, in a number of important areas, the statute is either vague or altogether silent. This could, under certain circumstances, jeopardize the progress that has been made in administering the law and the prospects for a sensible and credible successor to 18.50 RCW. The various shortcomings of the present law are detailed immediately below in discussing amendments to the statute.

Amending the Law

If the state is to continue to sanction the practice of midwifery independent of nursing, there are several arguments for revising the statute sooner rather than later. That the administration of 18.50 RCW appears to be functioning smoothly is due to the actions of responsible state officials and the voluntary cooperation of licensed midwives, nurse-midwives, physicians, and other concerned individuals. This favorable climate could change at any time as a result of a change in leadership in the Department of Licensing, an election, a legal challenge, or controversy that strains professional relationships. A new midwifery statute would establish responsibilities, procedures, and lines of authority that would be much less vulnerable to such unpredictable events.

In view of the many advances in maternity care since 1917, a desirable consequence of amending 18.50 RCW would be the opportunity to develop a definition of the scope of midwifery practice in keeping with contemporary knowledge and practices.

Revising the midwifery law would focus much needed attention on educational preparation and the standards for midwifery training

programs. These topics are barely dealt with by the current law which specifies only subject areas to be covered by the licensing examination and a fourteen month minimum duration of training.

At present, the Department of Licensing has neither the authority nor the resources to develop standards for training. While the Seattle Midwifery School has sought assistance from many sources in designing its program, it has been operating with no explicit guidelines encompassing the state's minimum expectations. Some believe that the School's current program is deficient in several areas--for example, hospital experience--that are necessary in the preparation of competent practitioners.

Developing a new midwifery statute would address another major weakness of the current law, namely, the absence of a professional body that would monitor administration of the law and the practice of midwifery itself. Common to other professions (e.g., boards of nursing, medical examiners), these statutory bodies can exercise responsibilities in the areas of education, discipline, the granting and renewal of licenses, special investigations, and liaison with other professional boards. Apart from the pooling of knowledge and insight in the performance of specific statutory duties, a major contribution of formally constituted midwifery body would be to lend respect and credibility to the credentialing process, and hence to the midwives themselves. This is particularly important with respect to the institutions and professional groups upon whose cooperation the success of midwifery practice will be in no small way dependent. For example, hospital officials and medical staffs have been reluctant to permit licensed midwives either to attend or simply accompany their clients when hospitalization becomes necessary. They have also been unwilling to commit any resources to the provision of supervised clinical instruction to student midwives. Similar reservations have been expressed by individual physicians, third-

party insurers, nurse-midwives, and others involved in maternity care. This hesitation is indeed understandable given that midwifery outside of nursing is unfamiliar to the health establishment and is lacking in definition, accepted standards of education and practice, and an organized, respected leadership component. Under a new midwifery statute, the establishment of a strong and visible regulatory body that will address the various areas of concern may do much to resolve the doubts and to open channels of communication that would otherwise remain closed.

In sum, the principal advantages of restructuring the present midwifery statute are to ensure the stability and integrity of the administrative process, to add specificity and definition in areas where they are needed, and to establish a credible regulatory authority that will both oversee and guide developments in midwifery in a manner that balances professional and public interests.

A Combined Midwifery Statute

There may be some advantage in considering a statute that provides a unified regulatory structure for both nurse-midwives and midwives outside of the nursing profession. As suggested by the earlier discussion of Europe, where individuals can qualify as professional midwives with and without basic nurse training, the distinction between the two groups may be artificial. Indeed, the term "nurse-midwife" appears unique to this country. The key factor is the level of training and expectations. When individuals can obtain equivalent competence through educational programs built upon nursing or separate from it, and when they are expected to perform the same functions, a single regulatory structure would appear to make sense. It could strengthen the state's oversight capacity in this occupational

category and minimize any confusion among the public as to who is and is not qualified to practice midwifery.

If the state is interested in advancing the practice of midwifery, a single regulatory apparatus may be useful. As mentioned earlier, there appear to be a positive professional relationship and common interests among practicing nurse-midwives and licensed midwives in this state. A combined midwifery statute might further focus and reinforce the efforts of these practitioners and lead to the strengthening of midwifery as a distinct component of maternity care in Washington.

The idea of a combined midwifery statute, however, may be premature at this time, given the current stage of development and acceptance of midwifery outside of nursing. The task of amending the existing law will probably be difficult enough without also attempting to include nurse-midwives under a new statute. Should midwifery, in general, become more firmly established in this state over the next several years, perhaps a combined statute would be more appropriate and feasible.

A New Midwifery Statute: The Critical Elements

Should the legislature decide to revise the current midwifery licensure statute, attention will focus on four key areas. These are the scope of practice (the activities a midwife may legally perform), training requirements, the credentialing process, and the relationship and degree of independence of midwives vis-a-vis other practitioners (the medical profession in particular).

In contemplating the proper public stance on these four parameters, it might be helpful to view the possible policy decisions as falling along a spectrum of minimum to maximum as illustrated in Table 4. Together, these decisions will represent the state's attitude and expectations with respect to midwifery outside of nursing.

Table 4

	Scope of Practice	Educational Requirements	Credentialing Process	Independence
MIN.	Prenatal care	General education	None	Direct supervision
	Intrapartum "			
	Postnatal "		Registration	Indirect supervision
	Neonatal care			Prior approval of patient
	Family planning			
	Gynecol. care	Comprehensive midwifery training	Certification	Consultation agreement
	Other			
MAX.			Licensure	
				Refer emergent or complicated cases

While each decision could be viewed separately, the scope of practice will largely determine the others. From the perspective of sound regulatory policy, the task of decision-makers is to match the requirements with the responsibilities. For example, if midwives are to be allowed a full scope of practice, it makes sense to require more rigorous education and credentialing procedures. In this instance, however, the arguments for requiring midwives to work under the direction of other professionals become less compelling. On the other hand, should midwives be restricted to a narrow scope of activities, training and credentialing requirements need not be as demanding. Under these circumstances, there would be a greater need to ensure the input of more highly skilled professionals so that all aspects of care are properly provided for.

The failure to strike a proper balance between responsibilities and requirements can have several consequences. If requirements of the scope of practice are too lenient, midwives may not obtain the knowledge and skills necessary to function according to expected standards of performance. If requirements are too strict, potential candidates may not come forward, or, more importantly, they may decide to ignore the law altogether and operate on their own with little chance of discovery or prosecution. In both cases, the consequences of a poorly

designed regulatory apparatus will fall most heavily on the mothers and babies whose health and well-being are at stake. It is important, therefore, that--whether by statute or by regulation--the decisions regarding midwifery be communicated with as much precision as possible. This will minimize any confusion or controversy that may arise in the administration of a new law.

The following chapters contain a more detailed discussion of the four major decision areas and several other topics relevant to the examination of public policy on midwifery outside of the nursing profession.

Chapter IV

SCOPE OF PRACTICE

The term "scope of practice" refers to the various activities and procedures that a practitioner is legally authorized to perform. Defining this range of activities is perhaps the central element in the area of occupational regulation.

As mentioned in the previous chapter, there is a broad spectrum of possibilities for specifying the scope of midwifery practice. At the minimum, a midwife may be limited to providing emotional support and general assistance during pregnancy and birth. This would be tantamount to legitimizing "lay" midwifery. Moving beyond the minimum, midwifery can be defined broadly to include a wide range of medical and non-medical skills applicable to all stages of childbirth. It can be further extended to encompass certain aspects of basic gynecological and family planning services. This broad view is more in keeping with the European concept of professional midwifery and also the philosophy of American nurse-midwives. In all cases, it should be emphasized again that the proper domain of midwifery is universally thought to be the basically normal, uncomplicated pregnancy.

Discussed below are the various phases of maternal and infant care and within each, the range of activities a midwife may properly perform, assuming a broad or maximum scope of practice (see Table 5, p.53). This comprehensive listing of possible functions and responsibilities can serve as a basis upon which the legislature pursues a definition of midwifery practice that best reflects the needs and conditions in Washington at this time.

The Prenatal Period

The prenatal period refers to the period from conception until the onset of labor. This period is important to the development of the fetus and also includes the preparation of the mother for childbirth and parenting. There is general agreement among obstetrical care providers that consistent prenatal care, averaging 12 visits during a pregnancy, contributes to increased chances of survival of the fetus and consequently to changes in infant mortality rates and to reductions in physical defects and mental retardation exhibited by the infant.

During the prenatal period, the midwife assesses the physical and psychosocial health of the pregnant woman and the likelihood of a normal delivery of a healthy child. Women who belong to various "high risk" categories or who develop complications at any time during pregnancy are referred to specialists for appropriate care and supervision.

The management of the pregnancy during the prenatal period includes the monitoring of weight gain, supervision of diet, and surveillance of physical vital signs and the collection and interpretation of blood and urine samples, monitoring of fetal growth and heart rate and intensive educational preparation of the parents for the labor and birth of the child. Several routine laboratory tests are also recommended during this period.

The information provided through regular testing and periodic physical examination alerts the midwife to changes in the progress of the pregnancy which may require the referral or transfer of a woman to a physician specialist.

The Intrapartum Period

The intrapartum period refers to the period commonly known as labor and birth. During the intrapartum period, the midwife may provide assistance to the woman through three stages: labor,

birth, and delivery of the placenta. The types of assistance during these stages may involve coaching, observation and assessment, intervention and manipulation, and administration of anaesthetic or analgesic medications under proper conditions.

Throughout labor a midwife will monitor the fetal heart rate and fetal position and determine if the fetus is aligned for the easiest, safest passage through the birth canal. During the birth phase, the midwife can perform the physical manipulations necessary to assist the emerging child. If needed, a midwife may also perform and repair an episiotomy--the cutting of the perineum to increase the diameter of the vagina through which the head of the newborn infant must pass. Episiotomies require the use of a local anesthetic for the comfort of the mother. As regards general pain medications (i.e., analgesics) which are widely used in obstetrical practice, midwives usually prefer to manage labor without them, substituting breathing and relaxation techniques for pain-killing medications. Finally, during delivery of the placenta following the birth, the contraction and involution process undergone by the uterus is monitored, and the placenta is examined upon expulsion. If necessary, oxytocic, antihemorrhagic medications may be used to hasten this stage of childbirth and control minor hemorrhaging that can occur.

Throughout these three stages, the midwife assesses deviations from the normal and determines the need for emergency measures and specialty assistance. Given the authority to do so, the midwife can initiate certain emergency procedures to decrease the risk of injury to or loss of life. Such measures may include intubation of the asphyxiated baby, mouth-to-mouth resuscitation, and the administration of oxytocic drugs.

The Postpartum Period

The postpartum period refers to the period following the birth and includes the immediate postpartum paried--the first two hours after birth--and the early postnatal period--the first ten days after birth. During the postpartum period, the midwife continues to assess and manage the progress of involution of the uterus begun immediately after childbirth. The importance of early contact between the mother and the child and the father is emphasized in the practice of obstetrics by most midwives and consists of supervising and assisting the bonding process between the child and the mother and the father. Advice is given on nourishment and nurturing of both the mother and child. During the ten days following the birth, instruction is offered to the mother on care of the breasts, breast feeding, self-care, and care of the newborn, including identification of abnormal signs which should be reported to the midwife for evaluation and possible referral.

The Neonatal Period

The neonatal period refers to the newborn's first 28 days of life.

During the first two hours after birth, the midwife provides immediate care and supervision of the newborn. This includes clearing the air passages, evaluating and recording the physical condition of the baby, attending to the umbilical cord, performing eye prophylaxis, determining gestational age and the presence of any physical deformations or anomalies, and obtaining blood samples for routine newborn screening procedures. If necessary, the midwife can respond to emergency needs of the newborn and arrange for transfer of the infant to a specialty care setting.

Family Planning and Routine Gynecological Care

In many parts of the world, the scope of midwifery practice has begun to include the area of family planning. Increasingly, midwives are able to counsel and advise women concerning their reproductive cycle and the options that can be exercised in controlling the timing and number of pregnancies. The gynecological care of the normal woman during her non-pregnant periods is also an area into which midwifery is expanding in some countries. Involved here are routine gynecological examinations and the treatment of minor gynecological problems. Midwives are being trained to assess relevant reproductive medical history, general physical and emotional status, and to offer counseling with respect to contraception. While some midwives are able to fit or insert contraceptive devices, these services are largely rendered by physicians. Lastly, midwives can offer advice and referral to specialists for the management of infertility, sexual dysfunction, or hormonal imbalance problems.

Table 5

SCOPE OF PRACTICE

PRENATAL CARE

Assess relevant historical data regarding the client and her family.
Assess general physical and emotional status of the client.
Diagnose and assess pregnancy and its progress.
Assess the bony pelvis.
Obtain and interpret laboratory/diagnostic test data.
Perform nutritional assessment and provide counseling.
Identify deviations from normal and refer to a specialty physician.
Plan and conduct classes in preparation for childbirth and parenthood.
Counsel the pregnant woman regarding pregnancy and childbirth.

INTRAPARTUM

Assess relevant historical data about client.
Assess general physical and emotional status of client.
Assess status of fetus.
Diagnose and assess labor and its progress through the three stages.
Obtain and interpret laboratory/diagnostic test data.
Provide support/coaching during labor and delivery.
Administer appropriate medications/solutions during labor.
Manage normal spontaneous vaginal delivery.
Assess and manage newborn's adaptation to extrauterine life.
Manage placental expulsion.
Assess and repair birth canal trauma.
Facilitate beginning of maternal/infant/family bonding process.
Identify deviations from normal and institute appropriate emergency measures.

POSTPARTUM

Assess relevant historical data about client.
Assess general physical and emotional status of client.
Obtain and interpret laboratory/diagnostic data.
Assess progress of normal involutional process throughout the puerperium.
Facilitate maternal/infant/bonding and breast-feeding process.
Provide anticipatory guidance regarding self-care, infant care, family planning, and family relationships.
Identify deviations from normal and institute specific emergency measures.

Table 5
(cont.)

NEONATAL

Assess relevant historical data about maternal and neonatal course.

Assess general physical status of newborn.

Assess gestational age of the newborn.

Assess nutritional status and needs of the newborn.

Obtain and interpret appropriate laboratory/diagnostic data.

Facilitate maternal/infant/family bonding process.

Identify deviations from normal neonatal course and provide appropriate intervention.

FAMILY PLANNING/GYNECOLOGICAL CARE

Assess relevant historical data about client/partner.

Assess general physical and emotional status of client.

Assess female pelvic organs.

Obtain and interpret appropriate laboratory/diagnostic test data.

Assess appropriateness of specific contraceptive method(s) for client.

Counsel for appropriate use of physiological, mechanical, or chemical methods of contraception.

Prescribe, fit, insert appropriate contraceptive agent.

Counsel/refer women/couples with unwanted pregnancies.

Counsel/refer women/couples with potential infertility problems.

Provide basic information on human sexuality including psychosocial aspects, reproductive functioning, and menopause.

Identify problems of sexuality and provide for appropriate follow-up.

Diagnose, manage and/or refer common gynecological problems.

Chapter V

EDUCATION AND TRAINING REQUIREMENTS

As suggested in Chapter III, the standards that are to govern the training of midwives under a new statute will depend upon the scope of practice provided for in the legislation. In addressing the question of standards, and midwifery education generally, mention should be made of several guiding principles endorsed by international professional bodies concerned with maternity care. Where midwifery training is concerned, countries are encouraged:

- to design programs making use of all available resources,
- to relate education and training to the tasks and functions to be performed,
- to legislate for the changing sphere of duties of the midwife, and
- to provide continuing education for all categories of midwives.[66]

It must also be remembered that at issue here is the training of midwives outside of the nursing profession. As discussed earlier, while basic nurse training (i.e., an RN or LPN qualification) need not be a prerequisite for midwifery, there is general agreement that certain nursing skills are indeed important to the practice of a midwife. The relevant nursing instruction could be provided through arrangements whereby nursing schools allow student midwives to participate in only those courses applicable to their training. If this is not possible, the teaching of necessary nursing skills will have to be incorporated into the midwifery program itself. The European experience suggests that either approach is acceptable.

It is not the intent of this chapter to devise or recommend detailed criteria and standards for midwifery training programs. That task is more properly the responsibility of an expert credentialing body that is likely to be constituted under any new midwifery statute (see p. 66). Rather, the purpose is to comment in general terms on some of the areas that will be central to the formulation of training requirements for midwives.

Content of Instruction

In one form or another, the following subject areas are usually included in midwifery training programs:

- Anatomy and physiology of the female and the newborn
- Nutrition of the pregnant woman and the newborn
- Basic medical procedures
- Maintenance of medical records and statistics related to birth
- Basic observation and examination skills
- Family planning counseling techniques
- Parent education for prepared childbirth
- Provision of maternal care during the pregnancy and post pregnancy periods
- Management of birth and the immediate care of the mother and newborn
- Pharmacology as applicable to maternal and newborn health
- Recognition of early signs of possible abnormalities
- Recognition and management of emergency situations
- Information regarding the laws and regulations relating to the practice of midwifery in the state issuing the license to practice
- Information regarding newborn screening for phenylketonuria and other congenital birth defects
- Prevention of infant blindness
- Control and reporting of sexually transmitted diseases

The question of how and where the clinical skills may be obtained is important in the design of midwifery training programs. There are several options for the provision of the clinical component of education. It can take place under the direct supervision of a physician, a licensed midwife, or a certified nurse-midwife. Clinical training can be provided in a variety of settings, including hospital obstetrical services, birth centers, clinics, private offices, and private residences.

The number of deliveries required before a candidate is eligible for examination varies between countries and between states. The common standard is between forty and fifty deliveries conducted by the midwife--under supervision.

Continuing Education

Assuring that competency is maintained subsequent to initial qualification is an important goal of any occupational regulatory scheme. Continuing education requirements, in various forms, are widely used among the health professions as a means toward this end.

Since it is one of several mechanisms for promoting proficiency over time, and in view of the controversy over its efficacy, continuing education is dealt with in the next chapter as part of the discussion of continued competence (see p. 73).

Accrediting Educational Programs

Among the established health professions, developing educational standards and approving training programs are usually functions of national professional organizations--the American Medical Association, American Nurses Association, etc.

At present, there is no such organization representing midwives outside of the nursing profession. Nor does it appear

that the state can look to an existing professional body for the purpose of accrediting midwifery training programs. While the American College of Nurse-Midwives might seem a suitable choice, the College, as mentioned earlier, has not yet expressed an interest in assuming such a role. With regard to the medical profession, and particularly the American College of Obstetricians and Gynecologists, physician leaders have been outspoken in their endorsement of nurse-midwifery as the model for midwifery practice in this country. Moreover, the orientation of midwifery, in general, is toward minimal intervention and the normal pregnancy characteristics which set it distinctly apart from the ethos of modern medical obstetrics. It is unlikely, therefore, that organized medicine would possess the balanced and flexible perspective that is appropriate in setting educational standards for midwives independent of nursing.

Under these circumstances, the legislature may wish to include accreditation as a state-based function within the credentialing process established under a new midwifery statute. This approach has been taken by Arizona, New Mexico, and Rhode Island under their newly revised midwifery regulations. There is no reason why the state cannot effectively exercise this responsibility and, as will be discussed in the next chapter, there are some grounds for suggesting the state may be best suited to this task.

Public vs. Private Education

There is also the question of whether the training should be provided in private institutions or as part of a state's higher education or vocational education activities. If it is a state-funded program, should it be lodged in the university system or in the community college system?

Most foreign countries train midwives in two to three year programs at publicly supported schools, which fall under the auspices of either educational or health authorities. At present,

the only school offering midwifery training in the state of Washington is the Seattle Midwifery School, a private, non-profit school registered with the Washington State Commission for Vacational Education.

Because there is little experience in this country with the training of midwives outside of nursing, those charged with the responsibility of devising training standards under a Washington statute will need to approach this task with flexibility and inventiveness. While much can be learned from the educational practices of American nurse-midwives and midwives abroad, standards will have to fit what is possible and practiced in this state at the present time. An "ideal" program can evolve from an initially "adequate" one.

Chapter VI

THE CREDENTIALING PROCESS

In recent years, increasing attention has been focused on the issue of occupational licensure. This is particularly true with respect to the health professions, as increasing specialization has brought forth many new groups claiming recognition and legal sanction from the state. Many have begun to question whether licensure and other credentialing practices primarily serve their intended purpose of protecting the public against incompetence and fraud, or whether their principal effect has been to enhance the economic and professional status of the occupational groups concerned. As a result, federal and state governments are examining new approaches to licensure and other forms of credentialing. The aim is to provide an acceptable level of public protection while avoiding the imposition of artificially high standards that serve only to limit entry into an occupation, career mobility, and economic competition. Policy-makers are beginning to ask whether credentialing is necessary at all, and if so, what form should it take?[67]

A detailed discussion of the ongoing developments in the area of credentialing is beyond the scope of this inquiry. Moreover, the present upsurge of interest in credentialing has to do with the emergence of the many new health-related occupations in recent years--the technicians, technologists, therapists, assistants, and the like. Out of this controversy have come ideas that are relevant to the state's current assessment of its stance toward midwifery outside of nursing. These are included in the discussion below.

Should the state decide to continue to sanction the practice of midwifery independent of nursing, three aspects of the credentialing process will be of principal importance in shaping a

new regulatory program. These are the credentialing mechanism (e.g., licensure, certification, registration, or none at all), the credentialing authority (e.g., an administrative agency, an autonomous professional board), and the provision for continued competency (e.g., reexamination, continuing education, peer review). As with educational requirements, the appropriateness of the credentialing process for midwifery (as for any occupation) depends to a large degree on the scope of practice specified and the potential for harm to the public. In general, the broader the scope of practice, the more rigorous and restrictive should be the credentialing requirements.

The Credentialing Mechanism

The existing statutory provisions under 18.50 RCW require that a license be obtained before a person can practice as, and use the title of, "midwife." In view of current thinking on the subject of occupational credentialing, state policymakers may wish to consider whether licensure is still the most suitable regulatory instrument or whether some other device can adequately serve to protect the public.

Licensure is the mechanism by which government grants permission to engage in an occupation or profession to individuals who have met predetermined standards that should reflect the minimum competence necessary to ensure that the public health, welfare, and safety are reasonably well-protected. To engage in such an occupation or profession without a license is unlawful.[68] Under typical licensing schemes, licenses are granted to individuals who satisfy requirements set down by a licensing board. These requirements usually deal with examinations, education, and experience. Licensing boards are often dominated by established members of the occupation in question. Entry of new members into a field, therefore, can be effectively controlled

by those already in it. Similarly, the behavior of existing members of an occupation can be influenced by the threat of suspension or revocation of a license.[69]

Limited in the beginning to a few "learned professions" (law and medicine, for example) where the function and activities were mutually exclusive, occupational licensure has now grown to include a wide variety of fields, professional and non-professional alike. Moreover, in some fields, health being a good example, various categories of workers are entitled to perform the same or similar services. In maternity care, physicians, nurse-midwives, licensed midwives, emergency medical personnel, and some others are permitted to assist women during pregnancy and birth. Hence, the exclusivity once implied by the granting of licenses no longer exists in some fields; indeed, it may not be warranted.

There is also the issue of enforcement. The legal sanction, which is the principal distinction between licensure and other forms of credentialing, implies that the state will have the means to take action against those who break the law. If the state is unable to readily identify and prosecute individuals acting outside of the law (i.e., without a license), then licensure loses its meaning and cannot be truly said to protect the public.

In considering whether to maintain licensure as the credentialing mechanism in a future midwifery regulatory program, certain questions arising out of the debate over credentialing new health professions have direct relevance.

The first, and most important, question is <u>in what way will the unregulated practice of midwifery clearly endanger the health and safety of the public, and is the potential for harm easily recognizable and not remote or dependent on tenuous argument?</u>[70]

Harm can be thought of along several dimensions of impairment: physical, mental, social, financial, and intellectual. The potential for harm can be judged in terms of the inherently dangerous nature of the functions of an occupation or the devices or substances used in performing those functions. It may also be associated with the frequent exercise of independent judgment by a practitioner for the purposes of identifying a problem, formulating a plan of care, or rendering services. The potential for harm can be documented by public testimony, research findings, and legal precedents. Generally speaking, the potential for harm can be viewed as remote when the instances of impairment are rare or minor in nature, and when they are due to secondary effects of the practice of the occupation.[71]

With respect to midwifery in general, the nature of the harm that could result from the practice of poorly-prepared or incompetent individuals is, in a sense, obvious. In the extreme, it could mean death or serious and lasting injury. Although tragic, mortality is fortunately a rare occurrence in modern times. This is due to the higher standards of living, general levels of education and awareness, the availability and capacity of medical science, and the general commitment to the welfare of mothers and infants on the part of all involved in the provision of maternity care. Apart from death or serious impairment, which are easily recognizable, the poorly managed pregnancy can have harmful consequences that may not be as readily apparent. These may have profound and irreversible effects on long term growth and development of the infant. As greater knowledge is acquired on the effects of birth outcome of smoking, alcohol, nutrition, obstetric medications and practices, and other factors, it is hoped that these more subtle hazards will be more clearly identified and effectively minimized.

From a more formal perspective, the nature of and potential for harm due to poorly controlled midwifery practice is directly

related to the definition of midwifery itself. Again, a critical variable is the state's determination of the scope of practice. If it is defined broadly in keeping with the concept and practice of midwifery as exists in other developed countries, more stringent regulatory provisions are called for. Clearly, if midwives are to perform tests and complex examinations, interpret results, diagnose abnormalities, administer medications, and carry out minor surgical procedures, the consequences of allowing ill-prepared practitioners into the field can be significant. In this case, the state is justified in imposing more formidable regulatory mechanisms.

On the other hand, if midwifery is defined narrowly so that practitioners are limited to doing little more than providing emotional support and "catching the baby," then the arguments for a more restrictive credentialing mechanism become less compelling. In the first place, no great degree of skill and learning is necessary. Second, as will be discussed in Chapter VII, a limited scope of practice would require provision being made for the input of more highly skilled personnel. In this way, the proper management of pregnancy will be assured and the likelihood of serious mishap will be greatly minimized. In this instance, a restrictive mechanism such as licensure does not appear necessary to protect the public interest.

In addition to assessing the likelihood of harm in determining an appropriate regulatory mechanism, a second relevant question is <u>can the public be adequately protected by means other than licensure?</u>[72] At issue here is the extent of other controls on a practitioner's activities, either formal or circumstantial, that effectively safeguard the public. For example, is there supervision of practitioners by physicians or other more skilled personnel? Are the individuals in question employed primarily in licensed health facilities required to maintain competent staff? Do standards for professional performance exist and are they effectively enforced? Are the applicants for credentialing

graduates of accredited or approved training programs? Do laws exist that effectively govern the devices and substances used in the occupation?[73] If these conditions apply--in this case to midwives--then there may be less of a need for more restrictive credentialing requirements.

Should the legislature wish to explore alternatives to licensure, there are two other credentialing mechanisms that are considered credible in the area of professional regulation--namely, certification and registration.

Certification or registration is the process by which a government agency or private organization grants recognition, or certifies that a person has met certain predetermined qualifications specified by that agency or organization. These qualifications may include graduation from an accredited or approved training program, satisfactory performance on a qualifying examination, or completion of a certain amount of work experience. Certification and registration differ only in that there is a general perception that the former is associated with occupations involving higher levels of skills and knowledge, although this need not be the case.

Through the specifications of qualification, certification or registration can easily accommodate occupations requiring high levels of skills and knowledge, and, in practice, they are common credentialing mechanisms among the professions. In the health field, for example, there are many groups that are certified or registered, including nurse-midwives and other specialty nursing personnel, inhalation therapists, dental assistants, medical technologists, and others.

Both of these alternative credentialing mechanisms can be used to demand the same level of competence as under a licensure program. The only difference is that they lack the legal ramifications and enforcement capabilities associated with licensure. Moreover, the legal sanction may no longer be relevant in modern times when the incidence of genuine quackery

in health care is not the concern that it was when licensing laws were first instituted to safeguard the public. Furthermore, when the public expects and the system can provide qualified practitioners, it is reasonable to suggest that it is the education, training, and the shaping of professional ethics instilled by that process that will ensure high standards of practice, and not the remote threat of legal prosecution.

If the legislature decides to adopt a credentialing mechanism for midwifery other than licensure, efforts should be made to ensure that the public understands its meaning. Many are familiar with the concept of licensure but may be hesitant in relating to skilled practitioners acting under new models of authority. This would be particularly important, for example, in the case of the third party insurers, who are accustomed to paying for the services of practitioners acting "within the scope of their license." Steps might have to be taken to see that third party payers understood both the meaning and rationale for different patterns of credentialing, lest they refuse to deal with midwives due to legitimate doubts as to their qualifications and authority.

The Credentialing Authority

Under Washington's existing midwifery statute, the Director of Licensing is responsible for all decisions regarding the operation of the law, the administering of examinations, assessing an applicant's eligibility (including the adequacy of training), disciplinary matters, etc.

At present, there is no statutory provision for the ongoing input of midwives or related professional groups in the administration of 18.50 RCW. As mentioned earlier, the Department has so far been successful in securing professional assistance on an ad hoc basis. Criticism of this loose partnership has been twofold. First, the activities of the professionals involved

have not been highly visible or well understood. Second, there has been some concern about the identity, accountability, and influence of the various individuals involved. Clearly, the matter of professional participation will be an important aspect in framing a new midwifery statute.

In considering how a formal credentialing body might be constituted, the three key elements are its membership, duties, and level of autonomy.

The membership of a credentialing body is crucial to establishing the credibility of the midwifery regulatory process (and midwifery itself) in the minds of the public and the professional community. From the public perspective, the issues are clear. The membership must possess sufficient knowledge of the essentials of sound midwifery practice and maintain a balanced point of view. This latter point has become increasingly significant in recent years. Concern has been mounting that the domination of licensing boards and other credentialing bodies by professional associations and educational interests has resulted in the standards for entry into a field being set at a far higher level than is necessary for the protection of the public. The consequences of this are the restriction of career opportunities and higher costs of services to the public.

The membership of a credentialing body must also reflect professional concerns. Not only must professional participants be competent in their respective areas, they must also have the confidence and trust of the professional community. This is particularly important in the case of midwifery outside of nursing, an area about which there have been much uncertainty, skepticism, and even hostility among professional groups.

In structuring the composition of a credentialing body for midwifery two concepts that have emerged from the debate over occupational regulation are relevant--the inclusion of public members and related occupational groups. In the latter instance,

the goal is a better understanding of relationships among groups that perform the same or similar services, or services that are dependent on the cocperation of others. In both cases, the underlying rationale is to ensure that in the process of exercising credentialing authority, an occupational group does not put its own interest over that of the public.

The participation of public members on official credentialing bodies is a growing trend. In this state, the public is currently represented in the regulation of physicians, nurses, chiropractors, and several other groups. In addition, the midwifery bill considered during the 1980 legislative session made provision for a public member on the professional committee designed to assist in the administration of the law.

The level of public participation is a matter of subjective judgment. While it is common to find one public representative on credentialing bodies, there is no apparent justification for this limitation, and there might be circumstances which would warrant a greater public role. For example, if it were anticipated that a moderating influence would be needed, greater public representation might be desirable.

While it is not nearly as common as public representation, the participation of related occupational groups on credentialing bodies seems clearly appropriate in the case of midwifery. Although midwives should have a strong voice in governing themselves, there are other practitioners--particularly physicians--to whom midwives must relate in the proper conduct of their practice. The value of the multi-disciplinary approach has been recognized by the other states which have recently established regulatory programs for midwifery independent of nursing. In Arizona, New Mexico, and Rhode Island, the credentialing bodies for midwifery include physicians, nurse-midwives, nurses, and other professionals with an interest in maternity care.

With regard to physician participation in the regulation of midwives, obstetricians play a key role. Their expertise is important in making judgments as to normal vs. abnormal obstetrics, that is, the conditions in which midwives should seek specialist services for their clients. Obstetricians can also bring to a midwifery regulatory program information concerning new developments in maternity care that can be beneficial to midwifery practice. Furthermore, as the opinion leaders among the medical community in the area of birth practices, the representation of obstetricians would go far toward establishing the credibility of any new program designed to guide the practice of midwives outside of the nursing profession. Finally, given the probable pattern of midwifery practice (at least in the short run) it would seem desirable that assistance be sought from those physicians--obstetricians or otherwise--who are not philosophically opposed to the notion of out-of-hospital birth.

Of the various duties usually assigned to an occupational credentialing body, the determination of educational requisites and the approval or accreditation of training programs will be the most crucial under a new midwifery statute. This country has not developed a generally accepted model for the training of midwives outside of the nursing profession. The programs that do exist have largely been isolated, individual efforts with a local rather than national focus. While the European experience offers useful guidelines, the United States--and Washington in particular--has unique social, economic, and professional characteristics that will have to be accommodated in any midwifery regulatory scheme.

In the absence of both a general consensus on midwifery and a professional association that could be entrusted to develop reasonable educational standards, the task of approving training programs may rest, as it has elsewhere, with a credentialing body constituted at the direction of the

state. With a carefully selected membership, such a group should be able to design a credible program approval process.

In carrying out the program approval function, and indeed all other regulatory functions, it is important that a credentialing body have the capacity for flexibility in both devising and interpreting standards. Given the innovative nature of regulating the practice of midwifery independent of nursing, it will not be possible to "get it right the first time." Clearly, many factors related to midwifery practice may be evolving for years to come--societal attitudes, professional relationships, educational and financial resources, practice patterns, and others. The challenge to those with regulatory responsibilities will be to pay careful attention to safety issues and, at the same time, to utilize existing resources and allow for change. It would be unfortunate if a credentialing body moved too far too fast and antagonized those individuals upon whose cooperation successful midwifery practice depends. Similarly, if it were too rigid or idealistic and set unnecessarily restrictive standards, the effect might be that no one would want to seek or, in fact, could obtain credentialing under a new statute. In both cases the ultimate intent of a new midwifery statute, namely, the protection of the public from unqualified birth attendants, would be seriously undermined.

On the question of autonomy, whether a newly constituted midwifery credentialing body should have ultimate decision-making authority or should be advisory to state government depends on the perceived need for public accountability. Autonomous, profession-dominated regulatory bodies have been criticized for allowing professional concerns to overshadow the public interest. As a consequence, much attention has focused on increasing the level of accountability in the credentialing process.

Almost without exception, occupational regulatory boards have been granted autonomous decision-making powers in carrying

out their statutory responsibilities. This pattern ostensibly has its origin in the belief that practitioners, because of their special knowledge and experience, are best suited to the task of defining educational requirements and standards of practice. Professional and non-professional groups alike have come to expect and to value the right to make these decisions free from direct public intervention.

In keeping with accepted patterns of occupational regulation, an autonomous midwifery board could be established to administer a new statute. Under this arrangement, the ability of midwives to pursue their own interests at the expense of the public could be minimized by a board membership that includes members of the public and of functionally-related groups (physicians, nurse-midwives, etc.). Moreover, autonomy is not absolute. Should a midwifery board exceed its authority or fail to fulfill its responsibilities, legislative remedy is available. The principal advantage of an autonomous board, of course, would be to protect the administration of the law and the practice of midwifery from arbitrary action by government or by powerful interest groups via the public process. It could not, however, safeguard against professional politics which can just as effectively thwart the administration of a law and which might be more of an issue, given the likelihood of a multi-disciplinary regulatory body under a new midwifery statute.

Under the present statute, the Director of Licensing is responsible for carrying out the provisions of the law. This line of authority has been maintained in the various legislative proposals that have been put forward to amend the current law. Recognizing the need for professional expertise, the several proposals have called for a professional "advisory" group to assist the Director in those areas where expert judgment is required. It should be mentioned here that Arizona, New Mexico, and Rhode Island have used the advisory committee concept in their recently established midwifery regulatory programs.

The use of a professional advisory group instead of an autonomous credentialing body may have several advantages. Since midwifery outside of nursing is a very controversial topic, granting the ultimate decision-making authority to an administrative agency could serve as a valuable moderating influence should the professional group adopt an extreme position in any direction. Second, given the innovative nature of a new midwifery statute, flexibility will be important during the initial years of its implementation. Placing decision-making power in an administrative agency might allow for more rapid responses to special situations as they occur and safeguard against any undue rigidity in the actions and decisions of the professional group. Finally, an administrative agency is likely to be more responsive than an autonomous body to legislative concerns as to the carrying out of legislative intent.

The major disadvantage of limiting the autonomy of a professional credentialing body is the danger of excessive or inappropriate interference in professional matters by the public official(s) having the ultimate authority. This could occur as a result of personality, ideology, or political pressure from various sources.

Should the legislature wish to use the advisory group approach, however, perhaps the best protection against unwarranted meddling by public officials is the selection of group members who are highly regarded by the professional community, the public, and the legislature. An advisory body of sufficient stature would be less vulnerable to manipulation or intimidation. Under extreme circumstances, the resignation of respected professional and public members would place an administrative authority in a difficult position both in terms of the operation of the regulatory program and accountability to the legislature.

Under an advisory group arrangement, therefore, the selection process should be designed to ensure the choice of highly regarded

individuals. Recent legislative proposals have called for members to be appointed directly by the Director of Licensing--with no limitation on the Director's discretion. While this may be an adequate process when there are harmonious relationships and general agreement as to the intepretation of statutory provisions (as under the present law), these conditions might not always prevail. One alternative would be for the Director to consider members from nominating lists submitted by each group to be represented on the advisory committee. Another would be for the governor or a legislatively constituted body to consider candidates from lists of preferred individuals. Whatever method is chosen, the goal should be to provide a reasonable balance of power in the administration of a new midwifery statute.

Assuring Continued Competence

While initial credentialing procedures (licensure, certification, etc.) may be adequate to establish minimum standards of competence at the time of entry into a profession, they cannot be taken to guarantee acceptable standards of practice over the course of a practitioner's lifetime. In an era when knowledge is expanding at a rapid pace, there is a danger of professional obsolescence. It is for this reason that a growing number of professional groups and state credentialing bodies have been urging--if not requiring--individuals to demonstrate that they are keeping abreast of developments in their fields. The issue of maintaining competence is particularly significant in health-related occupations where the consequences of poor judgment can be devastating.

While a number of approaches are thought to signify continued competence, there has been little substantive research to indicate which methods are better than others.[74] Indeed, there is much controversy over whether much of what is being done under the banner of maintaining competence has any effect on the quality of care which--after all--is the only justification for such activities. Perhaps the best things that can be said of continuing competence requirements in general is that

they assure that practitioners are at least thinking about their standards of practice in some way. On the other hand, where such activities are clearly superfluous to direct patient care, they are a waste of time, energy, and money.

Of the various continued competence mechanisms in use, the most common is the requirement for continuing education. For the most part, credit hour requirements are set for a specified time period and can be fulfilled by attendance at various courses, lectures, conferences, professional association meetings, and the like. Meeting these requirements can be a condition of renewal of one's license, certification, association membership, etc., depending on the occupation in question.

Traditional didactic continuing education activities have proliferated because they are easy to devise and can reach large numbers of individuals. Yet, they are widely questioned for being, as a recent report stated". . . often unvalidated and of questionable relevance to continued competence."[75] In addition to classroom situations, however, other types of educational techniques, such as self-assessment tests, simulated clinical situations, and review of actual practitioner-patient relationships, might be worthy of exploration.[76] Because of the poorly understood correlation between continuing education methods and quality of care, a variety of alternatives should be considered. For the same reason, any standards set ought to be as flexible as possible.

Although very limited in its current usage, re-examination is another concept which is being increasingly discussed in the area of continued competence. When it is used, re-examination is never applied to the basic authority (e.g., a license) to practice a profession. Instead it is used in specialty certification. For example, the American College of Family Practice requires those physicians who wish to establish their credentials as family practitioners to retake its national board examination

every six years. Failure to perform satisfactorily on this examination means only that a physician loses the endorsement of the College, not the license to practice medicine.

Because of the severe consequences that it can have on the individual practitioners, and because tests themselves can be imperfect predictors of competence, re-examination probably should not be tied to the basic authority to practice midwifery under a new statute. At least, it should not be the single deciding factor. More information and experience with this particular regulatory mechanism is necessary before its proper use can be established. Developments in other professions will certainly help to clarify this issue as time goes on.

Peer review, formal and informal, is another mechanism for promoting continued competence. Peer review occurs as a matter of course when professionals work together in organized settings, for example, in hospitals and clinics where there is a constant exchange of ideas and information on a day-to-day basis. More formally there are case review conferences, utilization review committees, and other structured opportunities for practitioners to have standards of care assessed by others.

It is where individuals operate more or less independently that effective peer review becomes difficult to achieve. Since the midwives recognized under any new statute would probably not be working in established institutions (at least in the short run), the legislature may wish to consider the development of a recordkeeping and reporting system that would be more focused than the existing birth certificate data process. A reporting system could be used to monitor the practice of midwives under a new act. Such a system has been used in Arizona for several years and is presently being implemented in New Mexico. The health authorities in Arizona report that it has been successful in helping them to monitor practice, identify problems, and develop strategies for corrective action when this

has been found to be necessary.

The design of such a system should be as simple as possible, perhaps a single page form for every birth that could be submitted by midwives at regular intervals--quarterly, semi-annually, etc. Such a system could certainly be used for the initial years of a new regulatory program and could easily be abandoned when midwifery reached a certain level of maturity. It would add an element of peer review and oversight that would add to the public's understanding of this re-emerging occupational pathway.

Just as the state is correct to demand a certain level of skill on the part of persons asking to enter certain professional categories, it is also reasonable for it to ask that steps be taken to ensure competence on an ongoing basis. However, given the tenuous connection between continuing competence activities and the quality of care, any requirements imposed by the state under a new midwifery statute should be flexible and within reasonable limits. Whatever method or methods are adopted, they should be readily available to the great majority of practitioners. Most importantly, they should be as directly related as possible to the actual tasks and functions performed by midwives.

Chapter VII

THE QUESTION OF INDEPENDENCE

In any revision of the state's midwifery statute, an important topic of discussion will be the nature of the relationship that should exist between midwives and physicians. Some may argue for direct, over-the-shoulder supervision by physician. Others will urge a less formal and more voluntary collegial association based on professional judgment. The current law takes the latter approach by declaring it to be ". . . the duty of a midwife to always secure the services of a legally qualified physician whenever any abnormal signs or symptoms appear either in the mother or the infant."[77]

The discussion of midwives' relationships to physicians parallels that which has surrounded the emergence of several new categories of health professionals, namely, Physician's Assistants (PA's) and Nurse Practitioners (NP's). In general, these individuals perform functions that were once the prerogative of physicians only. Within certain limits, they are trained and authorized to engage in the diagnosis and treatment of illness. The independence of these practitioners varies according to state law. In Washington, Physician's Assistants may practice either under the direct or indirect supervision of a physician, that is, a physician's physical presence is not essential to the PA's normal activities.[78] Nurse Practitioners, for example, nurse-midwives, are not required to work under medical supervision and may operate independently within their scope of practice. However, most establish "collaborative" relationships with physicians, pharmacists and other professionals.[79] These

are voluntary arrangements made on an individual basis, and they will vary according to the situation and personalities involved.

With respect to midwives, there can be little doubt that they cannot perform adequately in total isolation from physicians and other resources of the health system. Clearly, it is in the interests of mothers and children that the services of obstetricians or other physicians be available to the midwife whenever the need arises. Midwives, licensed or otherwise, generally recognize the need for contact with physicians. In this state, many have been able to establish various kinds of working relationships with physicians for consultation and referral should complications arise during the pregnancy or birth. Some will not accept a client unless she can document a recent, complete physical examination by a physician or present a signed statement from a physician stating that he or she will provide consultation or assume management of the case in the event of complications or emergencies. Nevertheless, there are some (primarily among unlicensed birth attendants) who have chosen not to associate in any way with physicians or the established medical care system.

The issue, therefore, is not whether the physician/midwife relationship should be addressed under a new statute, but rather in what terms should it be specified. As indicated in Chapter III, the nature of this relationship can span a variety of arrangements under which midwives are, to a greater or lesser degree, dependent on physician approval and oversight as a condition of their right to practice their profession. While the number and characteristics of the possible arrangements can be many and varied, several general models may serve as the basis for consideration of this important issue. In the direction of dependent to independent, these include requiring:

- direct supervision by physicians,
- indirect supervision,
- a written protocol signed by a physician indicating the midwife's routine scope of activities and circumstances under which referral or consultation is to take place,
- the examination of pregnant women by a physician before care is assumed by a midwife, and perhaps at regular intervals thereafter,
- a written plan submitted to the credentialing authority by the midwife describing his or her arrangements and policies with respect to referral and consultation, and
- the securing of physician services as the need arises according to the midwife's professional judgment.

In deciding how dependent or independent midwives should be in their association with physicians, two important considerations are the standards of education and the scope of practice. If midwives are well-trained to render the services they are authorized to perform, then greater independence would appear to be appropriate. The level of preparedness among midwives will be a function of the credibility of the credentialing process devised under a new statute and the existence of training programs that meet the requirements established under the law. If the scope of practice is to include all services relevant to the care of the normal pregnancy, then the need for close medical supervision does not seem warranted.

The main argument for requiring physician direction and oversight is that it will serve to guarantee the quality of care. If the basic competence of midwives is in doubt, or if their scope of practice excludes any critical aspects of care, then a strong role for physicians is desirable. However, if the quality of care can be assured through proper training, a

comprehensive scope of practice and diligent oversight by a credentialing authority, then the need for medical direction becomes less apparent.

Several examples may serve to illustrate these different perspectives. In Europe, where midwives are well-trained and are permitted a broad scope of practice, they are not legally bound to physicians and may act independently within their authority. It is expected that their training and professional code of conduct will guide their judgment as to when to seek physician consultation. Failure to exercise proper judgment is a matter that is dealt with by the official midwifery regulatory apparatus.

In contrast are the regulatory programs of Arizona and New Mexico. In these states, there are no recognized midwifery training programs and the scope of midwifery practices does not include a number of services considered basic to the practice of normal obstetrics (e.g., diagnostic testing, the use of medications). In Arizona, a midwife must show evidence that a client has been examined at least once during the last trimester of pregnancy by a physician or other practitioner operating under the supervision of a licensed physician. The midwife is further required to have formal arrangements--prior to each delivery--for back-up medical care for the mother and infant (see Appendix C, p. 119). Through the cooperation of the Arizona Perinatal Program and the Newborn Intensive Care Program, clinical services, consultation, transportation, and emergency services are available to midwives and can serve to satisfy these requirements.[80] In New Mexico, midwives may care for low risk patients determined by physician evaluation and examination to be prospectively normal for pregnancy and childbirth. In addition to the initial physician assessment, a medical evaluation is required between the thirty-sixth and fortieth weeks of pregnancy. Midwives must also make prior arrangements for hospitalization and obtain agreements for referral should either become necessary (see Appendix D, p. 137).

The requirements for physician input reflect concerns of public officials as to the general level of competence of midwives in these states at this time, as do the limitations on the scope of practice. These concerns are also illustrated, particularly in the case of New Mexico, by regulations which set out in great detail various aspects of care and the conditions that necessitate referral to physicians (see Appendix D, pp. 137-44).

Should the Washington legislature decide to make midwives dependent in some way on physicians, then the issue of physician cooperation is a relevant factor. That is, it would be the assumption of the legislature that the medical community would generally be willing to cooperate with midwives in the manner specified in the statute (or subsequent regulations). If physicians' participation was not forthcoming, midwives would be effectively barred from practice unless some alternative mechanism could be found to provide the necessary medical expertise. Arizona's use of the hospital-based perinatal care resources , mentioned earlier, is one example of such an alternative.

Since midwifery outside of nursing is somewhat controversial, the issue of physician cooperation may warrant careful consideration. In New Mexico, for example, the sole company providing malpractice insurance recently threatened to withhold coverage from physicians cooperating with the state's registered lay midwives. As a result, health authorities decided to adopt a flexible attitude with regard to the various regulatory requirements for physician contact.[81]

Chapter VIII

RELATED ISSUES

This chapter will contain a discussion of three issues that inevitably arise in any discussion of midwifery: the use of medications, third party reimbursement, and hospital admitting privileges.

Medications

Should the legislature, in defining the midwives' scope of practice, decide to permit the use of medications, the question will arise as to how midwives shall obtain them. Should they be obliged to secure the allowed medications through another practicioner, for example, under the prescription of a physician? Alternatively, should they be permitted to obtain the necessary drugs under their own authority, through prescriptive authority or some other mechanism?

The state may wish to define drug authority very narrowly, permitting midwives to use only those medications that are applicable to the labor and delivery processes in cases of normal or low risk pregnancy. This was essentially the proposal contained in the H.B.2713 which was heard during the 1980 legislative session. The bill would have given midwives the authority to use three categories of drugs: eye prophylaxis (presently a state requirement for all births), antihemorrhagics, and local anesthetics. Such authority is consistent with midwifery practices abroad and should serve to prevent unnecessary or inconvenient transport to hospital in cases involving minor hemorrhaging or for the repair of episiotomies or minor lacerations which may occur during birth.

Many believe that these drugs are basic tools of childbirth and should be available to midwives on their own authority. Others contend that all medications used by midwives ought to be obtained under the authority of another health professional, principally the physician. The rationale for this view is often stated in terms of general presumptions about safeguarding the quality of care, although these are not spelled out in any detail. The pharmacists, however, have a specific concern--prescriptive authority. Having dealt solely with physicians until recent years, pharmacists are understandably concerned about the growing numbers of practitioners being granted the right to prescribe drugs. These include physician's assistants, nurse-practitioners, and now--possibly--midwives. Pharmacists question the adequacy of the pharmacological preparation of these new practitioners and their professional relationships with these individuals. As a result of court cases in which pharmacists have been held liable for adverse drug reactions involving prescription drugs, they are concerned about questions of liability vis-a-vis new health practitioners.[82]

The three drugs mentioned above are widely used in modern obstetrical practice for the purposes indicated. The parameters governing their appropriate use are well understood. If midwives are granted the authority to use these substances and if the education and training requirements developed under a new statute provide adequate preparation in their use, a convincing rationale for making midwives dependent on physicians or other professionals does not become readily apparent. Further, given the medical community's general opposition to the practice of midwifery outside of nursing, physicians may not welcome being placed in a position of having to deal with midwives. If they refuse to do so, midwives will be deprived of a valuable tool. Mothers may be subject to unnecessary danger, inconvenience, and cost. Unpleasant legal challenges may arise, and the intent of the legislation may be generally undermined.

Should the legislature wish to grant midwives the authority to use these basic medications on their own authority, it can apparently be done without the granting of prescriptive rights. The critical factor is the difference between the "administering" and the "dispensing" of legend drugs.

Legend drugs, including those being discussed here, are those which state law requires "to be dispensed on prescription only."[83] Dispensing, according to state law, means "to deliver a legend drug to an ultimate user or research subject by or pursuant to the lawful order of a practitioner. . ."[84] This is what occurs at local pharmacies where patients purchase drugs on prescription for use at a later time.

"Administering" means "the direct application of a legend drug whether by injection, inhalation, ingestion, or any other means, to the body of a patient or research subject. . ." by a practitioner or a patient at the direction of a practitioner.[85] Prescriptive authority, therefore, is not necessary for a practitioner to be legally empowered to administer a legend drug. What would be necessary is statutory language that granted midwives the authority to "obtain and administer" a specified drug. In addition, midwives would have to be included in the definition of "practitioner" under the state's current drug laws.[86]

It would be appropriate for new legislation to refer to categories of drugs (for example, local anesthetics), leaving the precise listing of substances to be developed by the responsible credentialing authority through rule and regulation. This would eliminate the need for new legislation every time developments in the pharmaceutical field warranted an addition to or subtraction from the list.

In this manner midwives would be able to establish a direct purchasing relationship with pharmaceutical wholesalers and distributors as do physicians and other office-based practitioners who must have certain medications on hand on a day-to-day basis.

Because midwifery legislation would be unique, it might be useful to mention such purchasing arrangements in the statute itself, so as to avoid any confusion over how midwives are to obtain the medications used in their practice.

Depending on how broadly the legislature defines scope of practice, other drugs may be considered appropriate for use by midwives. For example, there are antibiotics commonly used in the treatment of minor gynecological conditions. There are also analgesics used for the relief of pain. Whether presriptive authority or medical direction (or both) is required depends largely on the nature of the drug and the circumstances under which it is used. In the case of antibiotics, prescriptive authority would probably be involved, since these drugs are not generally administered at the time of service. Prescriptive power would not be necessary in the case of analgesics (which are "administered"), although medical direction would be desirable. While midwifery's orientation toward the handling of pain usually emphasizes approaches other than the use of pharmaceuticals (e.g., exercise, breathing technique, emotional support), there are instances in which analgesics may be warranted. However, there seems to be widespread agreement among professionals that such cases should be handled in the hospital where medical consultation is readily available.

Health Insurance Coverage

The subject of health insurance coverage is relevant to the discussion of midwifery because of its heavy influences on the utilization of services and service providers.

The issue of coverage is not one that is really suitable for including in a basic practice act. However, as the state did in the case of registered nurses, chiropractors, and psychologists,[87] the state may wish to consider--separately--the possible extension of health insurance to the services for

midwives. Therefore, a brief overview of developments in the insurance industry is included.

In this state, the policy of insuring organizations toward reimbursement of licensed midwives seems to be directly related to the nature of its linkages with organized medicine. In general, the closer the linkages, the less favorable are the policies toward midwives.

At one end of the spectrum are the commercial insurance companies which have the least formal relationship with the medical profession. Like all parts of the insurance industry, the commercial groups are moving steadily toward the recognition of non-physician health practitioners. Policy language is being amended to include reimbursement for members of the "healing arts" professions. A number of commercial insurance companies in the state are currently paying for the services of licensed midwives. Others have taken no policy position--some because they have not had to deal with a claim from a licensed midwife and some who must rely for policy direction from company headquarters located in other states. In general, the commercial company representatives have expressed no basic reservations with respect to the practice of midwifery outside of nursing. Their key concern is that there be a formal licensing or credentialing process established by the state, including a specific statement of the scope of practice. As long as practitioners were duly credentialed and were acting within the scope of their authority, the commercial industry seems favorably inclined toward providing reimbursement.

There seems to be no strong objection to mandating benefits. The issue had little significance for those companies already paying for the services of licensed midwives. There is also consensus among companies that the coverage of midwifery services would provide a net savings to their clients. However, some insurance representatives suggested that any legislative directive mandate that companies "offer" midwifery coverage to their clients rather than impose such coverage without clients' consent.[88]

On the other end of the spectrum are the medical service bureaus (Blue Shield) which are closely tied to local medical societies. In formulating their reimbursement policies, they rely heavily on the prevailing opinions of the medical community and--in particular--the specialty groups. Since the obstetrician leadership has been opposed to the practice of midwives outside of nursing, it is unlikely that the service bureaus will choose to reimburse for the services of licensed midwives unless they are compelled to do so--either by law or by strong competitive pressures.[89]

Somewhere in between lies the Blue Cross organization. Because of increasing attention focused on midwifery in this state, Blue Cross has initiated an internal policy analysis process to clarify its position on the payment of midwives in general, nurse-midwives, and licensed midwives. It is expected that a position will be drawn up and presented to the Blue Cross governing body late in 1980.[90]

Public sector reimbursement practices are also relevant to the midwifery debate. State government, through its Medicaid program, is a major purchaser of maternity services. At present, Medicaid does not reimburse for the services of licensed midwives. Program officials have moved cautiously on the payment of new health practitioners. Their concerns are the standards of training, the provision for medical consultation and referral, and--in some instances--the costs of services. If the state's midwifery statute is revised, Medicaid's current policy toward midwives might be examined in light of the new law's potential for ensuring a high standard of care for public patients.[91]

Another development is a recent action by the State Employees Insurance Board. At its March meeting, the Board decided to include the services of licensed midwives as a covered benefit under its statewide uniform medical plan which is underwritten by Blue Cross. This plan is offered to all state employees as one of several benefit package options.[92]

A final item concerns the impact of federal legislation on the authority of a state to mandate benefits. At issue is the interpretation of Section 514 of the Employees Retirement Income Security Act of 1975 (ERISA) which deals with the federal and state role in the regulation of the insurance industry. Arguing that the mandating of benefits goes beyond the regulatory authority of the states as defined by ERISA, employer groups in several states have brought suit challenging state laws imposing new benefit coverage. The federal versus state role will ultimately be determined by the U.S. Supreme Court. As to midwifery, the relevant issue is whether requiring the reimbursement of practitioners providing a widely covered service (i.e., maternity care) is considered the mandating of a new benefit. On the surface, it would not appear so, but the answer is presently unclear.[93]

Hospital Privileges

Aside from the issue of whether midwives, other than nurse-midwives, will ever find employment opportunities in hospitals, there is the more sensitive subject of obstetrical admitting privileges for midwives practicing independently outside of hospitals. Many believe that--as in other countries--midwives should be permitted to arrange for the hospitalization of their clients when necessary and provide care within the institutions when appropriate. Some would like to see this authority mandated in legislation.

Under the regulations governing hospitals, the responsibility for ensuring the competence of patient care personnel (both employees and independent medical practitioners) is vested in the governing boards or boards of trustees. Hospital boards have delegated the task of granting admitting privileges to independent practitioners (until recently--only physicians) to the hospital medical staffs who are very protective of this privilege.

Hence, should any attempt to statutorily require hospitals to grant admitting privileges to midwives would probably run afoul of existing law, not to mention the strong opposition it would produce in the medical community. Should the legislature determine that independently practicing midwives should be able to hospitalize their clients when necessary, it would appear more appropriate for a new statute to declare that it is within the scope of a midwife's authority to practice in hospitals. This would allow agreements to be reached at the community level between individual practitioners and institutions.

Given the realities of professional and institutional policies and preferences, midwives are unlikely to secure obstetrical admitting privileges very easily. Indeed, nurse-midwives in independent practice have often had great difficulty in obtaining privileges.

The acceptance of non-nurse midwives by hospitals may increase, albeit very slowly, if psychological and informational barriers can be overcome. Much will depend on the attitudes and personalities of the individuals involved at the local level. Much will also depend on a statute which provides a clear definition of midwifery practice, a credible credentialing process, and acceptable standards of training. In Washington, examples of local accommodation can be found in the admitting privileges granted by the University Hospital (at the University of Washington) to a licensed midwife and a nurse-midwife providing home birth services and to several nurse-midwives based in freestanding birth centers.

Chapter IX

CONCLUSIONS

This report has attempted to analyze issues that have a direct bearing on the possible development of legislation to supplant the state's current midwifery statute enacted in 1917. Legislators' interest in a new midwifery law is the result of several factors. These include changing birth patterns, the appearance of candidates who have completed the requirements for licensure under present law, and the varied activities of midwifery advocates and supporters.

The controversy surrounding the recent movement toward a new midwifery practice act has little to do with the subject matter at hand. Indeed, midwifery--once a necessity for the poor and the isolated--is increasingly being viewed as a viable choice for the urban middle classes. The essence of the controversy lies in the fact that a new bill would give recognition and sanction to the practice of midwifery outside of nursing. To one degree or another, nurse-midwifery has been recognized in virtually every state. Most health care professionals believe that nursing education is essential to training of a competent midwife. However, there is good reason to believe that substantial numbers of people rendering midwifery services are not nurses nor members of other established professions. Yet few educational opportunities have been established for these individuals, and few states have attempted to regulate their practice so as to ensure a minimum level of competence necessary for the protection of the public.

That midwives can be trained to render a high standard of services without having first undergone basic nursing education seems clearly established by the experience of European countries.

In Europe, where both forms of practice are recognized, there has been no suggestion that the quality of services rendered by nurse-midwives is any greater than that provided by midwives trained independent of nursing (and vice versa). Moreover, the recommendations of international health professional groups have not called for nursing to be a prerequisite for midwifery practice. Instead there has been a general recognition that certain basic nursing skills are relevant to midwifery and ought to be included in the training of professional midwives. The decision of European countries to recognize nurse midwifery, independent midwifery, or both has had more to do with historical developments than with any observed differences in the caliber of services rendered by either group.

Therefore, the first major question to state policymakers--that is, can midwifery be safely practiced outside of nursing--seems to be answerable in the affirmative. This assumes, of course, adequate training and ready access to necessary back-up and support services, and general acceptance by the public and the health community. The second question--what to do with respect to the existing midwifery statute--is much more difficult to answer, since what is needed or desirable depends on how the problem is defined.

From the all-important perspective of public safety, no major problem is readily apparent. To date, the Department of Licensing seems to have acted cautiously and prudently in administering the current law. Furthermore, there has been no indication that midwives licensed under the present statute have jeopardized the health or wellbeing of those under their care. Finally, while there might be more legitimate concerns about the activities of unlicensed practitioners, the number of births involved is small.

The related questions of credibility and acceptance seem to be more of an issue. Within the professional community, some are wholly opposed to the idea of midwifery independent of nursing.

However, even among those who are inclined to be more tolerant of this concept, there are serious concerns about various aspects of the present law. Without widespread confidence and respect in the credentialing process, midwifery cannot flourish.

From yet another perspective, there is increasing discussion of the desirability of promoting more competitiveness and freedom of choice in the delivery of health services. Our medical care system has been criticized for being monopolistic and costly. In view of the experience with physician's assistants, nurse-practitioners (including nurse-midwives), and others, many urge that, where quality can be maintained, practices showing promise of greater patient satisfaction and lower cost should be encouraged. Perhaps this consideration is relevant to the debate over the current midwifery statute.

As in other complex areas of social policy, the legislature will have to decide on midwifery based on its best reading of the circumstances and mood in this state. This present investigation has not revealed compelling circumstances to indicate whether the state should move in a more restrictive or permissive direction on the practice of midwifery as distinct from nurse-midwifery. The state, therefore, may wish to consider allowing the present statutory authority to continue for a time in order to provide more information and perhaps greater insight as to the proper public stance toward midwifery. On the other hand, several years have already elapsed since this issue first attracted legislative attention. The discussion and events that have occurred during this period have highlighted a number of areas of general concern (e.g., professional participation, training standards), and so there may be ample grounds for prompt action.

Regardless of when the legislature decides to enact a new midwifery statute, a spectrum of choices will be available. At the minimum, the state may wish to do little more than legalize the practice of lay midwifery, subject to certain basic requirements. Conversely, state policymakers may wish to allow for the

practice of more highly trained professional midwives similar to those recognized in other countries. This would, of course, entail a higher level of training and practice standards.

Wherever the legislative consensus falls along this spectrum, several provisions would seem to be desirable in any new midwifery practice act. The first is a clear definition of the scope of midwifery practice. This can be embodied either in a statute or an administrative regulation, in which case the statutory language should indicate the direction of legislative intent. A second component would be the establishment of a credentialing body, representative of the professionals and the public, that could be relied upon to draw up a reasonable set of standards for the education and practice of midwives. In the absence of established patterns and standards of practice, the third element would be basic reporting requirements that would allow the state to monitor the development of midwifery practice, at least in the initial years of the new regulatory program. Lastly, consideration might be given to imposing certain minimal continued competence requirements that are directly relevant to the functions and responsibilities of midwives.

In the design and implementation of a new midwifery regulatory program, it is important that flexibility be allowed for and encouraged. Innovation emerges incrementally, and within the bounds of public safety decision-makers ought to be free to take advantage of gains already made as well as those that lie ahead.

Whatever approach the legislature decides to take with respect to the practice of midwifery outside of nursing, its first concern will be the welfare of the citizens of this state. Nevertheless, it should be recognized that the action taken in Washington will be of keen interest in other states where similar issues are continually being debated.

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APPENDIX A

Chapter 18.50
MIDWIFERY

Sections

18.50.010 Definitions——Gratuitous services——Duty to call physician.
18.50.020 License required.
18.50.030 Exemptions.
18.50.040 Application—— Eligibility requirements
18.50.050 Application——Examination fee.
18.50.060 Examination.
18.50.070 Recording license——Penalty for failure.
18.50.080 Recording——County clerk's duties.
18.50.100 Refusal and revocation of license——Grounds——Hearing.
18.50.120 Unlawful practice——Penalties.
18.50.130 "Certificate" and "license" synonymous.
18.50.900 Repeal and saving.

Reviser's note: "Director" and "director of licenses" have been substituted for "board", "board of medical examiners" and "secretary of the board" throughout this chapter, since the state board of medical examiners was abolished by 1921 c 7 § 135 and its powers and duties were transferred to the director of licenses by 1921 c 7 § 96 (RCW 43.24.020), which powers and duties subsequently devolved to the business and professional administration within the department of motor vehicles. See note following Title 18 RCW digest.

Abortion: Chapter 9.02 RCW.

Adoption of children through hospitals, doctors, midwives, etc.: RCW 26.36.040.

Crimes relating to pregnancy and childbirth: RCW 9A.32.060.

Filing certificate of birth: RCW 70.58.080.

Record as to patients or inmates for purposes of vital statistics: RCW 70.58.270.

18.50.010 Definitions——Gratuitous services——Duty to call physician. Any person shall be regarded as practicing midwifery within the meaning of this chapter who shall render medical aid to a woman in childbirth for a fee or compensation or who shall advertise as a midwife by signs, printed cards or otherwise. Nothing shall be construed in this chapter to prohibit gratuitous services. It shall be the duty of a midwife to always secure the immediate services of a legally qualified physician whenever any abnormal signs or symptoms appear either in the mother or the infant. [1917 c 160 § 8; RRS § 10181. Formerly RCW 18.50.010, 18.50.030, part, and 18.50.090.]

18.50.020 License required. Any person who shall practice midwifery in this state after July 1, 1917, shall first obtain from the director of licenses of the state of Washington a license so to do, and the said director is authorized to grant such license after examination of the applicant as hereinafter provided. [1917 c 160 § 1; RRS § 10174.]

18.50.030 Exemptions. This chapter shall not be construed to interfere in any way with the practice of religion, nor be held to apply to or regulate any kind of treatment by prayer. [1917 c 160 § 12; RRS § 10185. FORMER PART OF SECTION: 1917 c 160 § 8, part; RRS § 10181, part, now codified in RCW 18.50.010.]

Gratuitous services exempted: RCW 18.50.010.

18.50.040 Application——Eligibility requirements. Any person seeking to be examined shall present to the said director, at least ten days before the commencement of the said examination, a written application on a form or forms provided by the said director setting forth under affidavit the name, age, nativity, residence, moral character and time spent in obtaining a common school education or its equivalent; that the candidate has received a certificate or diploma from a legally incorporated school on midwifery in good standing, granted after at least two courses of instruction of at least seven months each in different calendar years or a certificate or diploma in a foreign institution on midwifery of equal requirements conferring the full right to practice midwifery in the country in which it was issued. The diploma must bear the seal of the institution from which the applicant was graduated. Foreign applicants must present with the application a translation of the foreign certificate or diploma made by and under the seal of the consulate of the country in which the said certificate or diploma was issued. The application must be endorsed by a duly registered reputable physician of the state of Washington. [1917 c 160 § 2; RRS § 10175.]

18.50.050 Application——Examination fee. If the application is approved and the candidate shall have deposited an examination fee determined by the director as provided in RCW 43.24.085 as now or hereafter amended with the director, the candidate shall be admitted to the examination, and in case of failure to pass the examination, may be reexamined at any regular examination within one year without the payment of an additional fee, said fee to be retained by the director after failure to pass the second examination. [1975 1st ex.s. c 30 § 51; 1917 c 160 § 3; RRS § 10176.]

18.50.060 Examination. The director of licenses is hereby authorized and empowered to execute the provisions of this chapter and shall hold examinations in midwifery on the first Monday in January and July, at such places as the director may select, from ten o'clock a.m. to five o'clock p.m., and at such other times as the said director may deem expedient. The examinations may be oral, written, or both, and shall be in the English language; if desired in any other language, an interpreter may be provided by said director upon notification of the director at least ten days before examination. The cost of said interpreter shall be defrayed by the applicant for the license.

Examinations shall be held on the following subjects:

(1) Anatomy of pelvis and female genital organs.
(2) Physiology of menstruation.
(3) Diagnosis and management of pregnancy.
(4) Diagnosis of foetal presentation and position.
(5) Mechanism and management of normal labor.
(6) Management of puerperium.
(7) Injuries to the genital organs following labor.
(8) Sepsis and antisepsis in relation to labor.
(9) Special care of the bed and lying-in room.
(10) Hygiene of mother and infant.
(11) Asphyxiation, convulsions, malformation and infectious diseases of the new-born.
(12) Causes and effects of ophthalmia neonatorum.
(13) Abnormal conditions requiring attention of a physician.
(14) Requirements of the vital statistics laws pertaining to the reporting of births and the rules of the state board of health relative to ophthalmia neonatorum or other infectious diseases of the newborn.

Said examination shall be sufficient to test the scientific and practical fitness of candidates to practice midwifery and the director may require examination on other subjects relating to midwifery from time to time. All application papers shall be deposited with the director and there retained for at least one year, when they may be destroyed.

If said examination is satisfactory, said director shall issue to such candidate a license entitling the candidate to practice midwifery in the state of Washington: *Provided*, That said license shall not authorize the holder to prescribe any drugs or medicine except some household remedy after the birth of the infant. [1917 c 160 § 4; RRS § 10177.]

Reviser's note: The last paragraph of 1917 c 160 § 4 reads: "If said examination is satisfactory, said board shall issue to such candidate a license with the certified copy signed by its president and secretary, and attested by its seal, entitling the candidate to practice midwifery in the state of Washington. *Provided*, That said license shall not authorize the holder to prescribe any drugs or medicine except some household remedy after the birth of the infant." This paragraph has been changed to refer to the "director of licenses" as the board of medical examiners was abolished and its powers and duties transferred to the director of licenses, which powers and duties subsequently devolved to the business and professional administration within the department of motor vehicles. See note following Title 18 RCW digest.

18.50.070 Recording license——Penalty for failure. Every person holding a license authorized in this chapter must have the same recorded in the office of the county clerk in the county in which the holder is practicing her profession, and the fact of such recording shall be endorsed on the certificate by the county clerk recording the same. Every such person, on a change of her residence, must have the license recorded in the county to which she shall have removed. The absence of such record shall be prima facie evidence of the want of possession of such certificate; and any person practicing midwifery in this state without first having filed her certificate with the county clerk as herein provided, shall be deemed guilty of a misdemeanor. [1917 c 160 § 5; RRS § 10178.]

18.50.080 Recording——County clerk's duties. The county clerk shall keep in a book provided for the purpose, a complete list of the certificates recorded by him, with the date of the record, and such book shall be open to public inspection during his office hours. [1917 c 160 § 6; RRS § 10179.]

18.50.100 Refusal and revocation of license——Grounds——Hearing. Said director may refuse to grant or may revoke any license herein provided for, for any of the following reasons: Persistent inebriety; the practice of criminal abortion; the commission of any crime involving moral turpitude; presentation of a certificate or diploma for registration or license illegally obtained; application for examination under fraudulent misrepresentation; neglect or refusal to make proper returns to the health officer or health department of births or of puerperal contagion or infectious diseases within the required limit of time; failure to record her license with the clerk of the county in which the licentiate resides or practices; failure to secure the attendance of a reputable physician in a case of miscarriage, hemorrhage, abnormal presentation or position, retained placenta, convulsions, prolapse of the cord, fever during parturient stage, inflammation or discharge from the eyes of a new-born infant, or whenever there are any abnormal or unhealthy symptoms in either the mother or the infant during labor or the puerperium.

In complaints of violations of the provisions of this section, the accused shall be furnished with a copy of the complaint and be given a hearing before said director in person or by attorney. Any midwife refused admittance to the examination or whose license has been revoked who shall attempt or continue the practice of midwifery, shall be subject to the penalties hereinafter prescribed. [1917 c 160 § 7; RRS § 10180. Formerly RCW 18.50-.100 and 18.50.110.]

Abortion: Chapter 9.02 RCW.

18.50.120 Unlawful practice——Penalties. Any person hereafter practicing midwifery in this state without first complying with the provisions of this chapter, shall be guilty of a misdemeanor and shall be punished by fine of not less than fifty dollars nor more than two hundred fifty dollars, or by imprisonment in the county jail for not less than ten days nor more than six months, or both, at the discretion of the court. [1917 c 160 § 9; RRS § 10182.]

18.50.130 "Certificate" and "license" synonymous. The words "certificate" and "license" shall be known as interchangeable terms in this chapter. [1917 c 160 § 11; RRS § 10184.]

18.50.900 Repeal and saving. All acts or parts of acts inconsistent with the provisions of this chapter may be and the same are hereby repealed: *Provided*, This chapter shall not repeal the provisions of the vital statistics laws of the state, but shall be deemed as additional and cumulative provisions. [1917 c 160 § 10.]

APPENDIX B

MIDWIFERY LEGISLATION
DECEMBER 1979

AN ACT Relating to midwifery; amending section 7, chapter 56, Laws of 1975-'76 2nd ex. sess. and RCW 7.70.020; amending section 8, chapter 160, Laws of 1917 and RCW 18.50.010; amending section 2, chapter 160, Laws of 1917 and RCW 18.50.040; amending section 4, chapter 160, Laws of 1917 as amended by section 43, chapter 158, Laws of 1979 and RCW 18.50.060; amending section 7, chapter 160, Laws of 1917 and RCW 18.50.100; amending section 21, chapter 266, Laws of 197[illegible] ex. sess. as last amended by section 100, chapter 158, Laws of 1979 and RCW 43.24.06[illegible]; adding new sections to chapter 18.50 RCW; repealing section 5, chapter 160, Laws of 1917 and RCW 18.50.070; repealing section 6, chapter 160, Laws of 1917 and RCW 18.50.080; and making an appropriation.

CB80B F H -2713 ;1 PARTA ;4

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Section 1. Section 7, chapter 56, Laws of 1975-'76 2nd ex. sess. and RCW 7.70.020 are each amended to read as follows:

As used in this chapter "health care provider" means either:

(1) A person licensed by this state to provide health care or related services, including, but not limited to, a physician, osteopathic physician, dentist, nurse, optometrist, podiatrist, chiropractor, physical therapist, psychologist, pharmacist, optician, physician's assistant, <u>midwife,</u> osteopathic physician's assistant, nurse practitioner, or physician's trained mobile intensive care paramedic, including, in the event such person is deceased, his estate or personal representative;

(2) An employee or agent of a person described in part (1) above, acting in the course and scope of his employment,

including, in the event such employee or agent is deceased, his estate or personal representative; or

(3) An entity, whether or not incorporated, facility, or institution employing one or more persons described in part (1) above, including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his employment, including in the event such officer, director, employee, or agent is deceased, his estate or personal representative.

NEW SECTION. Sec. 2. There is added to chapter 18.50 RCW a new section to read as follows:

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter:

(1) "Department" means the department of licensing.

(2) "Director" means the director of licensing.

(3) "Midwife" means a midwife licensed under this chapter.

NEW SECTION. Sec. 3. There is added to chapter 18.50 RCW a new section to read as follows:

The midwifery advisory committee is created.

The director shall appoint the members of the midwifery advisory committee. The committee shall be composed of one consumer, one midwife licensed under this chapter, one certified nurse midwife licensed under chapter 18.88 RCW, one physician licensed under either chapter 18.57 or 18.71 RCW, and one person who is active in health education. The members serve at the pleasure of the director but may not serve more than three consecutive years or more than five years in total. The terms of office shall be staggered. Members of the committee shall be reimbursed for travel expenses as provided in RCW 43.03.050 and 43.03.060 as now or hereafter amended.

NEW SECTION. Sec. 4. There is added to chapter 18.50 RCW a new section to read as follows:

The midwifery advisory committee shall advise and make recommendations to the director on issues including, but not

limited to, continuing education, mandatory reexamination, and peer review. The director shall transmit the recommendations to the social and health services committees of the senate and house of representatives on an annual basis.

Sec. 5. Section 8, chapter 160, Laws of 1917 and RCW 18.50.010 are each amended to read as follows:

Any person shall be regarded as practicing midwifery within the meaning of this chapter who shall render medical aid for a fee or compensation to a woman ((in-childbirth-for--a--fee or--compensation)) during prenatal, intrapartum, and postpartum stages or who shall advertise as a midwife by signs, printed cards, or otherwise. Nothing shall be construed in this chapter to prohibit gratuitous services. It shall be the duty of a midwife to always attempt to secure the immediate services of a legally qualified physician whenever any ((abnormal)) life-threatening signs or unhealthy symptoms appear either in the mother or the infant.

Sec. 6. Section 2, chapter 160, Laws of 1917 and RCW 18.50.040 are each amended to read as follows:

(1) Any person seeking to be examined shall present to the ((said)) director, at least ((ten)) forty-five days before the commencement of the ((said)) examination, a written application on a form or forms provided by the ((said)) director setting forth under affidavit ((the--name,--age,--nativity, residence,-moral-character-and-time-spent-in-obtaining-a--common school--education)) such information as the director may require and proof the applicant has received a high school degree or its equivalent; that the candidate has received a certificate or diploma from a ((legally--incorporated-school-on-midwifery-in good-standing,-granted-after-at-least-two-courses-of-instruction of-at-least-seven-months--each--in--different--calendar--years)) midwifery program accredited by the director and registered under chapter 28B.95 RCW, when applicable, or a certificate or diploma in a foreign institution on midwifery of equal requirements conferring the full right to practice midwifery in the country in which it was issued. The diploma must bear the

seal of the institution from which the applicant was graduated. Foreign applicants must present with the application a translation of the foreign certificate or diploma made by and under the seal of the consulate of the country in which the ((said)) certificate or diploma was issued. ((The--application must-be-endorsed-by-a-duly-registered-reputable-physician-of-the state-of-Washington;))

(2) The director shall promulgate standards under chapter 34.04 RCW for accrediting midwifery programs. The standards shall cover the provision of adequate clinical and didactic instruction in all subjects specified in RCW 18.50.060 and noncurriculum matters including, but not limited to, staffing and teacher qualifications. In developing the standards, the director shall be assisted by the midwifery advisory committee.

Sec. 7. Section 4, chapter 160, Laws of 1917 as amended by section 43, chapter 158, Laws of 1979 and RCW 18.50.060 are each amended to read as follows:

(1) The director of licensing is hereby authorized and empowered to execute the provisions of this chapter and shall ((hold)) offer examinations in midwifery ((on-the--first--Monday in--January--and-duly;)) at least twice a year at such times and places as the director may select((;-from-ten--o'clock--a.m.--to five--o'clock-p.m.;-and-at-such-other-times-as-the-said-director may--deem--expedient)). The examinations ((may)) shall be ((orals)) written((;--or--both;)) and shall be in the English language((;-if-desired-in-any-other-language;-an-interpreter-may be-provided-by-said-director-upon-notification-of--the--director at--least--ten--days--before--examination;---The--cost--of--said interpreter-shall-be-defrayed-by-the-applicant-for-the-license; Examinations-shall-be-held-on-the-following-subjects:

((1)--Anatomy-of-pelvis-and-female-genital-organs;

(2)--Physiology-of-menstruation;

(3)--Diagnosis-and-management-of-pregnancy;

(4)--Diagnosis-of-foetal-presentation-and-position;

(5)--Mechanism-and-management-of-normal-labor;

((6))--Management-of-puerperium; ((7))--Injuries-to-the-genital-organs-following-labor; ((8))--Sepsis-and-antisepsis-in-relation-to-labor; ((9))--Special-care-of-the-bed-and-lying-in-room; ((10))--Hygiene-of-mother-and-infant; ((11))---Asphyxiation;---convulsions;---malformation----and infectious-diseases-of-the-new-born; ((12))--Causes-and-effects-of-ophthalmia-neonatorum; ((13))---Abnormal---conditions--requiring--attention--of--a physician; ((14))---Requirements--of---the---vital---statistics---laws pertaining-to-the-reporting-of-births-and-the-rules-of-the-state board-- f--health--relative--to--ophthalmia--neonatorum-or-other infectious-diseases-of-the-newborn)).

((Said)) (2) The director, with the assistance of the midwifery advisory committee, shall develop a licensure examination in the subjects that the director determines are within the scope of and commensurate with the work performed by a licensed midwife. The examination shall be sufficient to test the scientific and practical fitness of candidates to practice midwifery ((and--the--director-may-require-examination-on-other subjects--relating--to--midwifery--from--time--to--time)). All application papers shall be deposited with the director and there retained for at least one year, when they may be destroyed.

(3) If ((said)) the examination is ((satisfactory)) satisfactorily completed, ((said)) the director shall issue to such candidate a license entitling the candidate to practice midwifery in the state of Washington((:---PROVIDED,--That--said license-shall-not-authorize-the-holder-to-prescribe-any-drugs-or medicine--except--some--household--remedy-after-the-birth-of-the infant)).

(4) No midwife licensed under this chapter may prescribe any drugs or medications: PROVIDED, That a licensed midwife is authorized to acquire and administer those drugs and medications necessary to protect the mother and infant. Those drugs and

medications shall be limited to:

(a) Eye prophylaxis;

(b) Anti-hemorrhagic; and

(c) Local anesthetics.

Sec. 8. Section 7, chapter 160, Laws of 1917 and RCW 18.50.100 are each amended to read as follows:

((Said)) The director may refuse to grant or may suspend or revoke any license ((herein-provided-for)), may reprimand or censure a license holder, or may place on probation subject to reasonable remedial conditions a license holder for any of the following reasons: Persistent inebriety; the practice of criminal abortion; the commission of any crime involving moral turpitude relevant to the practice of midwifery; presentation of a certificate or diploma for registration or license illegally obtained; application for examination under fraudulent misrepresentation; mishandling drugs authorized by this chapter; neglect or refusal to make proper returns to the ((health officer-or-health)) department of social and health services of births or of puerperal contagion or infectious diseases within the required limit of time; ((failure-to-record-her-license-with the-clerk-of-the-county--in--which--the--licentiate--resides--or practices;)) failure to attempt to secure the ((attendance)) services of a ((reputable)) physician in a case of ((miscarriage;--hemorrhage;--abnormal--presentation-or-position; retained-placenta;-convulsions;--prolapse--of--the--cord;--fever during-parturient-stage;-inflammation-or-discharge-from-the-eyes of--a--new-born-infant;-or-whenever-there-are)) any ((abnormal)) life-threatening or unhealthy symptoms in either the mother or the infant ((during-labor-or-the-puerperium)).

In complaints of violations of the provisions of this section, the accused shall be furnished with a copy of the complaint and be given a hearing before ((said-director-in person-or-by-attorney)) a hearing examiner, with right of appeal to the director. Any midwife refused admittance to the examination or whose license has been revoked who shall attempt or continue the practice of midwifery((;)) shall be subject to

the penalties hereinafter prescribed.

NEW SECTION. Sec. 9. There is added to chapter 18.50 RCW a new section to read as follows:

Registered nurses and nurse midwives certified by the board of nursing under chapter 18.88 RCW shall be exempt from the requirements and provisions of this chapter.

NEW SECTION. Sec. 10. There is added to chapter 18.50 RCW a new section to read as follows:

Nothing in this chapter shall be construed to apply to or interfere in any way with the practice of midwifery by a person who is enrolled in a program of midwifery approved and accredited by the director: PROVIDED, That the performance of such services is only pursuant to a regular course of instruction or assignment from the student's instructor, and that such services are performed only under the supervision and control of a person licensed in the state of Washington to perform services encompassed under this chapter.

NEW SECTION. Sec. 11. There is added to chapter 18.50 RCW a new section to read as follows:

The director, with the advice of the midwifery advisory committee, shall develop a form to be used by a midwife to inform the patient of the qualifications of a licensed midwife.

NEW SECTION. Sec. 12. There is added to chapter 18.50 RCW a new section to read as follows:

Every person licensed to practice midwifery shall register with the director of licensing annually and pay an annual renewal registration fee determined by the director as provided in RCW 43.24.085 as now or hereafter amended on or before the licensee's birth anniversary date. The license of the person shall be renewed for a period of one year. Any failure to register and pay the annual renewal registration fee shall render the license invalid. The license shall be reinstated upon written application to the director, payment to the state of a penalty fee determined by the director as provided in RCW 43.24.085 as now or hereafter amended, and payment to the state of all delinquent annual license renewal

fees.

NEW SECTION. Sec. 13. There is added to chapter 18.50 RCW a new section to read as follows:

Every licensed midwife shall develop a written plan for consultation with other health care providers, emergency transfer, transport of an infant to a newborn nursery or neonatal intensive care nursery, and transport of a woman to an appropriate obstetrical department or patient care area. The written plan shall be submitted annually together with the license renewal fee to the department.

NEW SECTION. Sec. 14. There is added to chapter 18.50 RCW a new section to read as follows:

The director shall promulgate rules under chapter 34.04 RCW as are necessary to carry out the purposes of this chapter.

Sec. 15. Section 21, chapter 266, Laws of 1971 ex. sess. as last amended by section 100, chapter 158, Laws of 1979 and RCW 43.24.085 are each amended to read as follows:

It shall be the policy of the state of Washington that the director of licensing shall from time to time establish the amount of all application fees, license fees, registration fees, examination fees, permit fees, renewal fees, and any other fee associated with licensing or registration of professions, occupations, or businesses, administered by the business and professions administration in the department of licensing. In fixing said fees the director shall, insofar as is practicable, fix the fees relating to each profession, occupation, or business in such a manner that the income from each will match the anticipated expenses to be incurred in the administration of the laws relating to each such profession, occupation, or business. All such fees shall be fixed by rule and regulation adopted by the director in accordance with the provisions of the administrative procedure act, chapter 34.04 RCW: PROVIDED, That

(1) In no event shall the license or registration renewal fee in the following cases be fixed at an amount less than five dollars or in excess of fifteen dollars:

Barber

Student barber

Cosmetologist (manager-operator)

Cosmetologist (operator)

Cosmetologist (instructor-operator)

Apprentice embalmers

Manicurist

Apprentice funeral directors

Registered nurse

Licensed practical nurse

Midwife

Charitable organization

Professional solicitor;

(2) In no event shall the license or registration renewal fee in the following cases be fixed at an amount less than ten dollars or in excess of twenty dollars:

Dental hygienist

Barber instructor

Barber manager instructor

Psychologist

Embalmer

Funeral director

Sanitarian

Veterinarian

Cosmetology shop

Barber shop

Proprietary school agent

Specialized and advance registered nurse

Physician's assistant

Osteopathic physician's assistant;

(3) In no event shall the license or registration renewal fee in the following cases be fixed at an amount less than fifteen dollars or in excess of thirty-five dollars:

Architect

Dentist

Engineer

Land Surveyor

Podiatrist

Chiropractor

Drugless therapeutic

Osteopathic physician

Osteopathic physician and surgeon

Physical therapist

Physician and surgeon

Optometrist

Dispensing optician

Landscape architect

Nursing home administrator

Hearing aid fitter;

(4) In no event shall the license or registration renewal fee in the following cases be fixed at an amount less than fifty dollars or in excess of two hundred dollars:

Engineer corporation

Engineer partnership

Cosmetology school

Barber school

Debt adjuster agency

Debt adjuster branch office

Debt adjuster

Proprietary school

Employment agency

Employment agency branch office

Collection agency

Collection agency branch office

Professional fund raiser.

NEW SECTION. Sec. 16. There is appropriated to the department of licensing from the state general fund for the biennium ending June 30, 1981, the sum of sixty-five thousand dollars or so much as may be necessary to carry out the purposes of this 1980 act.

NEW SECTION. Sec. 17. The following acts or parts of acts are each hereby repealed:

(1) Section 5, chapter 160, Laws of 1917 and RCW

18.50.070; and

(2) Section 6, chapter 160, Laws of 1917 and RCW 18.50.080.

APPENDIX C

STATE OF ARIZONA

DEPARTMENT OF HEALTH SERVICES

ARTICLE 2. LICENSING OF MIDWIFERY

R9-16-200. Reserved

R9-16-201. Minimum qualifications

An application for a license to practice midwifery shall submit:

1. An application on a form prescribed by the Department;
2. Evidence satisfactory to the Director of the Department of Health Services showing successful completion of a course of instruction meeting the requirements of R9-16-203;
3. The initial license fee prescribed by A.R.S.§36-754;
4. A request to undertake the next available qualifying examination to be administered by the Department.

Historical Note

Former Section R-9-16-201 repealed, new Section R9-16-201 adopted eff. Jan. 23, 1978 (Supp. 78-1).

R9-16-202. Renewal application

An applicant for renewal of a license to practice midwifery shall submit a renewal application on a form prescribed by the Department.

Historical Note

Former Section R9-16-202 repealed, new Section R9-16-202 adopted eff. Jan. 23, 1978 (Supp. 78-1).

R9-16-203. Course of instruction

A. Each applicant for an initial midwife license shall show evidence of having completed a course of instruction with a standard curriculum containing:

1. Information regarding the laws and Regulations concerning midwifery in Arizona;

2. Basic course in aseptic techniques, basic observational skills, recognition and management of emergency situations, and special requirements of home delivery;

3. Clinical courses covering the knowledge and skills necessary for:

a. Provision of care during the antepartum, intrapartum, postpartum and newborn periods, and

b. Management of birth and the immediate care of the mother and newborn infant;

4. Observation of a minimum of ten (10) births;

5. Delivery of a minimum of fifteen (15) women, under direct supervision by a licensed physician, licensed midwife or certified nurse-midwife, and verified by a written statement from the supervisor that competence has been demonstrated.

B. The program of study shall assure that course content includes the requisite knowledge and skills needed to recognize those conditions listed in R9-16-205.

Historical Note

Former Section R9-16-203 repealed, new Section R9-16-203 adopted eff. Jan. 23, 1978 (Supp. 78-1).

R9-16-204. Qualifying examination

Prior to receiving a license to practice midwifery, each applicant shall pass a qualifying examination administered at least twice a year by the Department which will consist of three parts:

1. A written examination designed to test knowledge of the subjects required in the course of instruction;

2. An oral examination designed to test clinical judgment in midwifery case management;

3. A practical examination designed to demonstrate the mastery of skills necessary for practice in midwifery, meeting the requirements of R9-16-203.

Historical Note

Former Section R9-16-204 repealed, new Section R9-16-204 adopted eff. Jan. 23, 1978 (Supp. 78-1).

R9-16-205. Responsibilities of the midwife

A. The midwife shall encourage all clients requesting her services to seek regular prenatal care, and shall require that they show evidence that they have been examined at least once during the last trimester of pregnancy by a licensed physician or other practitioner operating under the supervision of a licensed physician. Such examination shall include laboratory tests to determine the following:

1. Blood type, Rh group, and Rh titers if indicated;
2. Results of a serologic test for syphilis;
3. Hemoglobin or hematocrit level;
4. Results of a urinalysis for protein and sugar.

B. The midwife shall visit the prospective birth place at least once before the expected delivery date to make sure conditions are adequate for delivery and to prepare the family.

C. The midwife shall have formal arrangements prior to each delivery for backup medical care for the mother and infant. The midwife shall call a physician and/or transfer the mother and/or infant to a hospital whenever any of the conditions listed below are present:

1. Maternal conditions:

a. Abnormal vaginal bleeding before, during or after delivery;
b. Edema of the face and hands;
c. Excessive vomiting;
d. Persistent headache;
e. Visual disturbances such as blurring or dimness of vision;
f. Blood pressure elevated over 140 mm Hg systolic and/or 90 mm Hg diastolic, or an increase of 30 mm Hg systolic and/or 15 mm Hg diastolic during labor;
g. Blood pressure that falls below 90 mm Hg systolic and/or pulse rate that increases to 120 or above during or after labor;
h. A fetal heart rate that is below 100 or above 160 beats per minute between or during contractions, or a fetal heart rate that is irregular;
i. Meconium stained amniotic fluid;
j. Elevation in temperature over 100°F or 37.8°C, orally;
k. Unengaged head in primigravida or in multipara in labor;
l. Presenting part other than vertex;
m. Ruptured membrances of more than 24 hours;
n. Prolonged labor using established criteria;
o. Multiple gestation;
p. Retained placenta over 1 hour, earlier if bleeding occurs;
q. Retained placental fragments or membranes;
r. Persistent uterine atony;
s. Vaginal or perineal laceration;

t. Excessive pain or discomfort during or after labor;
u. Shortness of breath;
v. Seizures;
w. Wishes of the client.
2. Conditions of the infant:
a. Weight less than 2,500 g or 5½ pounds;
b. Congenital anomalies;
c. Apgar score less than 7 at 5 minutes;
d. Respiratory distress;
e. Irregular heartbeat;
f. Signs of immaturity, prematurity, or postmaturity on physical assessment;
g. Jaundice;
h. Abnormal cry;
i. Pale, cyanotic or gray color;
j. Excessive edema.

3. Any other abnormal condition not listed above that might endanger the woman or infant.

D. At the time of delivery the midwife shall:

1. Place two drops of 1 percent silver nitrate solution into each of the infant's eyes (or in lieu of silver nitrate, any other preparation specifically approved by the Director) in accordance with R9-6-115;

2. Inspect the umbilical cord for the appropriate number of vessels and record on the birth record;

3. Inspect the placenta and membranes to note their completeness;

4. Inspect the perineum for laceration.

E. The midwife shall observe both mother and infant for a minimum of two (2) hours following birth.

F. The midwife shall file a birth certificate with the local Registrar within ten (10) days after birth.

G. The midwife shall reevaluate the condition of the mother and infant between 36 and 72 hours of delivery to determine whether physician consultation is required.

H. All equipment used in the practice of midwifery shall be maintained in an aseptically-clean manner and in working order.

I. The midwife shall maintain records of each patient attended and make them available for audit and review as requested by the Director or his staff.

Historical Note

Former Section R9-16-205 repealed, new Section R9-16-205 adopted eff. Jan. 23, 1978 (Supp. 78-1).

R9-16-206. Reports

A. Each licensed midwife shall submit quarterly, to the Department of Health Services a summary report of each case on forms supplied by the Department. The report shall contain information concerning the pregnancy listed in "Responsibilities of the midwife" (R9-16-205).

B. Failure to submit quarterly reports on a timely basis shall constitute grounds to deny renewal of a license.

Historical Note

Former Section R9-16-206 repealed, new Section R9-16-206 adopted eff. Jan. 23, 1978 (Supp. 78-1).

R9-16-207. Prohibitions or limitations to the practice of midwifery

A. Prohibitions: The midwife shall not knowingly accept responsibility for births in which there are the following conditions:

1. History of third trimester bleeding;
2. Preaclampsia, eclampsia;
3. Persistent hemoglobin level below 10 g during the third trimester or at the time of delivery;
4. Multiple gestation;
5. Abnormal presentation or lie;
6. Client under 15 years of age;
7. Previous Cesarean section, or other known uterine surgery such as hysterotomy or myomectomy;
8. Rh negative with positive titers, or if titers are not available;
9. Syphilis or gonorrhea;
10. Active infectious diseases, i.e. tuberculosis, hepatitis, or genital herpes;
11. Severe psychiatric disorders;
12. Any systemic conditions which are generally recognized as having the potential for creating problems at delivery;
13. Suspected or diagnosed congenital anomaly that may require immediate medical intervention;
14. Contracted pelvis;
15. Current narcotic addiction;
16. Suspected prematurity, immaturity or postmaturity.

B. Limitations: The midwife shall not knowingly attend any childbirth where the following conditions exist except under the supervision of a licensed physician:

1. Women between 15 and 18 years of age, and over 35 years of age;
2. Parity greater than 4;
3. History of severe postpartum hemorrhage;
4. History of stillbirth or neonatal death;

5. History of birth injury to either mother or previous child;
6. History of difficult delivery and/or depressed baby at birth.

C. The midwife will not perform any operative procedures other than that of clamping and severing the umbilical cord.

D. The midwife will not use any artificial, forcible or mechanical means to assist birth, nor may the midwife attempt to correct fetal presentations by external or internal version.

E. Except as provided in R9-6-205.D.1. the midwife will not administer any drugs, medications or herbs.

Historical Note

Former Section R9-16-207 repealed, new Section R9-16-207 adopted eff. Jan. 23, 1978 (Supp. 78-1).

APPENDIX D

STATE OF NEW MEXICO
HEALTH AND ENVIRONMENT DEPARTMENT
POST OFFICE BOX 968
SANTA FE, NEW MEXICO 87503

REGULATIONS GOVERNING THE PRACTICE OF LAY MIDWIFERY

FILE CATEGORY:
REGULATION NO.: HED-80-3A (HSD)
ORIGINATOR: Health Services Division

STATUTORY AUTHORITY: The statutory authority for these regulations is contained in Section 9-7-6 and Section 24-1-3(R) NMSA 1978 and Section 61-6-16(C) NMSA 1978. Enforcement is provided by Section 24-1-21 NMSA 1978.

REASONS FOR ADOPTION:

(1) These regulations are an amended version of the similarly-named Regulations numbered HED-80-3(HSD), filed with the State Records Center on February 5, 1980.

(2) The changes made in this amendment are non-substantive, and there is no public interest that would require a further hearing. Therefore, they are adopted without a public hearing.

GEORGE S. GOLDSTEIN, Ph.D., Secretary
Health and Environment Department
Post Office Box 968
Santa Fe, New Mexico 87503

Health and Environment Department
Health Services Division
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HED-80-3A(HSD)

REGULATIONS GOVERNING THE PRACTICE OF LAY MIDWIFERY

General Provisions

100. LEGAL BASIS: The regulations set forth herein are promulgated by the Secretary of Health and Environment by authority of 9-7-6(F) NMSA 1978 and 24-1-3(R) NMSA 1978. Administration and enforcement of these regulations is the responsibility of the Health Services Division of the Health and Environment Department. Enforcement is provided by 24-1-21 NMSA 1978.

101. PURPOSE: These regulations establish policies, standards and criteria relating to registration, practice and continuing education of persons who practice lay midwifery. These regulations do not apply to any licensed medical or osteopathic physician or certified nurse midwife.

102. GUIDELINES: In the absence of specific direction in these regulations as to standards of practice or ethics, the Standards of Care of the American College of Obstetricians and Gynecologists and procedures and policies of the Health and Environment Department and Health Services Division are established as guidelines.

103. OTHER LAW AND REGULATIONS: These regulations are subject to the provisions of the Health and Environment Department's Regulations Governing Promulgation of Regulations and Regulations Governing Public Access to Department Records. In addition, department regulations on related subjects include: registration of nurse midwives; prevention of infant blindness; newborn screening for phenylketonuria and other congenital malfunctions; registration of births, deaths and fetal deaths, and control of diseases and conditions of public health significance. Copies of regulations may be obtained by writing to the Health Services Division, Post Office Box 968, Santa Fe, New Mexico 87503. Appeal of an adverse decision of the Division shall be in accordance with the Uniform Licensing Act, 61-1-1 thru 61-1-28 NMSA 1978.

104. DEFINITIONS: As used in these regulations, the following terms shall have the meaning given to them, except where the context clearly requires otherwise:

104.01. "Apprentice permit" means a permit issued by the Division to authorize a person desiring to become a lay midwife and pursuing the required course of study to obtain clinical experience under supervision of a physician, certified nurse midwife or registered lay midwife.

104.02. "Certified nurse midwife" means a graduate nurse licensed to practice in this state who has been certified by the American College of Nurse-Midwives and registered with the Division pursuant to the provisions of the Department's Nurse-Midwife Regulations.

104.03. "Contact hour" means a unit of measurement to describe 50-60 minutes of an approved, organized learning experience or two hours of planned and supervised clinical practice which is designed to meet professional educational objectives.

104.04. "Continuing education" means participation in an organized learning experience under responsible sponsorship, capable direction and qualified instruction and approved by the Division for the purpose of meeting requirements for renewal of registration under these regulations.

104.05. "Division" means the Health Services Division of the Health and Environment Department.

104.06. "Lay Midwifery" means the provision of health care services in pregnancy and childbirth by a person not a licensed physician or a certified nurse-midwife.

104.07. "Physician" means a person licensed to practice medicine or osteopathy in this state.

104.08. "Registered lay midwife" means a person who is currently registered and in good standing on the registry of lay midwives maintained by the Division.

104.09. "Registration" means a document issued by the Division identifying a legal privilege and authorization to practice within the scope of these regulations. Registration under these regulations is not transferable.

104.10. "Registration year" means the period from December 31 of any year through December 30 of the following year; initial registration may be issued at any time but shall expire on the following December 30; apprentice permits may expire at any time but no later than the following December 30.

104.11. "Supervision" means the coordination, direction and continued evaluation at first hand of the person in training or engaged in obtaining clinical experience or engaged in direct delivery of lay midwifery services within the scope of these regulations.

APPLICABILITY

200. LIMITATION: Lay midwifery in New Mexico is limited in scope to practice as outlined in these regulations.

201. SCOPE: The lay midwife may provide care to low risk patients determined by physician evaluation and examination to be prospectively normal for pregnancy and childbirth. Such care includes:

201.01. prenatal supervision and counseling;

201.02. preparation for childbirth;

201.03. supervision and care during labor and delivery and care of the mother and the newborn in the immediate postpartum period, so long as progress meets criteria generally accepted as normal.

202. REQUIREMENT OF REGISTRATION: From and after July 1, 1980 no person shall hold him/herself out as a lay midwife or offer, for compensation or otherwise, any services which constitute lay midwifery unless currently registered as a lay midwife under these regulations, or holding a provisional or apprentice permit issued by the Division. Violation of this provision is subject to prosecution or civil action as may be provided by law.

REGISTRATION OF LAY MIDWIVES

300. TYPES OF PERMITS AND FEES: Upon application, meeting requirements and payment of fees, a person subject to these regulations may be issued an apprentice permit, a provisional registration permit, or a regular registration permit, as applicable, in accordance with these regulations. Permits shall be issued without fee through December 31, 1980; thereafter fees, new or renewal, shall be submitted in accordance with the fee schedule prescribed in Section 400. hereof.

301. APPRENTICE PERMIT: An apprentice permit may be issued to any person for a period not to exceed one year and may be renewed once only for an additional one-year period. Education and clinical experience required for regular registration may be obtained during the apprentice period.

302. PROVISIONAL REGISTRATION PERMIT: Upon application a provisional registration permit may be issued to:

302.01. Any person who under former regulations of the Division is currently permitted to engage in lay midwife practice under the supervision of the District Health Officer, or,

302.02. Any person who presents satisfactory evidence of education, training and experience; such person shall submit:

302.02.01. Evidence of completion of at least a four year high school course of study or equivalent as determined by the Department;

302.02.02. Evidence of satisfactory completion of required clinical experience cited in Section 600.

302.02.03. Evidence of satisfactory completion of a Health Services Division approved course in prenatal nutrition (may be completed during provisional registration period);

302.02.04. Evidence of satisfactory completion of a course in prepared childbirth applicable to the home birth setting (may be completed during provisional registration period);

302.02.05. Current physician's statement certifying absence of communicable disease;

302.02.06. Satisfactory reference from a physician, certified nurse midwife or midwifery instructor;

302.02.07. Fee as prescribed by the Division.

302.03. A provisional permit may be issued for a period not to exceed one year and may be renewed once only for an additional one-year period.

302.04. The requirements of section 600 hereof may be met during the provisional registration period.

303. REGISTRATION UNDER REGULAR PERMIT: Upon meeting the requirements of Section 600, a person holding an apprentice or provisional permit may apply for regular registration as a lay midwife and shall submit:

303.01. An application to sit the next qualifying examination;

303.02. Evidence of completion of at least a four year high school course of study or equivalent as determined by the Department;

303.03. Evidence of satisfactory completion of a course in theory of pregnancy and childbirth;

303.04. Evidence of satisfactory completion of required clinical experience;

303.05. Evidence of satisfactory completion of an HSD approved course in prenatal nutrition;

303.06. Evidence of satisfactory completion of a course in prepared childbirth applicable to the home birth setting;

303.07. Evidence of satisfactory completion of a certified course in cardiopulmonary resuscitation of the adult and newborn;

303.08. Current physician's statement certifying absence of communicable disease;

303.09. Four recommendations (one each from a physician or certified nurse midwife, a midwifery instructor, a consumer and a member of the community); and

303.10. Fee as prescribed by the Division.

304. FOREIGN EXPERIENCE: Applicants for registration as a lay midwife who lack the required clinical experience in New Mexico, but who have equivalent experience from another jurisdiction, may apply to sit the qualifying examination after submitting evidence of experience and of all other requirements. Action of the Division on the request may be appealed under the provisions of the Uniform Licensing Act.

305. LIMITATION: Registration as a lay midwife in New Mexico is not to be construed as valid in any other jurisdiction.

306. EXAMINATION REQUIRED: Registration as a lay midwife in New Mexico is by examination only; there is no reciprocity with other jurisdictions.

307. RENEWAL OF REGISTRATION: Every lay midwife registration must be renewed annually. An applicant for renewal of registration shall submit to the Department:

307.01. A renewal application on the form prescribed by the Department;

307.02. Evidence of completion of eight contact hours of continuing education as required by Section 604; and

307.03. Renewal fee as prescribed by the Division.

308. GRACE PERIOD: Delinquency in renewal of registration of 6 months or greater shall result in termination of registration.

309. INACTIVE LIST: Any person registered as a lay midwife in New Mexico who moves from the state may retain registration by fulfilling the requirements previously described. Absence from the State of New Mexico for longer than 10 years shall result in termination of registration.

310. RECERTIFICATION: Any person previously registered as a lay midwife in the State of New Mexico whose registration has been terminated may be recertified as a registered lay midwife by:

310.01. Submitting evidence of eight contact hours of continuing education annually;

310.02. Submitting evidence of being current in practice in another jurisdiction;

310.03. Applying for a lay midwife apprentice permit in order to obtain clinical experience to become current in practice as determined by the Department;

310.04. Sitting any or all portion(s) of the qualifying examination as required by the Department; and

310.05. Submitting renewal fee as prescribed by the Division.

400. FEES: From and after January 1, 1981, all applications for apprentice permit or provisional or regular registration must be accompanied by a money order payable to the Division in the amount of fifty dollars ($50.00). Such fee provides for initial registration for the registration year, or part thereof, remaining. If the application is deemed insufficient, the fee will be returned.

400.01. Fee for annual renewal of provisional and regular registration shall be $25.00 a year.

400.02. Examination fee shall be $25.00 and is not included in registration fee.

500. REVOCATION OF REGISTRATION: The Division may refuse to issue, suspend for a definite period, or revoke a registration for any of the following causes:

500.01. Dereliction of any duty imposed by law;

500.02. Incompetence;

500.03. Conviction of a felony;

500.04. Practicing while suffering from a contagious or infectious disease;

500.05. Practicing under a false name or alias;

500.06. Violation of any of the standards of practice set forth in Sections 800 and 805;

500.07. Obtaining any fee by fraud or misrepresentation;

500.08. Knowingly employing directly or indirectly any suspended unregistered person or persons not holding an apprentice permit to perform any work covered by these regulations;

500.09. Using or causing or promoting the use of any advertising matter, promotional literature, testimonial, or any other representation however disseminated or published, which is misleading or untruthful.

500.10. Representing that the service or advice of a person licensed to practice medicine will be used or made available when that is not true, or using the words "doctor," "clinic" or similar words, abbreviations or symbols so as to connote the medical profession when such is not the case;

500.11. Permitting another to use his registration;

500.12. Directly or indirectly giving or offer to give, or permitting, or causing to be given money or anything of value to any person who advises another in a professional capacity as an inducement to influence him or have him influence others to use the services of the registration or permit holder, or to influence persons to refrain from seeking services elsewhere; or

500.13. Violating any of the provisions of these regulations.

EDUCATION

600. COURSE OF STUDY: The Division shall, on the advice of the Lay Midwifery Advisory Board, periodically maintain and periodically revise a list of approved courses, texts, and trainers covering at least the following subject matters. The Division may use the list as a guideline in determining the acceptability of a non-listed educational source which an applicant submits as complying with any educational experience requirement. A course of study in theory of pregnancy and childbirth must include the following:

In each category applicant shall cite approved training source or indicate reasons why source should be approved.

		Provisional Requirements	Regular Requirements
600.01.	Basic aseptic techniques	Required by both the registration levels	
600.02.	Basic Observation skills	Required by both the registration levels	
600.03.	Basic prenatal nutrition	May be done during provisional registration period	Required at application
600.04.	Basic parent education for prepared childbirth	May be done during provisional registration period	Required at application
600.05.	Provision of care during the antepartum, intrapartum, postpartum and newborn periods	Required by both the registration levels	
600.06.	Management of birth and immediate care of the mother and the newborn Identify source of Education	Required by both the registration levels	
600.07.	Recognition of early signs of possible abnormalities Identify source of Education	Required by both the registration levels	
600.08.	Recognition and management of emergency situations	Required by both the registration levels	

		Provisional Requirements	Regular Requirements
600.09.	Special Requirements of home delivery	May be done during provisional registration period	Required at application
600.10.	Information regarding the laws and regulations relating to the practice of midwifery in New Mexico	Required by both the registration levels	

601. LIMITATION: The course of study must not include the independent, medically unsupervised use of any drugs in the antepartum, intrapartum, postpartum or newborn periods except for prophylactic treatment of the eyes; and the course must not contain any training in any surgical procedures other than the procedure for repair of a first or second degree laceration.

602. CLINICAL EXPERIENCE: Clinical experience in lay midwifery may be obtained in any setting (i.e., office, clinic, hospital, maternity center, home). Clinical experience must include at least the following types and numbers of experiences:

		Provisional Requirements	Regular Requirements
602.01.	Prenatal visits at least 15 different women	60	100
602.02.	Labor observations (at least 10 must be before first delivery; all deliveries may be included in this number	20	40
602.03.	Delivery of newborn and placenta	10	20
602.04.	Newborn examinations	10	30

		Provisional Requirements	Regular Requirements
602.05.	Postpartum home visits (within 36 hours of delivery	10	30
602.06.	ECMC Department of Pediatrics NICU and Nursery (8 hours minimum). Other acceptable observations entities will be considered	May be done during registration period	Required at application
602.07.	ECMC Department of Obstetrics and Gynecology High Risk perinatal Unit observation entities will be considered	May done during registration period	Required at application
602.08.	Observation of one complete series of prepared childbirth classes	May be done during registration period	1-6 hour class series preferred
602.09.	Observation of one complete La Leche League series	May be done during registration period	1 series of 4 meetings

602.10 Five experiences in each of categories 602.01, 02, 03 and 04 must be with an approved physician or certified midwife trainer. Required at application.

603. SUPERVISION OF CLINICAL EXPERIENCE: Clinical experience may be obtained under the supervision of a physician, certified nurse-midwife or registered lay midwife. This must be direct, present in the same room supervision. Those providing supervision must be approved by the Division for training and should have had previous experience with home birth. Postpartum home visit supervision may be provided by an HSD public health nurse.

604. CONTINUING EDUCATION: Continuing education is required for annual renewal of registration.

604.01. In each calendar year, eight contact hours of continuing education must be obtained. One hour each of management of antepartum, intrapartum, and newborn periods and one hour of recognition and management of emergency situations must be obtained: other hours may cover any topics applicable to midwifery practice.

604.02. Continuing education may be obtained through convention, conferences, area midwives meetings or other mechanism as approved by the Division.

604.03. In any calendar year the Department may require specific topics for continuing education based upon any problem areas indicated by registered lay midwives' semi-annual reports.

700. REQUIREMENTS OF EXAMINATION: Any person applying for regular registration, as a lay midwife must pass a qualifying examination administered under the auspices of the Department. The Department shall offer the examination at least twice a year.

701. FIELDS TESTED: The examination shall consist of three parts:

701.01. A written examination designed to test knowledge in theory regarding pregnancy and childbirth;

701.02. An oral examination designed to test clinical judgment in lay midwifery case management; and

701.03. A practical examination designed to demonstrate the mastery of skills necessary for the practice of lay midwifery.

702. SCOPE OF WRITTEN EXAMINATION: The written examination shall cover:

702.01. Theory regarding pregnancy and childbirth including but not limited to:

702.01.01. Anatomy and physiology of the female reproductive system, in both pregnant and non-pregnant states;

702.01.02. Normal growth and development of fetus and placenta;

702.01.03. Normal progress of pregnancy, labor and delivery;

702.01.04. Comfort measures in the antepartum, intrapartum and postpartum periods;

702.01.05. Significance of laboratory studies in pregnancy and the neonatal period; and

702.01.06. Prenatal nutrition.

702.02. Patient teaching;

702.03. Special requirements of home delivery;

702.04. Risk factors in pregnancy;

702.05. Terminology used in the practice of lay midwifery;

702.06. Normal newborn characteristics and possible problems including anomalies;

702.07. Care of the newborn; and

702.08. Pertinent legislation and regulations for lay midwifery in New Mexico.

703. SCOPE OF ORAL EXAMINATION: The oral examination shall cover:

703.01. Evaluation of judgment to cover areas of:

703.01.01. Early recognition of abnormalities in the antepartum, intrapartum, postpartum and neonatal periods: their significance and possible sequelae if untreated

703.01.02. Recognition and treatment of emergency situations

703.01.03. Course and management of normal labor and selected normal antepartum situations (nutritional counseling, patient teaching, dealing with normal discomforts).

704. SCOPE OF PRACTICAL EXAMINATION: The practical examination shall cover basic observational skills:

704.01. Temperature, pulse, and respiration

704.02. Blood pressure

704.03. Fetal heart tones

704.04. Abdominal palpation

704.05. Cervical dilatation

704.06. Fetal position

704.07. Measurement of fundal height

704.08. Exam for edema

DUTIES AND RESPONSIBILITIES

800. COVERAGE: The registered lay midwife must assure that all women she plans to deliver receive required tests.

801. MEDICAL EVALUATION: The lay midwife must require the patient to have a risk evaluation and physical examination by a physician before a registered lay midwife assumes her care.

802. REQUIRED TESTS: Initial physician examination shall include clinical pelvimetry and the following laboratory tests — VDRL, GC screen, blood type and group, hematocrit and hemoglobin, rubella titer and urinalysis. Hematocrit must be rechecked at 28 and 36 weeks gestation.

803. PRENATAL VISITS: Prenatal vists should be every 4 weeks until 28 weeks gestatation, every 2 weeks from 28 until 35 weeks gestation and weekly from 36 weeks until delivery.

804. PHYSICIAN VISITS: Each woman must also have one prenatal visit with a physician at 36 to 40 weeks.

805. RECORDS: The lay midwife shall maintain records of physician's visit with evidence of his/her exam for the Division.

806. ADVANCE PREPARATION FOR NEED: The registered lay midwife, prior to the onset of labor, must have:

806.01. Arrangements made for transport of mother and/or infant to a hospital; and

806.02. Agreement for medical referral and/or hospitalization of mother and/or infant, if it should become necessary.

807. INFORMED CONSENT: The registered lay midwife must inform any woman seeking home birth of possible risks of home birth and must obtain informed consent of the woman for home birth prior to the onset of labor on a form provided by the Department.

808. COMMUNITY RESOURCES: The registered lay midwife must be familiar with community resources for pregnant women such as prenatal classes, WIC program, La Leche League and HSD clinics.

809. LATE PREGNANCY PERIOD: The registered lay midwife will make a home visit no more than 4 weeks prior to the EDC to assess the physical environment, to ascertain that the woman has all necessary supplies to prepare the family for the birth and to instruct the family to correct problems or deficiencies.

810. NORMAL DELIVERY: The registered lay midwife must remain with the mother and infant for at least two hours postpartum, or until the mother's fundus is firm and lochia normal, the mother has voided and the infant has a normal temperature and is nursing well, whichever is longer.

811. HOSPITALIZATION: The registered lay midwife must accompany to the hospital any mother or infant requiring hospitalization, giving any pertinent written records and a verbal report to the physician assuming care. If possible, she should remain with the mother and/or infant to ascertain outcome.

812. PHYSICIAN EVALUATION OF NEWBORN: The registered lay midwife must recommend that any infant delivered at home be evaluated by a physician within 3 days of age, or sooner when it becomes apparent that the newborn needs medical attention.

813. POSTPARTUM VISITS: The registered lay midwife shall make postpartum home visits to evaluate the condition of mother and infant at least twice - once within 36 hours of birth and once on the fourth or fifth postpartum day. Additional visits shall be made as indicated.

814. RH BLOOD FACTOR: In the case of an unsensitized Rh negative mother, the registered lay midwife shall:

814.01. Obtain a sample of cord blood from the placenta and deliver it to a laboratory within 24 hours of the birth.

814.02. Be certain that the mother consults a physician within 24 hours.

815. PREVENTION OF INFANT BLINDNESS: Within one hour of birth, the registered lay midwife shall administer two drops of 1% solution of silver nitrate or other antiseptic of equal potency and harmlessness into the eyes of the infant in accordance with the Health and Environment Department's Regulations Governing the Prevention of Infant Blindness.

816. BIRTH REGISTRATION: The registered lay midwife must complete a birth certificate and file it with the local registrar within ten days of the birth.

817. SANITATION: The registered lay midwife shall maintain all equipment used in the practice of midwifery in an aseptically clean manner and in working order.

818. RECORDS: The registered lay midwife shall maintain records of each patient on forms approved by the Department. Inactive records shall be maintained no less than ten years.

819. ANTEPARTUM: The registered lay midwife shall refer for medical evaluation and/or care any woman who during the antepartum period:

819.01. Develops a blood pressure of 140/90 or an increase of 30 mm Hg systolic or 15 mm Hg diastolic over her normal blood pressure.

819.02. Develops edema of the face and hands.

819.03. Develops severe, persistent headaches, epigastric pain or visual disturbances.

819.04. Does not gain 14 pounds by 30 weeks gestation or at least 4 pounds a month in the last trimester or gains more than 6 pounds in two weeks in any trimester.

819.05. Develops glucosuria or proteinuria.

819.06. Has symptoms of vaginitis.

819.07. Has symptoms of urinary tract infection.

819.08. Has vaginal bleeding before onset of labor.

819.09. Has premature rupture of membranes.

819.10. Noted decrease in or cessation of fetal movement.

819.11. Has inappropriate gestational size.

819.12. Has demonstrated anemia by blood test (hematocrit less than 30%).

819.13. Has a fever of 100.4 degrees F. or 38 degrees C for 24 hours.

819.14. Has effacement and/or dilatation of the cervix prior to 36 weeks gestation.

819.15. Has polyhydramnios or oligohydramnios.

819.16. Has excessive vomiting or continued vomiting after 24 weeks gestation.

819.17. Is found to be Rh negative.

819.18. Has severe, protruding varicose veins of extremities or vulva.

819.19. Is 36 years of age or older.

820. INTRAPARTUM: The registered lay midwife shall refer for medical evaluation and/or care any woman who during the intrapartum period:

820.01. Develops a blood pressure of 140/90 or an increase of 30 mm Hg systolic or 15 mm Hg diastolic over her normal blood pressure.

820.02. Develops severe headache, epigastric pain or visual disturbance.

820.03. Develops proteinuria.

820.04. Develops a fever over 100.4 degrees F or 38 degrees C.

820.05. Develops respiratory distress.

820.06. Has fetal heart tones below 100 or above 160 beats per minute between or during contractions, or a fetal heart rate that is irregular.

820.07. Has ruptured membranes without onset of labor after 12 hours.

820.08. Has bleeding prior to delivery.

820.09. Has meconium stained amniotic fluid.

820.10. Has a presenting part other than a vertex.

820.11. Does not progress in effacement, dilatation or station after 2 hours in active labor (or 1 hour if distance to hospital is greater than 60 miles).

820.12. Does not show continued progress to delivery after 2 hours of second stage labor (or 1 hour if distance to hospital is greater than 60 miles).

820.13. Does not deliver the placenta within 2 hours if there is no bleeding and the fundus is firm (or 1 hour if distance to hospital is greater than 60 miles).

820.14. Has a partially separated placenta with bleeding or has a blood pressure below 100 systolic or a pulse rate over 100 beats per minute or is weak or dizzy.

820.15. Bleeds more than 500 cc (2 cups) with or after the delivery of the placenta.

820.16. Has retained placental fragments or membranes.

820.17. Desires medical consultation or transfer.

821. POSTPARTUM: The registered lay midwife shall refer for medical evaluation and/or care any woman who during the postpartum period:

821.01. Has a second, third or fourth degree laceration.

821.02. Has uterine atony.

821.03. Bleeds in an amount greater than normal lochial flow.

821.04. Does not void within 6 hours of birth.

821.05. Develops a fever greater than 100^{4}°F. 38°C on any 2 of the first 10 days postpartum excluding the first 24 hours.

821.06. Develops foul smelling lochia.

822. NEWBORN PROBLEMS: The registered lay midwife will refer for medical evaluation and/or care any infant who:

822.01. Has an Apgar score of 7 or less at 5 minutes.

822.02. Has any obvious anomaly.

822.03. Develops grunting respirations, retractions or cyanosis.

822.04. Has cardiac irregularities

822.05. Has a pale, cyanotic or grey color.

822.06. Has an abnormal cry.

822.07. Weighs less than 5 1/2 pounds or 2500 grams or weighs more than 9 pounds or 4100 grams.

822.08. Shows signs of prematurity, dysmaturity or postmaturity.

822.09. Has meconium staining.

822.10. Does not urinate or pass meconium in the first 12 hours after birth.

822.11. Is lethargic or does not nurse well.

822.12. Has edema.

822.13. Appears weak or flaccid, has abnormal feces or appears not to be normal in any other respect.

PROHIBITION AND LIMITATION IN THE PRACTICE OF LAY MIDWIFERY

900. UNAPPROVED PRACTICE: The registered lay midwife shall not knowingly accept responsibility for the prenatal or intrapartum care of a woman who:

900.01. Has had a previous Cesarean section or other known uterine surgery such as hysterotomy or myomectomy.

900.02. Has a history of difficult to control hemorrhage with previous deliveries.

900.03. Has a history of low birth weight infants (2500 grams or less), stillbirths or neonatal deaths.

900.04. Has a history of birth injury to mother or infant in any previous delivery.

900.05. Has a history of third trimester bleeding.

900.06. Has a history of thrombophlebitis or pulmonary embolism.

900.07. Has diabetes, hypertension, Rh disease with positive titer, active tuberculosis, active syphilis, active gonorrhea, epilepsy, hepatitis, heart disease or kidney disease.

900.08. Has genital herpes simplex in the first trimester or in the last four weeks of pregnancy.

900.09. Has a contracted pelvis.

900.10. Has severe psychiatric illness or a history of psychiatric illness in the 6 month period prior to pregnancy.

900.11. Is addicted to narcotics or other drugs.

900.12. Ingests more than 2 ounces of alcohol or 2 beers a day on a regular basis or participates in binge drinking.

900.13. Has a multiple gestation.

900.14. Has a fetus of less than 37 weeks gestation at the onset of labor.

900.15. Has a gestation beyond 42 weeks by dates.

900.16. Has a fetus in any presentation other than vertex at the onset of labor.

900.17. Is a primigravida with an unengaged fetal head at the onset of labor, or any woman who has rupture of membranes with unengaged fetal head, with or without labor.

900.18. Has a fetus with suspected or diagnosed congenital anomalies that may require immediate medical intervention.

900.19. Has pre-eclampsia.

900.20. Has a parity greater than 5.

900.21. Is 17 years of age or younger.

900.22. Smokes 20 cigarettes or more, per day, and is not likely to cease in pregnancy.

901. EXAMINATION IN LABOR: The registered lay midwife will not perform any vaginal examinations on a woman with ruptured membranes and no labor, other than an initial examination to be certain there is no prolapsed cord. Once active labor is assuredly in progress, exams may be made as necessary.

902. OPERATIVE PROCEDURES: The registered lay midwife will not perform any operative procedure other than: clamping and cutting the umblical cord; repair of a first or second degree laceration.

903. MEDICATIONS: The registered lay midwife will not administer any drugs, medications or herbs except when specifically ordered to do so by a physician and when administering medication in accordance with Regulations Governing the Prevention of Infant Blindness.

904. ARTIFICIAL MEANS: The registered lay midwife will not use any artificial, forcible or mechanical means to assist the birth.

905. CORRECTION OF PRESENTATION: The registered lay midwife will not attempt to correct fetal presentations by external or internal version.

SUPERVISION BY DIVISION

1000. ADVISORY GROUP: The Division shall appoint a Lay Midwifery Advisory Group which will assist in the development, practice and problems of lay midwifery, assist Division staff in the development of examinations (written and oral). The Lay Midwifery Advisory Group will be composed of five (5) members:

1000.01. One physician who must be active in perinatal care;

1000.02. One certified nurse midwife;

1000.03. Two regularly registered lay midwives;

1000.04. One member at large.

The Lay Midwifery Advisory Group will meet at least biennially to evaluate practice of lay midwifery as reflected in the semi-annual reports during the time that the program is becoming established.

1001. QUARTERLY REPORTS: The registered lay midwife shall submit quarterly to the Health Services Division, Health and Environment Department, a summary report in a form prescribed by the Division. This report must be submitted within 30 days of the end of the quarterly period. Individually identifying information shall not be required.

1002. MORTALITY: IMMEDIATE REPORTING: The registered lay midwife must report within 48 hours to the Health Services Division any fetal, neonatal or maternal mortality in patients she has cared for or any major morbidity as outlined in the section Prohibitions and Limitations of Practice.

1003. FORMS SUPPLIED: The Department will send to each registered lay midwife an ample supply of quarterly reports one month prior to the beginning of each three month period. The Division will also furnish any other forms required.

1004. STATISTICS: The Department will compile annual lay midwifery statistics and make them available to registered lay midwives and other interested groups or persons.

1005. PREVENTION OF INFANT BLINDNESS: The Department will provide necessary supplies for prophylactic treatment of infant eyes as required by these regulations.

1006. These regulations supersede the Regulations Governing the Practice of Midwifery adopted by the State Board of Public Health, May 4, 1944, and the previous version of the same Regulations, No. HED-80-3 (HSD) filed on February 5, 1980.

RULES AND REGULATIONS

FOR

LICENSING OF MIDWIVES

State of Rhode Island and Providence Plantations

Department of Health

March 1978

APPENDIX E

INTRODUCTION

These rules and regulations are promulgated pursuant to the authority conferred under sections 23-13-9 and 23-1-1 of the General Laws of Rhode Island of 1956, as amended, and are established for the purpose of defining the minimal standards for the licensure of midwives and the practice of midwifery.

Compliance with these rules and regulations in no way conveys assurance of the quality of care but rather provides the basic capabilities for adequate performance.

900.0 DEFINITIONS

Wherever used in these regulations, the following terms shall be construed as follows:

900.1 "Midwifery" shall mean the practice of performing the service of a midwife or the practice of attending women in childbirth for hire.

900.2 "Midwife" shall mean a person who has successfully completed an Approved Educational Program in Midwifery and is licensed to practice midwifery in Rhode Island.

900.3 "Director" shall mean the Director, Rhode Island Department of Health.

900.4 "Council" shall mean the Advisory Council on Midwifery as established by the Rules and Regulations herein.

900.5 "Approved Educational Program in Midwifery" shall mean an academic and practical program of midwifery approved by the American College of Nurse-Midwives or an equivalent program approved by the Director of Health.

900.6 "Physician" shall mean an individual licensed under the provisions of Chapters 5-36 and 5-37 of the General Laws of Rhode Island 1956, as amended, to practice medicine or osteopathy with current obstetrical privileges in a licensed hospital.

901.0 LICENSE REQUIREMENT

901.1 Any person practicing or offering to practice midwifery shall be required to submit evidence that such person is qualified to practice and shall be licensed as herein provided, in order to safeguard the life and health of the people. It shall be unlawful for any person to practice or to offer to practice midwifery in this state or to use any title, abbreviation, sign, card or device to indicate that such a person is practicing midwifery unless such person has been duly licensed as a midwife in accordance with section 23-13-9 of the General Laws of Rhode Island 1956, as amended, and the Rules and Regulations herein.

902.0 ADVISORY COUNCIL ON MIDWIFERY

902.1 Within the Division of Professional Regulation in the Department of Health, there shall be established an Advisory Council on Midwifery which shall meet at least once a year, and consist of five (5) members; two (2) physicians; two (2) midwives, one of whom shall be a nurse-midwife; and one (1) consumer.

902.2 Members of the Council shall be appointed by the Director of Health: two (2) to serve for one (1) year; two (2) to serve for two (2) years; and one (1) to serve for three (3) years. The first two midwives appointed shall be considered to have met the requirements for licensure pending actual fulfillment of the requirements herein.

902.3 Successors to members of the Council whose term expires shall be appointed in such year by the Director to hold office for three (3) years or until their respective successors are appointed.

902.4 The Director may remove any member of the Council for neglect of duty or incompetency and may fill vacancies which occur for any purpose for the remainder of the unexpired term.

903.0 FUNCTIONS OF ADVISORY COUNCIL

903.1 The Council shall serve in an advisory capacity to the Director in matters pertaining to the licensing of midwives and the practice of midwifery. The Council shall advise the Director on such matters as policies affecting examination, qualifications, issuance and renewal, denial or revocation of licenses, and the development of rules and regulations.

904.0 ADMINISTRATION

904.1 The Administrator of Professional Regulation shall be responsible for the administrative functions required to implement the provisions of sections 23-13-9 and 23-1-1 of the General Laws of Rhode Island 1956, as amended, and the Rules and Regulations herein including such duties as: maintaining a register of all licensed midwives; maintaining all records pertaining to the licensing of midwives; conducting examinations as required; staffing the Council; and discharging such other duties as may be warranted.

905.0 QUALIFICATIONS OF MIDWIVES

905.1 Applicants for a license to practice as midwives in Rhode Island shall submit evidence that said applicants are of good moral character, are in satisfactory physical and mental health, and have been graduated from an Approved Educational Program in Midwifery.

906.0 LICENSING OF MIDWIVES

906.1 BY EXAMINATION:

Applicants shall be required to pass written and/or oral examinations in such subjects as determined by the Council and approved by the Director. Upon successfully passing such examinations, applications shall be eligible for licensure.

906.1.1 The Council, in concert with the Administrator of Professional Regulation, with the approval of the Director of Health, shall determine the type, scope, subjects and form of licensing examinations and shall determine the minimal passing score of each examination administered, which shall be the same for all candidates.

906.1.2 Examinations shall be given at least twice a year at such time and place as designated by the Administrator of Professional Regulation.

906.1.3 All applications and supporting credentials as required in section 905.1 herein shall be filed with the Administrator of Professional Regulation at least thirty (30) days prior to the date of the examination for which the application is filed.

906.1.4 Confidential identification numbers shall be assigned to each candidate by the Administrator of Professional Regulation and the names shall not be made known to the Council until the scores have been recorded.

906.2 WITHOUT EXAMINATION:

A license to practice midwifery may be issued without examination to an applicant who has been duly licensed by examination as a midwife under the laws of another state or territory, if, in the opinion of the Council, the applicant meets the qualifications required of a licensed midwife in this state.

906.3 FOREIGN TRAINED MIDWIVES:

All midwives prepared in a midwifery program outside the United States of America shall submit evidence of having graduated from a midwifery program and of holding a license in midwifery from a given foreign country and in addition shall be required to have completed a supplementary refresher course in the United States approved by the Director of Health and shall furthermore be required to satisfactorily pass an examination for licensure in this state in accordance with section 906.1 herein.

906.4 RE-EXAMINATION:

In case of failure of any applicant to satisfactorily pass an examination such applicant shall be entitled to a second examination. In the event of a second failure, opportunity for re-examination(s) shall be subject to the applicant's completion of additional requirements as recommended by the Council.

907.0 RENEWAL OF LICENSE

907.1 On or before the first day of August of every second year commencing in 1979, the Administrator of Professional Regulation shall mail an application for renewal of license to every midwife to whom a license has been issued or renewed for the period ending 1 September 1979 and for each two (2) year period thereafter. Every person so licensed who intends to engage in the practice of midwifery during each ensuing two (2) years shall apply for a license by application to the Administrator of Professional Regulation.

907.1.1 Such renewal application shall include documentary evidence satisfactory to the Council of practice as a licensed midwife within the past two (2) years including the performance and/or supervision of deliveries; or documentary evidence of completion within the past two (2) years of a refresher course or its equivalent, satisfactory to the Council and approved by the Director.

907.2 Upon receipt of the application and accompanying documentation required herein, the accuracy of the application shall be verified and the Director may grant a license renewal effective 1 September and expiring the thirty-first day of August in the odd numbered year following the issuance of such license and shall render the holder to be a legal practitioner of midwifery for the period stated on the license renewal unless sooner revoked.

907.3 Any licensee who allows his or her license to lapse by failing to renew the license by the appropriate date may be reinstated upon submission of an application with the accompanying data as required herein and as approved by the Director.

907.4 Any person practicing midwifery after lapse of licensure shall be considered an illegal practitioner and subject to the penalties of the provisions of section 23-13-9 of the General Laws of Rhode Island 1956, as amended.

907.5 Persons possessing valid licenses as of the effective date of these Rules and Regulations shall continue to be licensed subject to the relicensure provisions herein.

908.0 PRACTICE OF MIDWIFERY

908.1 The license to practice midwifery authorizes the holder to attend cases of normal childbirth, to provide prenatal, intrapartum and postpartum care, including the immediate care of the newborn, in continual collaboration with a physician and in accordance with acceptable standards or practice.

908.1.1 All complications shall be referred to the physician immediately.

908.1.2 No midwife shall attend at childbirth unless transportation is immediately available for the transfer of the mother or newborn to a hospital.

908.2 Licensed midwives shall conform to all state laws pertaining to the conduct of childbirth and management of the newborn, including the provisions of: sections 23-13-4, Ophthalmia Neonatorum; 23-13-12, "Phenylketonuria"; and 23-3-10, "Birth Registration" of the General Laws of Rhode Island 1956, as amended.

909.0 RECORDS AND REPORTS

909.1 A medical record for each mother and newborn shall be maintained which shall include documentation of all care rendered.

909.2 All medical records shall be retained for a period of five (5) years in accordance with the provisions of section 23-3-26 of the General Laws of Rhode Island 1956, as amended, except in the case of minors (17 years of age and under) which medical records shall be kept at least five (5) years after such minor has reached the age of eighteen (18) years.

910.0 DENIAL AND REVOCATION OF LICENSE

910.1 The Director is authorized to deny or revoke the license of any midwife who: (1) is found guilty of fraud or deceit in procuring or attempting to procure a license to practice midwifery; (2) is unfit or imcompetent by reason of negligence, habits or other cause; (3) is guilty of unprofessional conduct; (4) is mentally incompetent; (5) is habitually intemperate in the use of alcohol or is addicted to drugs; (6) has aided, abetted or permitted any illegal act or conduct adverse to health, welfare and safety of mothers and infants; (7) has willfully and repeatedly violated state laws; (8) has failed to report to a physician the occurrence of complications during pregnancy, labor or the immediate postpartum period and (9) has failed to comply with the Rules and Regulations herein.

910.1.1 Complaints charging a person with violation of any rule herein or state law, shall be maintained on file by the Administrator of Professional Regulation and shall be considered in rendering determination to deny or revoke the license of a midwife.

910.2 Upon receipt of a complaint charging a person with violations of the provisions of section 23-13-9 of the General Laws of Rhode Island 1956, as amended and the Rules and Regulations herein, an investigation of the charges shall be initiated by the Administrator of Professional Regulation or the Director, thence referred to the Council for recommendation to the Director for appropriate action.

910.3 Whenever an action shall be proposed to deny or revoke the license, the Administrator of Professional Regulation shall notify the person by certified mail setting forth the reasons for the proposed action and the applicant or licensee shall be given an opportunity for a prompt and fair hearing in accordance with the provisions of Chapter 42-35 of the General Laws of Rhode Island 1956, as amended.

910.4 Furthermore, when it appears to the Director after due process that a person is violating any provisions of section 23-13-9 of the General Laws of Rhode Island 1956, as amended, or any of the Rules and Regulations herein, the Director may initiate an action in accordance with the provisions of such statute.

911.0 SEVERABILITY

911.1 If any provision of these rules and regulations or the application thereof to any person or circumstances shall be held invalid, such invalidity shall not affect the provisions or application of the rules and regulations which can be given effect, and to this end the provisions of the rules and regulations are declared to be severable.

The foregoing Rules and Regulations after due notice and opportunity for hearing are hereby adopted and filed with the Secretary of State this 6th day of March 1978, to become effective twenty (20) days thereafter, in accordance with the provisions of sections 23-13-9 and 23-1-1, and Chapter 42-35 of the General Laws of Rhode Island, 1956, as amended.

Joseph E. Cannon, M.D.
Director of Health

Notice given on: 1/9/78

Hearing held: 1/31/78

Filed: 3/6/78

(Robert F. Burns)
Secretary of State

Attest: A true copy

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PLANNED HOME CHILDBIRTHS:

PARENTAL PERSPECTIVES

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PLANNED HOME CHILDBIRTHS:

PARENTAL PERSPECTIVES

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Being pregnant with you was one of the most beautiful and weird experiences I have had, and to bring it to a climax in a hospital, drugged and intimidated and frightened and at the mercy of the medical profession was too much for me to handle. That's why I decided to have you at home....

A mother's letter to her infant

Anne Gardon
Research Assistant

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Preface

During a series of Fall 1979 meetings, the Maternal and Child Health Nursing Consultants of the Michigan Department of Public Health identified a trend toward increasing home deliveries as an area for public health concern. It was from those meetings that this study was conceived.

Initially, only a small, informal survey was conducted. With the help of local public health nurses, a brief questionnaire was administered to women who had delivered at home in 1975. The responses were thought provoking in light of the advances made in the obstetrical field. As a result, the need was demonstrated for an expanded, systematic study. This was undertaken in 1977 and is presented in this text.

This study of planned home births benefited from the encouragement and assistance of many individuals to whom we wish to express our gratitude. From the Michigan Department of Public Health, R. Gerald Rice, M.D., Chief, Bureau of Personal Health Services and Jeffrey R. Taylor, Ph.D., Chief, Division of Maternal and Infant Health, supported this project by their professional counsel. Also of the Michigan Department of Public Health, Sheila Ward, R.N., Chief,

Maternal and Child Health Nursing, was instrumental in identifying home births as a relevant focus of concern. Her continued interest, critical suggestions and provocative questions encouraged us to expand the brief, informal study to a more comprehensive project.

We are also grateful to Professor Murray Wylie, M.D., Department of Health Planning and Administration of the School of Public Health, University of Michigan, and to J. Robert Willson, M.D., Department of Obstetrics and Gynecology, University of Michigan Medical School, for their thoughtful comments in reviewing this manuscript.

Anne Gardon provided the research assistance to this project. Her efforts in developing the codebook, in the coding itself, in writing an annotated bibliography and in assisting in the analysis of the data and the preparation of this manuscript were invaluable. Her critical insight and keen perception provided a real challenge and made working with her a professional and personal delight.

From the Michigan Department of Public Health, George Van Amburg, Chief, Office of Vital and Health Statistics, and Janet Eyster, Chief of Technical Services, supported the project from its inception. In addition, Statistician Dennis Dodson provided considerable assistance in sampling and data management. His prompt response to innumerable requests for computer printouts greatly facilitated this project.

Our field interviewer, Jane McNamara Ronk, was untiring in her efforts to contact and locate respondents. We are very appreciative of her perseverance in conducting the interviews. Additionally, the public health nurses who participated in the preliminary study contributed significantly to the initial effort.

Throughout the study period we have been fortunate to have the expert secretarial assistance of several people but especially of Mary Jane Belsito. We are grateful for her efforts in preparing numerous drafts during the completion of the manuscript.

Finally, we wish to acknowledge and thank the many families who were interviewed and whose responses are the basis of this survey.

PLANNED HOME CHILDBIRTHS:

PARENTAL PERSPECTIVES

INTRODUCTION

Most births in the United States occur in a hospital, but this has not always been the case. In 1935, only about 40% of all deliveries took place in a hospital; by 1978 the rate had increased to over 99%. This substantial growth in the number of hospital deliveries has been the result of a determined effort on the part of health care professionals. Their conviction that a hospital is the safest place to deliver is shared widely by the American public. The increase in hospital deliveries has been paralleled by a decline in maternal and infant mortality due, at least in part, to the supervision by health care professionals and the increasingly sophisticated obstetrical technology which characterizes the hospital.

In spite of the strong preference for a hospital, a small yet increasing number of women are electing to deliver their babies at home. The National Center for Health Statistics (1978) reports a recent substantial increase in the number of home deliveries. In Michigan the percentage of out-of-hospital births has increased from 0.21% of all births in 1970 to 0.41% of all births in 1976 (see Appendix A). Similar increases are reported for other states. This small yet important trend has been interpreted as a growing preference for home confine-

ment as distinct from an increase in the number of emergency home births. The movement has been met with surprise and concern by most health professionals. When one considers the extensive efforts of the preceding decades to make hospital facilities available to every pregnant woman, their concern is understandable. This present study of planned home births was undertaken in an effort to understand the preference of families for home births. Before presenting the survey results, the current thinking on home births is briefly reviewed.

The American College of Obstetricians and Gynecologists (ACOG) has been outspoken in its criticism of the home birth movement and has adopted the policy that

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

ACOG has been so concerned over the increasing interest in home births that it asked all state health departments to collect statistics about the number of home births and deaths associated with out-of-hospital deliveries. In its analysis of the information received, ACOG argued that mortality rates associated with home deliveries are several times higher than for hospital births.

A study of home births in North Carolina (Burnett, et. al., 1977), which included a control group of hospital deliveries, concluded tentatively that home delivery for some women is associated with increased risk. The neonatal mortality rate** for home births in the study was computed to be 35 per thousand, while that for hospital deliveries was 5 per thousand. Emery (1973) reports several mortality measures for California, all indicating high rates for home births. Neonatal mortality for 1973, for example, was 10.2 per thousand for the state and 17.8 for out-of-hospital births.

---

* "Statement on Home Deliveries." American College of Obstetricians and Gynecologists statement of policy as issued by the executive board in May 1975 and reaffirmed in 1976.

** Neonatal mortality rate is the number of deaths during the first 28 days of life per 1,000 live births.

In order to interpret these statistics accurately, it is necessary to examine what is being measured. While it is essential to assess the risks associated with home delivery, it is equally important that the risks measured are those associated with planned, as distinct from unplanned, home deliveries. We need to know whether home deliveries that occur out of choice are more dangerous than those that occur in a hospital. The subject of emergency out-of-hospital births and the undoubtedly high risk associated with them is a separate concern.

Unfortunately, statistical analyses based on birth certificates cannot differentiate between elective and unplanned home births. Birth certificate information distinguishes between hospital and out-of-hospital births and, within the latter category, between births that occur in the home of the mother and births that occur in other locations outside of a hospital. But there is no category on the certificate that states whether the out-of-hospital location was or was not planned. Statements by ACOG and findings by Burnett, et. al. (1977) that infant mortality rates* for home births are higher than those for hospital deliveries are based on birth certificate information and, therefore, do not measure the risks associated with planned home births. They are a combined measure of the hazards of planned and unplanned home confinements. Given the lack of distinction between planned and emergency home births, comparisons of home and hospital births based on birth certificate information are likely to yield misleading findings about the risks associated with planned home births. One would expect emergency out-of-hospital births to be more dangerous than planned ones, causing the combined measure of neonatal mortality to be high. For example, an analysis of the mortality statistics of home births indicates that low birth weight and prematurity are common. These are more likely to be associated with emergency home births than with those that are planned. In order to distinguish the mortality rates specifically associated with planned home births, data other than those obtained from birth certificates are required.

In a study of home births using the medical records of five home birth services in Northern California, Mehl, et al. (1976,

* Infant mortality rate is the number of deaths in the first year of life per 1,000 live births.

p. 8) calculated a perinatal mortality rate* of 9.5 per thousand for the study population which compared favorably with the rate of 20.3 per thousand for California as a whole. These figures include information on women who began labor with the intention of delivering at home but who had to be transferred to the hospital because of complications. This is an important point, for a complete examination of planned home births should include all women who enter labor with the intention of delivering at home and not only those who do actually deliver at home. Ignoring the women who had to be taken to the hospital would only partially present the experience of women who choose home birth.

Mehl (1976, p. 1) concluded that for a self-selected, medically screened population, home delivery can be a reasonable alternative. Yet, as he himself is ready to admit, more studies are needed before the home birth phenomenon can be fully understood. Mehl's work is a valuable beginning on the study of planned home births, but an examination of the experiences of five home delivery services does not provide representative information about planned home births, even in California. There also are difficulties with the reliability of a retrospective chart review which uses recordings made by different types of health care providers. Moreover, it cannot be assumed that all women have the supportive health care facilities that existed for Mehl's study population.

As home births are increasing, it is important to carefully examine the risk factors and to determine whether there are conditions under which elective home confinements are safe for both mother and child. It would indeed be useful, as Annas (1977) suggests, to establish a national demonstration project to test the proposition, advanced by the supporters of alternative childbirth, that home deliveries are cheaper and safer than those occurring in a hospital. For a valid comparison of the risks of hospital versus planned home births, one would want a sample of women with a wide range of characteristics to be assigned at random to a home birth or a hospital. Furthermore, the experiment should include controls for the type of

* Perinatal mortality rate in the State of California is neonatal deaths per 1,000 live births plus fetal deaths per 1,000 live births.

services provided under each treatment. Planned home births can take place under a variety of circumstances: under medical supervision with pre- and post- delivery attendance of a nurse, with a lay midwife or without the attendance of any health professionals. Variations also exist in the type of hospital setting. Such experimental research would be extraordinarily complex and time consuming; but it is important to recognize that in the absence of tightly controlled studies, conclusions about the comparative risks of planned home births versus hospital deliveries will always remain tentative in character.

Although the comparison of risks is important, it is equally important to understand more thoroughly why an increasing number of women decide to have a home confinement. Some proponents of the movement view the increased interest in elective home births as an expression of growing consumer consciousness and as a new willingness to assume responsibility for the management of one's own health. Choosing a home birth also is believed to represent a greater concern for involving the fathers and family in the birthing experience, for maintaining close contact between newborns and their mothers and for providing a nurturing, supportive atmosphere to both mother and newborn. Often it stands for an explicit rejection of the technology-dominated atmosphere of a hospital and its mechanistic, impersonal procedures. But while the broad philosophy of the home birth movement has become widely known through a growing number of popular articles and books and through the representatives of several organizations with a focus on alternatives in childbirth, there is, nonetheless, very little known about the type of people who choose home birth and their actual reasons for avoiding a hospital.

Literature reviews of socio-demographic characteristics likewise leave some uncertainty as to who elects home birth. In her study of the attitudinal profile and social background of 300 home birth parents in California, Hazell (1974, p. 8) concluded that couples who plan a home birth are average people with middle class lives. Kendall (1972) and Edwards (1973), on the other hand, have associated the home birth movement with the counter-culture. In Burnett's (1977) North Carolina study, 80% of the mothers in the sample were black in contrast to a black population of 21.9% in North Carolina as a whole. Even taking into account that the study population in North

Carolina included both emergency and planned home births, this racial composition differs from the predominantly white Californians reported by Hazell (1974) and Mehl (1976). It may be that the reasons for choosing a home delivery vary by social class and region and that the health consequences of a home birth differ accordingly. However, the only two major research projects on planned home births have been conducted in California and we know relatively little about planned home births in other parts of the United States.

The relevance of economic factors should also be determined. With rising costs of hospital care and medical insurance, some women may elect a home delivery primarily because they cannot afford hospital care. If the thrust of the planned home birth movement is economically motivated, policy responses would have to be different in nature than if the major reasons related to a general rejection of hospital procedures and the technical-medical model.

This report will present findings from a study of planned home births in Michigan in 1976. Although the outcomes of deliveries are reported, this is not intended to be a comparison of risks associated with planned home birth versus hospital deliveries. The study's major purpose is to describe the characteristics of women in Michigan who choose to deliver at home and to understand the basis for their decision as well as the circumstances of the birth. Insight into these issues will permit both consumers and health professionals to acquire a common background of fact as they struggle to improve maternal and child health.

METHODOLOGY

The study is based upon survey interviews with 74 women in Michigan who had a planned home delivery in 1976. The study design and questionnaire were pretested in a small exploratory study conducted with women who had a home delivery in Michigan during 1975.

Sample Selection

The major goal in sampling was to interview a sufficiently large number of women so that meaningful descriptive state-

ments could be made about the experience of women who had a planned home delivery in 1976 in Michigan. Birth certificates were used as the starting point for the sampling process because they provide the only existing data base for a study that seeks to be representative. However, since birth records do not record whether a birth was planned to take place at home, but merely whether it did or did not take place in a hospital, it was necessary to go through a screening process to determine which families were eligible for inclusion in the study. This was accomplished by randomly sampling certificates of out-of-hospital births. Then the selected parents were contacted by mail and/or by phone to determine whether the delivery was a planned home birth.

Contacting families selected through the random sample of out-of-hospital births was accompanied by major difficulties. Even though the telephoning was done both during the day and in the evening, it was not possible to reach some people. In other cases, telephone numbers could not be obtained. In a few instances, the physician listed on the birth certificate was contacted to ascertain whether the home birth had been planned. In general, however, the entire process was complicated by the fact that at least a year had elapsed since the home birth.*

As a result of these difficulties, it was necessary to go through three waves of random selections of out-of-hospital birth records in order to meet the predetermined quota of approximately 75 interviews. Moreover, births to unwed women could not be included in the study because these records were confidential in Michigan at the time of the sampling and were unavailable for study purposes.

Since 123 of a total of 539 out-of-hospital births in Michigan in 1976 were to unwed mothers, the basic universe of the sample was 416. Of these, 276 certificates were selected in three successive waves of random sampling. A total of 163 women who had delivered out of a hospital could be located, the remaining 113 were not traceable. After telephone con-

* As a result of letters written to the families of our sample, several lengthy replies were received from couples who had moved out of Michigan since 1976. Two of these letters are quoted in full in Appendix B. These letters reflect the receptivity of many people to our interest in home births.

tacts with these 163 women, 74 qualified as having had a planned home birth and were interviewed while 76 indicated that their out-of-hospital birth had been involuntary. The other 13 women were eligible for interviewing but refused.

Interviewing

One female interviewer conducted the entire field work, thus assuring maximum uniformity and consistency of interviewing. In addition to instruction in interviewing techniques, her training included review of the 1975 home birth study and basic instruction to understand the process of pregnancy, labor, delivery and the various complications that may arise in connection with birth. The interviewer also participated in the final stage of developing the questionnaire and, thereby, became well acquainted with the goals and purposes of the study. Interviews were conducted between June and September 1977.

Although 13 respondents refused to participate in the study, the interviewer was generally well received by the participants, in many instances with the warmest hospitality. For many women the interview seemed to be a welcome opportunity to speak with another adult during the day or to have a chance to discuss personal problems. Many people were excited and anxious to tell about their birth experience. On the other hand, several did not seem to care one way or another if they were interviewed. They answered all the questions but gave the impression of being uncomfortable and looking forward to the end of the interview. Some respondents were suspicious that "the state" was interested in them and their home birth. One woman, for example, asked if her child's behavior and development would be followed through school. A major difficulty with the interviewing was locating the respondents' residences which were located throughout the state.

The Questionnaire

The initial version of the questionnaire was based on the exploratory study of 1975 home births. It was revised to accommodate more open-ended questions in the hope of eliciting detailed information on the reasons women chose a home delivery. It was pretested in the Lansing, Michigan area and finalized in April 1977 (see Appendix D).

HOME BIRTH PARENTS

Since the decision to have a home birth stands in stark contrast with the societal norm that women who are about to give birth belong in a hospital, it seems plausible to expect that this decision is made by a group of people who have rejected existing social norms more generally. Kendall (1972) has argued that home birth parents are part of the commune culture, whereas Hazell (1974, p. 8) concluded that the majority of the women who deliver at home are "quite average people," and that only ten percent of them are members of the "hip" culture. Our study reveals that the home birth parents come from a variety of socio-economic, educational and religious backgrounds, but almost all are white Americans.

INCOME AND HOSPITAL INSURANCE

The average income of the home birth parents was $16,770 as compared to a $15,258 average family income for the state of Michigan.* Almost 20% of the families in the sample

* Michigan average income was obtained from U.S. Department of Commerce, Bureau of Census, "Household Money Income in 1975, by Housing Tenure and Residence for the United States, Regions, Divisions and States" (Spring 1976 Survey of Income and Education), Current Population Report, Series P-60, Consumer Income No. 108, November 1977, prepared by K. Apple.

earned less than $8,000 (Table 1). Two-thirds of the respondents had hospital insurance. As Table 2 indicates, low income is associated with lack of hospital insurance, but the relationship is not strong.

TABLE 1
Family Income Distribution of Home Birth Parents

Income Bracket Dollars Per Year	Number of Respondents	Percentage
1,000 – 3,999	3	4.0
4,000 – 7,999	11	14.9
8,000 – 9,999	8	10.8
10,000 – 12,999	13	17.6
13,000 – 19,999	20	27.0
20,000 – 29,999	10	13.5
30,000 – 49,999	2	2.7
50,000 and over	5	6.8
Not ascertained	2	2.7
Total	74	100.0

TABLE 2
Parents' Income by Hospital Insurance

Income	Parents have hospital insurance				Total
	Yes		No		
	Number	Percent	Number	Percent	Percent
Less than $8,000	5	35.7	9	64.3	100
$8,000 – $12,999	12	57.1	9	42.9	100
More than $13,000	31	83.8	6	16.2	100
Not ascertained	2				

RACE

Respondents were essentially homogeneous in their racial background. One oriental and four black women were among

those interviewed. Hazell (1974, p. 9) viewed the absence of black women in the home birth movement in California in light of their broader aspirations.

> Black people are beginning to be found in childbirth classes, but they are upwardly mobile and tend to opt for the "best" physician and hospital available. This tends to mean that they have the modal American birth, leaving responsibility for management to doctors, nurses and other hospital personnel.

One would expect this statement to be true for black women with higher incomes. Black families with low incomes, however, may well choose a home delivery for economic reasons. This study cannot provide evidence for this point since there were only four black women in the sample, none of whom had an income below $8,000 per year.

In interpreting the racial and other social characteristics of the women in the sample, it should be remembered that the sampling conditions may have introduced a bias whereby people from minority, ethnic or lower socio-economic groups were underrepresented. For example, out-of-hospital births to unwed women could not be included in our sample for legal reasons, but the racial and educational distributions of this group are known. Of the 123 such births in Michigan, 65 were to black women and 58 were to white women. This stands in marked contrast to the racial distribution of the study population. Also, the unwed mothers were generally less educated than the planned home birth mothers. Fifty-two percent of the unwed women had not completed high school, compared to 10% of the study population. Of course, it is not known how many of the out-of-hospital births to the unwed mothers were planned; but even assuming that only a small percentage were planned home births, the social characteristics of the study population would have been significantly different had they been included.

RESIDENCE

The majority of the women in the sample (42) had spent most of their lives in an urban area and 52 had lived primarily

in Michigan. Nineteen women previously lived in other parts of the United States and three in foreign countries. At the time of the interview, respondents were distributed over 26 counties in Michigan, with the heaviest concentration in Oakland, Wayne, Ingham and Kent counties.

RELIGION

Almost one fourth (16) of the respondents said they had no religion. Over half identified with either Catholic or Protestant religions, or they simply indicated that they were nondenominational or Christian. The remainder were members of religious groups such as Jehovah's Witness, Christian Science, Divine Light Mission and Church of God. It is noteworthy that some of these religions reject certain forms of modern medical and health care.

EDUCATION

The home birth parents had generally achieved a fairly high level of education. The majority of the husbands had attended at least one to two years of college, and 46% of their wives also were college educated. The second largest group consisted of those who had completed high school. A small group, 10% of the mothers and 5% of the fathers, had not completed high school.

TABLE 3
Education of Home Birth Parents

Educational Level	Mother		Father	
	Number	Percent	Number	Percent
Some high school	8	10.8	4	5.4
High school completed	32	43.2	29	39.2
College and beyond	34	46.0	41	55.4
Total	74	100.0	74	100.0

AGE

Almost 79% of the respondents were in their twenties, 28% were between 30 and 34 years old, and the balance was either

18 or 19 (4.1%) or between 35 and 39 years old (4.1%). Thus, the overwhelming majority of mothers was in what is normally considered the optimal child bearing age of 20-34 years.

FACTORS INFLUENCING THE DECISION TO DELIVER AT HOME

PREVIOUS HOSPITAL DELIVERY

Most of the women (44) in the sample had delivered a child in a hospital prior to their home delivery in 1976. Because previous research had established negative reactions to the hospital as a major element in the attitudinal profile of couples who opt for a home birth (Hazell, 1974), it seemed important to ask the respondents of this study how they felt about their previous hospital deliveries. The women had much to say in response to this open-ended question. Their answers can be grouped into three broad categories: positive, tolerable and negative hospital experiences. The majority of women (26) fell in the latter category, while 10 women reported a tolerable and 7 a positive experience (1 not ascertained).

Why do so many women react negatively to their hospital experience? A loss of control, which has several facets, was the most frequently mentioned reason. To many, a loss of control meant not being able to participate in decisions concerning the conduct of their care. Some said it meant a loss of dignity and a failure to be recognized as an individual with unique needs and desires. Additionally, for some women loss of control meant an inability to actively participate in their own

delivery. More specific reference to loss of control included responses that they were given medication when they did not feel it was necessary; that they were "put down," as the respondents phrased it, for wanting to nurse; or that they were left unattended in labor. As can be seen from Table 4, resentment of the institutional atmosphere of the hospital is mentioned more frequently than resentment of physicians.

TABLE 4

Reason for Negative Feelings About Hospital Deliveries† (Multiple Responses)

	Respondents Citing Reasons	
	Number	Percent
Loss of control due to hospital procedures	28	63.6
Separation from baby	24	54.5
Impersonal, non-supportive relationship with staff	20	45.5
Dehumanized, assembly-line hospital atmosphere	14	31.8
Separation from husband	8	18.2
Resentment of doctors	8	18.2
Hospitals are for the sick	8	18.2
Total number of respondents who had previous hospital delivery	44	

† Q: How did you feel about your hospital delivery?

Quotations from two women may give some of the flavor and detail of the concerns which were expressed:

> I felt like I was a sick patient and treated as such. I didn't like the idea of taking the baby away at birth. Babies need the closeness of their mother. The people in the hospital were kind, but they were anti-nursing,° so I didn't receive encouragement when I needed it. The main thing that bothered me in the hospital was that their routines did not allow me to be in the positions during labor that I found comfortable. Instead of being able to lay on my side, I had

° Anti-nursing here means against breast feeding.

to lie on my back. They believed in Lamaze so they let my husband into the labor and delivery rooms. But I was very lonely and forced to lie on my back for 22 hours. My pregnancy and labor were normal so there was no reason for the restrictions.

They were giving the baby supplementary formulas and sugar water when I was trying to breast feed. Hospital personnel and doctors alike need to school themselves on nursing . . . and be able to help and advise the nursing mother. They kept me for two extra days. They did not respect my wishes as the mother of the child. They had rigid standard procedures. My bed was next to the nursery and instead of sleeping I lay awake listening to the baby cry. Instead of nursing on demand they brought the baby on their schedule.

What emerges from these answers is the fundamental conflict between the way the respondents view their role in the labor and delivery process and the view of the patient that is implicit in the organization of hospitals. These women feel strongly that they understand the birthing process and that they are often a better judge of how to proceed than the physician or the staff. In holding this view, they are not arguing that they are the experts and the hospital staff and physicians are not. However, they do view themselves in conflict with the procedures which they believe exist for the convenience of the staff or are anchored more in hospital tradition than in expert knowledge. Above all, the women want to be active participants in what they consider a very crucial experience in their lives, whereas the hospital staff insists upon passive submission. Most of the women walked away from a hospital delivery with a deep sense of deprivation, as if they had been robbed of something that they had reason to expect should be their own.

THE DECISION TO DELIVER AT HOME

How do women who have chosen to depart from the generally accepted norm of delivering in the hospital explain their decision?

Many of the themes that emerged in the women's replies were similar to those mentioned in connection with the discussion of previous hospital deliveries. Dissatisfaction with hospital procedures was most frequently listed. For example, respondents were critical of hospital nursery practices that separate the mother from her newborn. The argument that a hospital is an inappropriate place to deliver a baby because pregnancy is not a disease, and a distrust of doctors were also mentioned here. But the decision to have a home birth was not entirely based on a negative reaction toward hospitals. The women who planned home births did so with much appreciation for the emotional support of relatives and friends which exists in the home. Furthermore, they wanted to assume an active role in the birthing process. The importance of exercising control and an emphasis upon *natural* delivery figured prominently in the responses. For many women the home was viewed as the most natural place to deliver a child.

> I felt the hospitals were unwilling to make changes that would permit the pregnant woman to have an active part in the labor and delivery. I felt that childbirth should be a natural process — not surgery.

> Because of the previous hospital experience, I really wanted to be able to control the delivery in a normal relaxed atmosphere. I wasn't relaxed in the hospital.

> I wanted to have my friends and family with me during the birth. I just feel more comfortable at home. . . . I believe in doing things the natural way. It was easier to deliver at home.

When asked why they decided to deliver their baby at home, 21 women mentioned economic factors. For example:

> I've never considered any other way. I had seen a home delivery with a midwife and a doctor and I thought I would be more relaxed here. I didn't really have the money and I didn't want to pay $2,000 unnecessarily. I'm healthy . . .

and didn't anticipate any complications. After I did some reading I found many more reasons. I wanted to keep the baby with me and breast feed; I didn't want to be hassled by the nurses about it. When I thought of the birth I envisioned the family being with me and a few friends — not making a big deal about it. I wanted my husband to be involved — as did he — and I didn't foresee the hospital agreeing to this.

My decision was a result of all the things I went through in the hospital. Also the financial part. With my last child the bill was $1,500. I looked for quite a while to find a doctor who would deliver at home. I called all over . . . and they all acted like I was crazy. I had talked to somebody in the congregation who knew someone who had a doctor who did home deliveries. Finally I found a doctor when I was seven and a half months pregnant. Having a baby at home is natural. The other children accepted him. . . .

It is apparent from these answers that financial concerns were among many issues in the home birth decision. Their importance, as compared with the other factors, is difficult to establish. It should also be pointed out that a direct question about the importance of financial factors was not asked. Instead, there was an open-ended question about the general reasons for the home birth decision. This was done in order

TABLE 5

Parents' Income by Importance of Economic Reasons for Home Birth Decision

Income	Financial Factors Given for Home Birth Decision: Yes		No		Total
	Number	Percent	Number	Percent	Percent
Less than $8,000	3	21.4	11	78.6	100
$8,000 – $12,999	6	28.6	15	71.4	100
More than $13,000	12	32.4	25	67.6	100
Not ascertained	2				

to avoid suggesting answers. It may well be that some women chose not to mention economic issues even though they played a role in their decision. People may have been hesitant to mention financial reasons to a stranger. More important, women may have forgotten that economic reasons were an important component in this decision which they themselves have increasingly come to view in terms of either their criticism of the hospital or in terms of the importance of assuming active responsibility for the delivery.

In reflecting about the importance of economic factors in the decision to deliver at home, it is worthwhile to again refer to the incomes of the respondents. With more than half of the families earning over $13,000 per year, it is difficult to

TABLE 6

Reasons for Home Delivery† (Multiple Responses)

Reasons	Number	Percent
Dissatisfaction with hospital procedures and routines, and loss of control in hospital	49	66.2
Emphasis on comforts and emotional security in home	40	54.1
Desire to be close to and/or involve family and friends in birth process	39	52.7
Wanted natural birth, no drugs, no intervention	34	45.9
Control in the birth process (either loss of control in the hospital and/or positive control at home)	33	44.6
Desire to care for infant	28	37.8
Economic factors (e.g., no insurance)	21	28.4
Hospital is for sick people and/or concern over infection	19	25.7
Resentment towards or distrust of doctors	16	21.6
Total number of respondents 74		

† Q: Why did you decide to deliver at home?

explain the planned home birth phenomenon entirely in terms of poverty. Moreover, there is no statistically significant relationship between income and the reporting of financial reasons in the decision to deliver at home. That is to say, women in the higher income brackets are just as likely as those with lower incomes to mention economic factors. Therefore, it can be concluded that although the cost factor is certainly an element in the decision, it does not appear to be central to the decision to avoid a hospital.

THE DECISION-MAKING PROCESS

When did women decide to have a home birth and who participated in or tried to affect the decision? Thirty-seven women made the decision to deliver at home during the pregnancy which lead to the 1976 home birth; 33 decided at an earlier date, either before their first pregnancy (12), during a previous pregnancy (12), between the last and recent pregnancy (6) or during previous labor and delivery (3).

Given the emphasis which women placed on the role of family and friends, it is interesting to know who participated in the decision. In the majority of cases (65) the father was involved, but the woman generally suggested the idea first (44 instances). In 43 cases, others encouraged the home delivery — friends primarily (34), but also relatives (15), a physician or other health professional (6).

Although encouragement from others was forthcoming, efforts to discourage the woman from delivering at home were even more frequent. Sixty women, or 81%, said efforts had been made to discourage them from having a home birth. A variety of specific concerns were expressed in the attempt to discourage women — fear of complications during birth, concerns over the safety of the mother or the child — indicating that some of the relatives, friends or health professionals with whom the respondent was in contact considered the risks of a home birth to be extensive.

Most of the women (59) knew someone who had had a home delivery and 15 had attended a home delivery other than their own. As can be seen from the following quote, knowing someone who had delivered at home can be an important element in the decision making process.

> One reason for our home birth was that we didn't have insurance and hospitals are expensive. After we talked to a woman who had two babies at home . . . she recommended a couple of books and reading the books we decided to have the baby at home. My mother had 14 children at home and no complications. Knowing that helped me to decide.

The experience of an older relative who delivered at a time when home births were still common and the experience of contemporaries who chose a home birth more recently seem important in influencing women in their decision. This finding stands in contrast to Hazell's (1974) observation in one California study in which members only occasionally knew others who had a home birth.

TABLE 7

Who Discouraged Home Delivery† (Multiple Responses)

Who Discouraged Home Delivery	Respondents Who Cited Sources of Discouragement	
	Number	Percent
One or more members of mother's family	26	43.3
Friends	23	38.3
Physician	21	35.0
One or more members of father's family	18	30.0
Everyone	12	20.0
Nurses or other hospital personnel	6	10.0
Total number of respondents who received discouragement	60	

† Q: Did anyone discourage you from having a home delivery?

RISKS

How do women who have delivered at home view the question of risks? As can be seen from Table 8, the attitudes of the women in the sample can be distributed along a continuum. At one end of this continuum are those women who

state definitely that there are risks in home deliveries (16); at the other extreme are those who state that there are fewer risks in delivering at home than in the hospital (18). In between these extremes are those respondents who are of the opinion that there are risks if (a) the woman has not received prenatal care or (b) during prenatal care, the pregnancy is diagnosed as problematic. Others state that the decision to deliver at home has to be based on individual circumstances or that there are no special risks unique to a home birth. On the whole, most women do not feel that there are major risks attached to delivering at home, especially if proper steps have been taken to ascertain potential problems through prenatal care. These answers are not surprising. If women perceived major risks, one would not expect them to make a decision in favor of a home confinement. Moreover, by definition, only those who successfully completed a home birth were surveyed. Women who planned a home delivery but had to go to a hospital because of major complications during labor or delivery are not included in the sample. One would expect women who had complications to be less sanguine about the risks involved in a home birth. Perception of risks was not related to level of education.

TABLE 8

Perception of Risk

Perception of Risk	Number of Respondents	Percent
There are risks in home deliveries	16	21.6
Yes, there are risks if pregnancy is diagnosed as problematic or if no prenatal care	15	20.3
Decision has to be based on individual circumstances	8	10.8
No special risks unique to home deliveries	17	23.0
Fewer risks at home than in the hospital	18	24.3
Total	74	100.0

In summary then, there were four major reasons that led to the decision to deliver at home: a strongly negative orientation toward a hospital, a commitment to an active role in the birthing process, a desire for emotional support from relatives and friends, and economic reasons. Not one, but several of these concerns influenced the decision of each woman. The husband played a major role in the decision, and many respondents knew of others who had elected a home delivery. Although relatives, friends and occasionally health professionals cited the perceived risks of home births in attempts to discourage respondents from their decision, most of the respondents did not view risks in the same light.

These results capture the major concerns of the women who decided not to deliver in a hospital. Being survey results, they cannot portray the depth and full flavor of the women's concerns. One of the respondents provided a copy of the letter which she wrote to her newborn baby. She describes the circumstances of her birth, touching upon many of the themes which have been discussed.

LETTER TO SASHA

Dear Sasha, little strong baby, you've made it past one week of life. Your first critical week, and it looks like you'll be around for a while.

As ten o'clock came around tonight, I recalled last Thursday when contractions of my uterus told me you were going to be born soon. The contractions had begun at about two in the afternoon, weak and sporadic at first, then growing in rhythm and intensity, slowly, progressively. All the while I tried to ignore them—No, I'm not ready yet, this can't be the real thing, it's too soon, I haven't gained enough weight yet, it'll be too small. And on and on like that all afternoon and evening while I did laundry and typed on some work I had brought home.

But you kept coming, getting more and more ready to be born whether or not I was ready. I was scared, too, would everything be okay, please, I need more time to think things over, get ready in my head.

But the body is ready even if the mind is not quite. By ten o'clock, after visiting with your then uncle-to-be, and my roommate, and getting some calm and quiet around here, I flipped into being relaxed. Mellow and relaxed–like I can't be anywhere but at home. The fear left as the time went on.

You were born in your home, Sasha, an unusual thing the year you were born for women to even consider. Can't imagine except in a nightmarish way how things will be when and if you even decide to have a child. But in 1976, hospitals, along with much of everything are pretty messed up. Things are backwards–health is sickness, peace is war, honesty is lies, love is hurt. But hospitals are particularly messed up, and I didn't want to bring a child into the world in a cold, sterile, germ-infested, profit-oriented, impersonal, inhumane place that a hospital is.

Being pregnant with you was one of the most beautiful and weird experiences I have had, and to bring it to a climax in a hospital, drugged and intimidated and frightened and at the mercy of the medical profession was too much for me to handle. That's why I decided to give birth to you at home. I hope that it's a commonplace practice by the time you can read this, that women get control of their heads and their bodies to know that they can do it. That giving birth is/can be a warm, personal, intense experience to share with people you love rather than to endure or escape from–or be "quick and painless, easy and efficient," like the doctor tried to tell me.

Well, by ten o'clock my midwives had come and visited and made some preparations and timed some of my contractions, which were now five minutes apart and a full minute long–strong and regular. I thought I was in the early stage of labor and it had all really just begun until the midwife did a vaginal exam and told me I was six centimeters dilated (about four more to go) and that she could feel your head and the hair on it. I burst into tears when she said that–tears of joy, happiness, fear, excitement, everything at once. She said you'd be born in a few hours!

I began to make some phone calls between my contractions to people I wanted to share the news with or ask to come. My friend and your aunt, who was excited and nervous at first but calmed down and watched and helped. My mother, who was also very nervous and frightened by what was happening. She didn't agree with my decision to birth you at home but

didn't come down on me or try to scare me out of it. "It's your decision," she said, "you know what's best for yourself." I hope I can be that way with you some day.

Your father had come back from a meeting which I had talked him into going to earlier, to give the contractions and me time and space to get our rhythm together.

Your birth here was about the most beautiful thing I could have imagined, if I had been able to imagine it, which I hadn't. The house was warm and filled with people and concern and support and love for both of us. Most of my labor was done in a comfortable big chair in the living room, talking and drinking tea between times, making phone calls and feeling better and better about your coming. When the contractions became more intense, we moved into the bedroom which had been made ready with extra sheets, a plastic sheet a few days earlier and last minute preparations by our friends which I wasn't much aware of. I changed into an old yellow nightgown and my sister helped me change my socks—didn't like the short blue socks I'd been wearing all day, so I changed to beige knee socks, a concession to vanity. By the time your birth came, the nightgown had been shed and I wasn't even aware of the socks.

The room was filled with people who came in and out during the next few hours. They watched and breathed with me, encouraging my efforts and telling me what a good job I was doing. I wasn't aware of the goodness of what I was doing just that I was doing what my body was telling me needed to be done. Breathing and relaxing and panting and relaxing and nothing else was on my mind.

It all happened much quicker than I thought it would. The contractions had become more and more intense but I was staying with them. Then, all of a sudden my body did something very different—it really took over for the final big pushes. Felt like I was going to take a huge crap whether I liked it or not and you would explode into the world. Then the harder work began. I could feel those pushes so clearly, could help them along by holding my breath and concentrating on pushing down until I would feel some burning and let up, relaxing my muscles in the pelvic floor and waiting for the next contractions to come. Those pushes had brought your head out and during the relaxing it would slip back in. There were a lot of cheers from everyone watching when your head

came out and sighs when it went back in. But it kept coming further and further with each one, and after six or seven of those heavy contractions, I felt that your head was almost all out.

I couldn't see your head emerging like everyone else could. I was feeling all the sensations, concentrating fully on what I was doing. Such a beautiful cheerful sigh filled the room when your head was completely out! You were born with a cowl over your head–I'm told that's a sign of psychic power.

The next contraction brought out your arm and then the rest of your body. My friend said your hand and arm came out and up like a gesture of greeting. I looked down between my legs, opening my eyes at last, and saw your little head looking all around and your eyes, I swear, checking out the new world you'd come into.

You went through a struggle coming and staying in this world the first week of your life. You were so tiny we didn't know if you would survive. Even considered taking you to a hospital where they would have put you in an incubator and probably fed you artificial milk and kept you away from me until you had gained a few pounds. I almost did it, as much as I didn't want you or me on the inside of a hospital. But I wanted you to survive, Sasha, and I would have done whatever was necessary. Decided to keep you at home, do all we could for you here, before taking that big step and turning you over to a hospital. We incubated you in the bedroom. I fed you every two hours whether you wanted it or not, kept a record of all that went in your body and came out, weighed you constantly, held you and gave you every encouragement I could, day and night for almost a week. And you thrived, Sasha, grew bigger and stronger and more alive each day.

You are now almost two weeks old and weigh over five pounds and have a habit of sleeping most of the day and staying awake most of the night, a habit you picked up from your mother. Your baby uterine skin is almost all peeled away, you're growing eyelashes and your lung capacity has increased. You cry much louder than a few days ago. And you let out little squeaks and smiles and giant burps. You seem peaceful and contented most of the time (not so sure about myself these days but that has more to do with me than you.) You give me much joy just looking at your peaceful sleeping face and know-

ing that my milk and my care are keeping you alive and well. You have a lot of growing to do, Sasha, and I'm looking forward to us growing and learning and loving together.

Your Mother.

OBSTETRICAL HISTORY, PREPARATION FOR HOME BIRTH AND CARE DURING LABOR AND DELIVERY

The "Letter to Sasha" illustrates a dramatic rejection of hospitals. In deciding to nurse their premature infant at home, Sasha's family was assuming a tremendous responsibility. Though this is an extreme example, its spirit is not atypical of that expressed by many of the respondents whose decision to deliver at home was often based on negative hospital experiences. But did all the women take on the responsibility of a home birth with the same diligence as Sasha's mother? Critics of the home birth movement frequently state that those delivering out-of-hospital are unaware of the risks they are taking. Would some of these women have been considered high risk cases because of serious complications during a previous pregnancy and delivery? In order to assess this item, the women who participated in the study were asked about their obstetrical background.

Prior to the home birth in 1976, 14 of the 74 women interviewed had experienced an interrupted pregnancy; 10 had an involuntary abortion (miscarriage), 4 a voluntary abortion. No woman reported having more than one miscarriage or abortion. Since only women with three consecutive spontaneous abortions are considered habitual aborters, medical

opinion would not consider them at greater risk than other women. In the case of the voluntary abortions, information about the month of the pregnancy in which the abortion was performed is not available and, therefore, the risk factor cannot accurately be judged. If the women had had their voluntary abortions in the second trimester, they may have been at greater risk in their 1976 pregnancy than other women.

For 19 women, the 1976 home birth was their first delivery. Of the 55 women who had previous deliveries, 28 had one child, 15 had two children, 7 had three children, 3 women had four children, and 2 women had five children. As Table 9 indicates, 36 of the 55 mothers who had children before 1976 had not experienced any complications during their previous pregnancies or deliveries. However, 10 women did report complications during a prenatal period. These include two cases of toxemia, one ectopic pregnancy and one instance where problems resulted from obesity. Others described minor problems such as spotting, morning sickness and colds. Ten had complications during their labor and delivery: breech presentation (2), face or posterior presentation (3), blue baby (1), vomiting and delayed delivery of the placenta (4). Two women reported complications during both the prenatal period and delivery. While several of the complications listed are potentially serious at the time they occur, most would not necessarily redevelop in a subsequent pregnancy.

TABLE 9

Previous Pregnancies: Problems During Prenatal Period by Problems During Labor and Delivery

Problems During Prenatal Period	Problems During Labor and Delivery		
	Yes	No	Total
Yes	2	8	10
No	8	36	44
Not ascertained			1
No previous pregnancy			19
Total	10	44	74

Judging from their histories, most of the women in the sample who had given birth before 1976 do not appear to have been at greater risk than the general population. The exceptions to this are the respondent who cited obesity as a complication and the two grand multiparas. The 19 primiparas, of course, did not have an obstetrical history which could contribute to judging risk factors.

PREPARATION FOR THE HOME BIRTH

There were several dimensions to the preparation of planned home births on the part of the parents. Preparation may have included any one or a combination of the following: prenatal care, reading, childbirth preparation classes, special instruction for home birth, physical preparation of the environment and preparation for possible complications.

Prenatal Care

Prenatal care is essential if certain complications of pregnancy are to be recognized and appropriately managed. Sixty-eight women in our sample recognized the need for prenatal care, although the type varied. Most women sought care from medical physicians; several others from osteopathic physicians; and three women reported care from either a chiropractor, a midwife or a Christian Science practitioner. As Table 10 indicates, care from a medical physician was supplemented with care from an osteopathic physician or midwife in six instances.

The American College of Obstetricians and Gynecologists has established guidelines for prenatal care.

> A normal patient should generally be seen at least every four weeks for the first 28 weeks of pregnancy, every two weeks until the 36th week, and weekly thereafter. Weight, blood pressure, urinalysis, height of fundus, abdominal findings on palpation and character and location of fetal heart tones should be determined at each visit.*

* From "Standards for Obstetric-Gynecologic Services", Committee on Professional Standards of the American College of Obstetricians and Gynecologists, 1973-1974, p. 36.

TABLE 10

Prenatal Care Provider by Month Care Began

Prenatal Care Provider	Month Care Began			Total
	1st-3rd	4th-6th	7th-9th	
M.D.	38	12	2	52
D.O.	3	2	–	5
M.D. and D.O.	1	1	1	3
M.D. and midwife	3	–	–	3
Chiropractor	1	–	–	1
Midwife	–	1	–	1
Christian Science practitioner	–	–	1	1
Not ascertained	1	1	–	2
Total who received prenatal care	47	17	4	68
No prenatal care				6
Total				74

Almost 60% of the women (44) who received prenatal care had 10 or more visits and, hence, compare quite favorably with the ACOG standards. On the other hand, 22 respondents (32.4%) reported having fewer than 10 visits. Obviously, this constitutes limited prenatal care.

Table 11 shows the number of prenatal visits the women had relative to the month of pregnancy in which they began receiving care. While there is some relationship between a high number of visits and early prenatal care, there are also a few women who started prenatal care early but had very few visits. These women may have encountered resistance from health care providers when they discussed their plans for a home birth, or possibly they may have had other negative reactions to the health care system that influenced their decision not to return. Emrey's (1973, p. 2) discussion of why there is inadequate prenatal care for women who plan a home birth in California may provide insights into what is happening in Michigan as well.

> *Another difficulty experienced by many families seeking home births is the reluctance or refusal of established medical care systems, such as clinics or private physicians, to accept or continue them for prenatal care if their wishes for*

home birth become known. Some wishing to approach delivery with as much knowledge and assurance of their risk status as possible choose to hide their delivery plans. Others, attempting to be honest, find themselves terminated from care or subjected to considerable hostility and insensitivity. Many physicians, on the other hand, fear medicolegal implications if they are called in to salvage a failed home labor or birth. In this situation, the physician may have difficulty establishing effective communications with the family and providing the needed care in an acceptable manner, which reinforces his reluctance to deal at all with families seeking such alternatives. Frequently they face a family with whom they have not developed a trust relationship and who may present considerable fear or hostility toward the traditional medical establishment. Often, there has been too long a delay in obtaining hospital care, no adequate history or prenatal data is available, medical or surgical intervention may be needed. The fear of such an occurrence may have prompted the choice for home birth in the first place.

TABLE 11

Number of Prenatal Visits by Month Care Began

Month Care Began	Number of Visits					Not Ascertained	Total
	Under 5	5-9	10-14	15-19	20 & over		
1st	–	2	7	4	–	1	14
2nd	1	5	8	4	4	1	23
3rd	–	4	4	1	–	1	10
4th	1	4	2	–	–	–	7
5th	2	1	4	–	–	1	8
6th	–	1	1	–	–	–	2
7th	1	–	–	–	–	–	1
8th	1	–	–	–	–	–	1
9th	1	–	–	–	–	–	1
Unknown	–	–	–	–	–	1	1
	–	–	–	–	–	–	–
Total who received prenatal care	7	17	26	9	4	5	68
No prenatal care							6
Total							74

This reluctance of the established medical care system to provide care to women who have elected a home birth may in part explain the lower level of prenatal care received by some of the respondents (37), as contrasted with the level of prenatal care reported for Michigan residents in 1976 (see Table 12). Interestingly, when total care is reviewed, the percentage of those having 20 or more prenatal visits is more than three times as great in the home birth group as in the total state population. Those receiving between 15 and 19 visits is twice as great in the home birth group as in the total state population (13.2% compared to 7.1% respectively). Reasons for this may be varied. It may be attributed to recognition of the need for careful risk assessment for planned home births and comprehensive prenatal care in order to detect and/or avoid complications.

TABLE 12

Frequency of Prenatal Care for Planned Home Birth Sample as Compared to Prenatal Care for Michigan Residents, 1976†

Frequency of Visits for Prenatal Care	Planned Home Birth Sample		Michigan Residents	
	Number	Percent	Number	Percent
No care	6	8.1	923	0.7
Under 5	8	10.8	6,993	5.3
5-9	17	23.0	36,670	27.9
10-14	25	33.8	71,075	54.1
15-19	9	12.2	9,377	7.1
20 or more	4	5.4	2,273	1.7
Not stated	5	6.8	4,067	3.1
Total	74	100.1	131,378	99.9

† Information regarding Michigan residents obtained from the Office of Vital and Health Statistics, Michigan Department of Public Health, Lansing, Michigan.

Sixty-six (97.1%) of the 68 women who received prenatal care had their blood pressure checked at each prenatal visit. Sixty-four women (94.1%) reported that the fetal heart was

checked at least once after the fifth month of pregnancy.* Fifty-seven women (83.8%) said their urine was checked at every visit. These assessments are valuable in the early detection of some complications of pregnancy such as preeclampsia or urinary tract infection. Prompt treatment of complications can help reduce perinatal mortality and morbidity. The fact that all women did not have these assessments routinely may be due to the varying philosophies of the practitioners from whom the women received care.

While the value of prenatal care is recognized by the majority of women in the sample, the six women who did not receive prenatal care are of special interest, and it is important to recognize who they are. All of the women who did not have prenatal care had previously uncomplicated, easy births. Five had delivered in a hospital before 1976 and their descriptions of the experience were fairly representative.

> . . . I don't have anything against the medical staff, but I didn't like my experiences in the hospital. Both of my children were born half an hour after I got to the hospital. I had no problems while pregnant, no problems in delivery. . . . In the hospital I felt uninvolved. You lay on the table and they do everything . . . it is all very cold. They took my child away and I didn't see her for two days. I felt more comfortable at home. . . . After all, having a baby is not a sickness or a disease.

The only woman who had not had a hospital birth delivered her first child at home in 1975 and had been counseled by a physician at the time.

Contrary to what one might expect, the lack of prenatal care among the respondents was not related to low educational achievement or low income. All of the mothers finished high school, at least two attended college and one did postgraduate work. Of the six women not receiving prenatal care, one was a

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* During the interview, respondents were asked if anyone listened to the fetal heart after the fifth month. They were not asked if it was assessed at each visit nor were they asked if they had abdominal palpation at each visit. Hence, it is not possible to compare this with the ACOG standard.

chiropractor, and one was a nurse. Moreover, two others were married to health professionals, a chiropractor and a physician. It is interesting to speculate why these women did not have any prenatal care. The women married to health care professionals may have received care from their husbands but not reported it as such. The nurse and chiropractor may have felt they could take care of themselves.

Those not receiving prenatal care had varied incomes. There were two low income families. One woman, who was separated from her husband, earned between $4,000—$8,000, received Medicaid assistance and was included in this group. The second family had recently immigrated from Korea and earned between $7,000 and $8,000 yearly for a family of six. Neither mentioned financial factors as motivating their decision. Two other families reported earning between $13,000 and $20,000 and the fifth between $20,000 and $30,000. Finally, one family in which both the husband and wife were chiropractors earned over $50,000. Interestingly, it was this family who mentioned financial factors as influencing their decision to have a home birth.

Four of the women without prenatal care took childbirth preparation classes, usually Lamaze. All of them read some literature on the subject and/or had special instructions and "pointers" from friends who had delivered at home. The nurse from Korea had attended other births in Korea. Several of her relatives and her mother-in-law delivered their children at home.

Reading

Reading is a means by which many women in today's society take an active role in preparing themselves for childbirth, and the women in the sample were no exception. Almost all (68 of 74) did some reading in preparation for the birth. For some, this was a casual perusal of pamphlets and magazines°, but most of the 68 read books such as *Birth Without Violence, Childbirth Without Pain, Immaculate Deception, Commonsense Childbirth* and *Thank You, Dr. Lamaze.*

° One woman stated she became interested in the idea of a home birth from an article in *Vogue Magazine.*

Childbirth Preparation Classes

In addition to reading, some women find prenatal education classes helpful in preparing for childbirth. In the sample, 46 women (62.2%) attended such classes. The majority of them (32) studied the Lamaze method. One woman attended classes at Planned Parenthood, another at a feminist health center and a third at the Childbirth Without Pain Association. A few of the women had exposure to birth preparation in their professional nursing education.

Special Instructions

In addition to childbirth classes, some women received special instruction for the home birth. These special instructions often included a discussion of problems associated with pregnancy, labor and delivery and, in each case, provided the woman with an opportunity to ask questions. Some of the issues discussed were problems that may arise during the actual birth (e.g., hemorrhaging, positions of the newborn), those associated with the newborn (e.g., apnea, respiratory distress, prematurity) and the infant (e.g., birth defects).

Table 13 shows the relationship between the number of women who had special instructions and the number of women who attended birth preparation classes. While 26 women received special instructions in addition to attending birth classes, 15 women received only special instructions and 13 received no instruction of any kind. In 19 cases, the instructor was a physician, in 9 cases, a midwife and in another

TABLE 13

Number of Women Who Attended Childbirth Classes and Had Special Instructions

Preparation	Respondents	
	Number	Percent
Childbirth classes and special instruction	26	35.1
Childbirth classes	20	27.0
Special instruction only	15	20.3
Neither	13	17.6
Total	74	100.0

9 instances, licensed practical nurses. Four others had instructions from registered nurses.

Since 19 of the respondents were having their first baby, it is interesting to note their specific preparations in these areas. Table 14 illustrates these preparations.

TABLE 14
Preparation of Primiparas

Preparation	Respondents
Reading only	4
Classes only	0
Special instruction only	0
Reading and special instruction	6
Classes and special instruction	1
All three	8
Total	19

Additional Preparations

In addition to educating themselves, many women prepared their homes and assembled equipment. When the women in the survey were asked what they did to get ready for the home delivery, answers ranged from "shampooing the rug" to "praying everyday." They were most concerned with acquiring general supplies, such as plastic sheets, pads and bulb syringes for the newborn, and with their own personal, physical and emotional preparation for the event. The following quotes are representative of the answers obtained.

> I studied, did breathing and physical exercises. Collected various items necessary to have on hand listed by the H.O.M.E. book. I saw the doctor every three weeks. I cleaned the house and collected baby clothes and knit a baby blanket.

> I exercised daily and was very careful about my diet. I went to the doctor regularly. Read books about what was happening . . . so we could be aware. We got the child's environment ready. We were living in a one bedroom apartment which we rearranged for him. He got the best of everything.

Some women did not make any specific preparations, leaving the provision of equipment to the attendant.

Preparation for Possible Complications

During pregnancy most women can anticipate and plan for a normal labor and delivery. However, they must consider the possibility of complications. Seventy-one of the 74 women in this study had done so and said they would have gone to the hospital in the event that complications arose. Twenty-four of these women gave general responses when asked under what circumstances they would go to a hospital; they felt they would make the decision at the time. Nineteen others stated that they would go to the hospital "for any problems" or if they felt a sense of "lacking control" in the situation. Seventeen of the 71 women who had backup plans responded that they would rely on the judgement of their doctor or midwife. The remaining 11 women listed specific complications, such as abnormal presentation, slow progress in labor or hemorrhage, that would cause them to seek hospital care. Forty-one of the women would have gone by car to the hospital. Others stated they would have called an ambulance or the fire department.

The possibility of complications during the home birth appeared to be the area in which the respondents had made the least definite plans. In contrast to the specificity of their responses to other questions, their replies to questions about complications and backup plans were general. There may be several reasons for this. First, there had been a significant time lapse between the home birth and the interview. Secondly, most had a positive experience. The negative potential may have been minimized or discarded in the women's recollection. Finally, the women may have found it difficult to contemplate truly signficant complications, because this would have prevented them from following through on their plans for a home birth.

CARE DURING LABOR AND DELIVERY

The impersonal, technical, routine-laden atmosphere of the hospital has been cited in the literature (Hazell, 1974, Lubic, 1976, Cook, 1977), as well as by the respondents in this study,

as being an important reason women and their families are turning to home birth. In fact, what care did our respondents receive during their labor and delivery?

We asked questions about specific aspects of conventional obstetric practices during labor and delivery, as we had regarding prenatal care. Twenty-six of the women (35.1%) had their blood pressure assessed during labor. Time intervals cited by the respondents were "hourly," "once during labor," and "occasionally" (that is, less frequently than once per hour). Responses were almost equally distributed in these categories. Three of the 74 respondents had their urine tested in labor and 46 (62.2%) had the fetal heart rate monitored at least once during labor and delivery. Eleven of the women (14.9%) stated that they used some type of tranquilizer or medicine for pain; however, in at least two cases this consisted of calcium tablets.

It is evident that respondents also took advantage of their freedom from conventional hospital routines, which often dictate the positions a woman may or may not assume in labor and delivery. Women in the study experimented with different positions in both their labor and delivery. Some chose to walk about in labor or to squat and support themselves with pillows. Thirty-four (45.9%) were lying down, propped with pillows during delivery. Only 7 women (9.6%) chose to be flat on their backs, while 17 (23%) delivered in a sitting position. Others opted for positions on their hands and knees.

The majority of the delivering women consumed some type of liquids or foods during labor. Tea, juices, water, yogurt, cereal and fruit were most often listed. Sixty-six women (89.2%) utilized massage or breathing exercises to manage the discomfort of contractions. This figure is especially noteworthy in light of the fact that only 46 of the women attended birth training classes.

After the birth, most of the women held the infant immediately. Of the six who did not, several said that their husband or other family member held the child. In one case the mother did not hold her newborn until after she was sutured.

When respondents were asked if they nursed the child "immediately" after delivery, there were different responses depending on their interpretation of "immediately." For ex-

ample, some answered, "yes, after the cord was cut. . . ." Others answered, "no, I had to wait until the cord was cut". However, it is clear that most women breastfed soon after delivery.

In descriptions of their deliveries, the women generally mentioned the presence and support of their friends and family whose participation was a major incentive for the home birth. A wide range of people were with the women during the event (see Table 15), but most noteworthy is the fact that the father of the newborn was present in almost all instances.

TABLE 15

Non-Health Professionals Present During Labor and Delivery†

Individual Present	Women Reporting Presence	
	Number	Percent
Husband/father of newborn	71	95.9
Mother	18	24.3
Friends	10	13.5
Brother/Sister	10	13.5
Children	10	13.5
Mother-in-law	7	9.5
Others	11	14.9

†Q: Who was with you during labor and delivery?

TABLE 16

Health Care Practitioners Who Attended the Home Delivery†

Health Care Practitioner	Number	Percent
Doctor	10	13.5
Doctor and nurse	21	28.4
Doctor, nurse and lay midwife	2	2.7
Doctor and lay midwife	2	2.7
Nurse	7	9.5
Lay midwife	8	10.8
Birth attended by practitioner	50	67.6
No health care practitioner present	24	32.4
Total	74	100.0

†Q: Who was with you during labor and delivery?

PRESENCE OF HEALTH CARE PRACTITIONER AT DELIVERY

One of the critical variables during the delivery is the presence of a physician or other health professional. Fifty of the respondents had at least one attendant who was a member of a health care profession, while 24 did not. There was a discrepancy between the birth attendant identified on the birth certificate and during the interview. According to the interviews, 35 of the women (47.3%) delivered in the presence of a physician (see Table 16). According to the birth certificates, a physician was present in 48 of the deliveries (64.9%).*

The relationship between physician attendance and a number of socioeconomic characteristics and health care variables was examined. Education, income and hospital insurance were unrelated to physician attendance. However, as Table 17 indicates, women who reported either no prenatal care or a

TABLE 17

Frequency of Prenatal Visits by Physician's Attendance at Delivery

Physician Attendance	Number of Prenatal Visits							
	None	1-3	4-6	7-8	9-10	11 or more	Not Ascertained	Total
Yes	0	1	6	2	3	22	1	35
No	6	7	3	2	4	12	5	39
Total	6	8	9	4	7	34	6	74

* There may be several explanations for this discrepancy. Some believe that a physician must sign the birth certificate as the attendant or certifier for legal reasons. Hence, a physician may sign the certificate even if he was not present at the delivery. The fact that physicians occasionally do this has been argued by Sartwell. (Sartwell, Philip E., ed., *March-Rosenau Preventive Medicine and Public Health*, New York, 1973, p. 779). It is also possible that because the question was open ended – "Who was with you during the delivery?" – some women may have forgotten to mention that a physician was present. It is noteworthy that even if one was to consider the birth certificate information to be more accurate than the respondents' replies, one-third of the women delivered their babies without a physician.

minimum number of visits also were more likely to deliver without a physician. Note that the six women who reported not receiving prenatal care were all in the latter category. Furthermore, seven of the eight mothers whose infants had not been seen by a physician or clinic since birth were unattended by a physician during delivery.

POSTPARTUM CARE

Follow-up care immediately after the birth and in succeeding weeks is as critical to the well being of mother and child as the events during labor and delivery. Sixty-two women (83.8%) received some type of care the same day of the birth. The answers to a question regarding this care included some very general and some more specific replies. They are summarized in Table 18.

TABLE 18
Care for the Mother Immediately After Delivery†
(Multiple Responses)

Type of Care	Number	Percent
Measures related to the removal and examination of the placenta	27	43.5
Suture for tears	16	25.8
Injection to control or prevent hemorrhage from the uterus	13	21.0
Massage of the uterus	13	21.0
A general, possibly superficial, examination	12	19.4
One of the vital signs taken (temperature, pulse, respiration or blood pressure)	12	19.4
Examination for tears	8	12.9
Other (herbal teas or douching)	17	27.4
Women who received immediate care	62	

†Q: Right after the baby was born, was any particular care given to you (the mother) to make sure you were alright?

In the weeks following delivery, 54 of the women (73.0%) received postpartum care. Physicians provided the majority of this care, and a chiropractor provided care to one woman. Those who had received prenatal care from lay midwives, and

the woman who received care from a Christian Science practitioner, did not report receiving postpartum care from them.

Sixty-one mothers (82.4%) stated that some type of care was provided to the infant immediately after birth. The specific measures mentioned are listed in Table 19, but these findings should be read with caution. For example, note a dramatic discrepancy between the information obtained in the interviews and that gathered from birth certificates regarding silver nitrate treatment to the infant's eyes. The birth certificates show that silver nitrate was used in 50 of the 74 cases studied. However, during the interview only 15 women specifically mentioned the use of silver nitrate. Sixteen women mentioned eye care in general, and three mentioned other types of eye care. This example is of special interest because silver nitrate treatment to the eyes of newborn infants is mandatory in Michigan.

The women were asked about immediate follow-up care to assess their awareness of the newborn's adaptations to extrauterine life, specifically their breathing patterns, skin color and alertness. For example, did the attendants keep the infant warm and dry? As shown on Table 19, respondents noted some of these aspects of care. On the other hand, no respondent referred to any of the profound cardiovascular changes infants experience at birth. Were they unaware of them? The time lapse between the birth and interview and the large number of successful outcomes may account for the low number of responses to this open-ended question.

The majority of the infants (66 or 89.2%) had been taken to the doctor or the hospital between the time of birth and the interview. The reasons for these visits were, in order of frequency with which they were mentioned, checkups, immunization, circumcision, illness or accidents.

Eight infants had not seen a physician or been to a clinic or hospital since birth. Upon closer examination it is clear that five of these eight had some contact with a health professional. In three cases the father of the infant was a chiropractor, and two other families were visited by a public health nurse. Five of the mothers whose infants had no follow-up care did not receive postpartum care themselves. However, since two of these women were married to chiropractors, they may have had some form of care. Only one of the eight

TABLE 19

Special Care for the Infant Immediately After Delivery† (Multiple Responses)

Type of Care	Number	Percent
Infant cleaned, washed and dressed	37	60.7
General check-up	21	34.4
Unspecified care to eyes	16	26.2
Silver nitrate treatment to eyes	15	24.6
Special care to the cord	14	23.0
Infant weighed and measured	12	19.7
Infant's heart rate, breathing, state of alertness noted	10	16.4
Special care to nose and throat with suctioning explicitly mentioned	10	16.4
Special care to nose and throat but suctioning not explicitly mentioned	6	9.8
Eyes washed with warm water, boric acid or antibiotics	3	4.9
Total number of infants who received immediate care	61	

†Q: Right after the baby was born, was any special care given to him/her?

mothers reported that she delivered the child in the presence of a physician. The three who were married to chiropractors were attended by their husbands. The other four deliveries were attended by nurses or a nurse midwife. Thus, upon closer examination of the interviews, the total number of infants without care is reduced. However, there remain several women who had neither a physician present at their delivery nor contact with a health professional afterward for purposes of postpartum or pediatric care. In our entire sample 12 mothers were visited by a public health nurse.

OUTCOMES OF THE HOME BIRTH

It is apparent both in the amount and in the nature of their preparation that the planned home births presented considerable emotional and psychological investments for the women interviewed. Though many of them had been warned of potential dangers in delivering outside a hospital, each woman had a clear concept of the advantages and positive psychological effects of a home birth. How did these women feel about the experience in retrospect?

WOMEN'S FEELINGS ABOUT THE HOME BIRTH

When discussing the details of the delivery, 66 of the women (89.2%) in the study described their home delivery in distinctly positive terms. Of these women, 16 described it with superlatives such as "beautiful," "wonderful," and "great"; 39 spoke in terms of a "smooth," "fast," "easy" birth. Eleven of the women were not so exuberant in their descriptions but felt that their experience had definitely been positive. The remaining eight felt their delivery had been slow or difficult, but they did not necessarily perceive it as a negative experience. None of the respondents described their deliveries in strong,

negative terms. In fact, 73 of the 74 women answered that they felt "very positive and enthusiastic" about their home birth in retrospect.

Seventy-one of the women (95.9%) said they would have another home birth; however, nine of these women qualified their responses. These unsolicited qualifications were related to good prenatal care, the absence of complications and the presence of a physician during delivery. One woman stated that she would have an out-of-the hospital delivery only if it was to occur in the doctor's office, as had her first.*

Thirty-four of the women (45.9%) stated they would enthusiastically recommend a home delivery to others. Twenty-eight women (37.8%) would recommend a home delivery, though somewhat less enthusiastically than the others. Ten of the respondents (13.5%) hesitated to make a recommendation, stating that the decision should be an individual one based on personal circumstances. One woman said she would not recommend a home delivery.

All three of the women who would not plan another home birth for themselves recommended that others consider it an option. They had very unique reasons for their personal decisions against another home birth. One of the women had a very long and difficult labor and delivery during the 1976 birth of her sixth child. In addition, she felt that her age (she was 38 years old) would make a home delivery prohibitive. The second woman would not deliver at home again because she felt that she would need a "break and besides, hospitals are becoming more lenient." The third had gone against her mother's wishes in delivering at home and did not wish to do so again. The latter two women spoke enthusiastically about their experience at home.

BIRTH WEIGHTS

In the recent past, a 5.5 pound weight limit was one major criterion in the diagnosis of prematurity. With the advances in neonatology, it is now known that mature infants may be very small as a result of maternal conditions, such as hypertension, and immature babies may be very large due to ma-

* Seven women in the sample had arranged for their 1976 deliveries to occur in a physician's office. In our screening process these were considered planned out-of-hospital deliveries, hence their inclusion.

ternal diabetes. Though gestational age is increasingly emphasized in newborn assessments, weight continues to be a significant factor. Babies born after uncomplicated pregnancies to parents of average build range from 2500 grams to 4300 grams (5.5 lbs. to 9.5 lbs.). The average weight of newborns is 3400 grams or 7.5 lbs.

Table 20 illustrates the importance of distinguishing between planned and unplanned home births. The birth weights of planned home births are higher than those of unplanned ones, and they even surpass those of the total population. For unplanned home births, 26.3% of the newborn weights fall below 2500 grams as compared with only 1.3% for planned home births. The difference between planned and unplanned birth weights is of high statistical significance. The weights for the birth-certificate-derived categories of non-hospital and home-births have been included to show their inappropriateness as indicators of the birth weights of planned home deliveries. They are misleading because they combine the weights for planned and unplanned home deliveries, yielding the interpretation that planned home births have lower weights than hospital births.

MATERNAL AND INFANT MORBIDITY

None of the women described the occurrence of any complications for themselves during delivery. Although 16 of the women required sutures, none of them viewed this as a complication. Could this be a reflection of the natural orientation of the home birth mothers and their attendants?

In interpreting highly favorable feelings about the home birth and the low incidence of complications during delivery, it is important to recall the nature of the sample. The women interviewed were those who actually had their babies at home. The sample did not include women who planned a home birth but were hospitalized in the course of the delivery because of serious complications.° Obviously, these would have been

° Edwards reports that in a study of 38 women who had planned a home birth in California, 11 had to go to the hospital because of suspected complications. Mehl's study of elected home births reported that "of the 1,146 women beginning labor at home with the intention of delivering there, 136 (12%) were sent to the hospital to complete their delivery, for treatment of intrapartum (11%) or postpartum problems."

TABLE 20

Birth Weights for Michigan Residents, Non-Hospital Births and Home Births[1] for 1976[2] as well as for Unplanned and Planned Home Deliveries of the 1976 Study Population

Birth Weight in Grams	MICHIGAN RESIDENTS						1976 STUDY POPULATION			
	Total Population		Non-Hospital		Home Births		Planned		Unplanned	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
500 or below	186	0.1	2	0.4	0	0.0	0	0.0	0	0.0
501-1,000	642	0.5	11	2.0	7	1.9	0	0.0	4	5.3
1,000-1,500	877	0.7	10	1.9	8	2.1	0	0.0	2	2.6
1,501-2,000	1,974	1.5	18	3.3	15	4.0	0	0.0	4	5.3
2,001-2,500	6,105	4.6	45	8.3	35	9.3	1	1.3	10	13.2
2,501-3,000	21,761	16.6	80	14.8	58	15.5	6	8.1	11	14.5
3,001-3,500	48,018	36.6	168	32.1	117	31.2	25	33.8	20	26.3
3,501-4,000	37,577	28.6	125	23.2	83	22.1	26	35.1	15	19.7
4,001-4,500	11,657	8.8	58	10.8	35	9.3	11	14.9	9	11.8
4,501 and over	2,501	1.9	13	2.4	9	2.5	5	6.8	0	0.0
Not Stated	80	0.1	9	1.7	8	2.1	0	0.0	1	1.3
Total	131,378	100.0	539	100.0	375	100.0	74	100.0	76	100.0

1—Where place of birth and address of mother match.

2—Data from Michigan Vital Statistics System.

recorded as hospital deliveries on the birth certificates.

During one interview, the mother reported complications for the newborn.

> There was a lot of meconium on her so they had to clean her up... They cut the cord and laid her beside me; she started breathing, then faded away. The heart stopped — the doctor did artificial respiration then placed her in warm water because she went into shock. He (the doctor) felt she had a slow start, later she had hylaine membrane disease. He thought there were too many people in a small room and not enough ventilation. (It) would have happened in the hospital.

The mother reported the infant had increasing respiratory difficulties and was admitted to the hospital the next day, placed in an isolette and given I.V. therapy.

UNANTICIPATED OUTCOMES OF THE STUDY

As a result of the home interviews, two special health problems were brought to the attention of community health nurses. Both referrals were made to local public health departments with parental permission. In one family the interviewer noted that the infant was unable to hold up his head or to sit, both of which would have been developmentally appropriate for his age. This family, with annual income of less than $8,000, had recently immigrated from Korea. The mother had not received prenatal care. There was some difficulty in communicating during the interview. However, the interviewer learned that the baby did not breathe immediately after birth. The family was grateful to be referred to a health agency that could help them, because they did not know where to go for care. The child was subsequently diagnosed as having cerebral palsy.

The second referral was also from a low-income home in which two children appeared unable to speak. In addition, the mother had delivered another child at home weeks prior to the interview and the infant appeared to the interviewer to be in need of physical attention. The public health nurse who followed up the referral reported that the two older children

were able to speak, though they had difficulty with enunciation and it was hard to understand them. The same nurse has not heard the child born in 1976 speak, however, she is reportedly very shy. She appears to be normal. The family lives in the country and their life style is simple and basic. Although their location may be socially isolating for the children, the parents are said to be very caring and protective. The public health nurse has assisted the family in updating the children's immunizations and continued follow-up is anticipated.

SUMMARY

This study has explored the reasons why women decide to deliver their babies at home rather than in a hospital. Specifically, the study addressed itself to several broad questions: Who are the women who choose to have a home birth? What motivated their decision? How did they prepare for the birth? What were the circumstances under which it took place, and what care did the mother and child receive? The study has focused on planned home births in Michigan in 1976. A systematic effort was made to have a representative sample of women who chose to deliver at home. However, it must be remembered that the study excludes births to unwed mothers because those birth certificates were not available for purposes of a study such as this one.

BACKGROUND

While essentially homogeneous in racial background, the home birth parents in the sample came from a cross-section of socio-economic groups. A substantial number of the women were college educated as were the majority of their husbands. Some of these couples identified with religions that reject

certain forms of modern medical and health care, but essentially, a wide range of religions were represented in the sample. The majority of the women had spent most of their lives in an urban area, but women with rural backgrounds were also represented in a fairly substantial proportion.

PREVIOUS HOSPITAL EXPERIENCE AND THE DECISION TO DELIVER AT HOME

More than half of the women in our study had delivered in a hospital prior to 1976, and most of them described their hospital experience in negative terms. Such issues as the loss of control, separation from the baby, and impersonal relationships with the hospital staff concerned them. Similar issues were cited in response to the question, "Why did you decide to deliver at home?" Five reasons emerged as major influences in the decision: (a) these women viewed pregnancy and delivery as a healthy life process rather than a disease; (b) they had a strong negative orientation toward hospitals; (c) they were committed to assuming an active role in the birth process; (d) they desired emotional support and involvement of friends and relatives in the experience; finally, (e) economic factors appeared to be an additional reason for some. The father usually participated in this decision. Most of the women were exposed to efforts to dissuade them from proceeding with their plans for a home delivery. However, in general, the respondents did not believe that there were major risks attached to having a home birth, especially if the mother had prenatal care.

OBSTETRICAL HISTORY, PREPARATION FOR HOME BIRTH, AND CARE DURING LABOR AND DELIVERY

Based on their reported obstetrical histories, only two of the women who had a hospital delivery previous to 1976 would have been considered at risk.

Preparation for the home birth assumed various forms: prenatal care, participation in childbirth classes, reading, special instructions, and preparation of the physical environment. While the overwhelming majority of women (68) had prenatal care, the percentage of women without prenatal care was higher for the sample than for the total population of

women who delivered in 1976 in Michigan. Sixty-eight women read books about childbirth, and 61 either attended birth preparation classes, had special instruction about the birth process or both. Most women indicated they would have gone to the hospital in case of an emergency.

Perhaps the most noteworthy finding concerning the care during labor and delivery is that only 35 of the 74 women said they delivered in the presence of a physician. Fifteen of the women who delivered without a physician present were attended by a nurse or a midwife; 24 delivered without either a physician or any other health professional. As a result, conventional medical monitoring of blood pressure, urine, etc. was less extensive and frequent than it would have been in a hospital. Women experimented with different positions and food consumption patterns during labor and delivery. They also took advantage of the home situation by allowing their husband, relatives and friends to attend the birth. The majority of the women and their infants received follow-up care in the weeks or months after the birth; however, in eight cases it was reported that, as of the date of the interview, the baby had not been seen by either a physician or a clinic since birth.

OUTCOMES

While it was not the intent of this study to evaluate the risks of planned home births, a few observations were made concerning birth weights, infant and maternal morbidity and the women's retrospective feelings about home births.

A large majority of the women described the experience of the home birth in distinctly positive terms, and almost all said they would have another home birth. The majority would also recommend a home birth to others. One woman, however, stated explicitly that she would not recommend a home birth. A comparison of birth weights of babies born outside of the hospital and those in the sample generally show a marked difference. Birth weights included in the sample of planned home deliveries are significantly higher than those of all out-of-hospital or home births as defined by birth certificates. The birth weights of the babies born to women in the sample were also higher than those for all Michigan births in 1976. Two referrals were made to community health nurses as a

result of the interviews. In both cases the referrals were based on the interviewer's observation that the child did not appear to function normally and seemed to be in need of health care.

OVERVIEW AND RECOMMENDATION

Today, women who decide to deliver their baby at home are non-conformers; they have made a decision that the majority of women and health care professionals would probably regard as ill-advised and dangerous. In light of this, it is not surprising that women who carry through with their plans for a home birth have strong views supporting the decision they have made. The women interviewed had a holistic perception of the birthing process. They viewed pregnancy as a well condition rather than a disease, and delivery as a joyful occasion in the life of women and their families. By contrast, hospital care was perceived as being compartmentalized, often separating the woman from her family and the newborn from its mother, in a highly technological, routinized environment. These women preferred the home as the location for birth because there they were able to experience childbirth as a family event in which they were active participants. Most of them argued that, with medical screening, good prenatal care, and adequate preparation for the home birth, it does not involve major risks. In fact, some of them suggested, a home birth may present fewer hazards to the mother and her infant than a hospital.

The emphasis upon pregnancy and delivery as a healthy life process for which the woman herself assumes responsibility, the rejection of current hospital practices and costs, and the low assessment of the risks of a home birth form a logically coherent attitudinal profile. This profile bears much resemblance to a variety of other, more general efforts directed at seeking alternatives to the established health care facilities. While the individuals in the sample were not necessarily active in the women's health movement or holistic health approaches, there is a strong similarity of purpose which links the decision to have a home birth to such movements.

In light of the strongly non-conformist position these women have taken with regard to birthing, it is important to note that the home birth movement is spread over a fairly broad section of society. It is not limited to women in counter-culture or unusual religious groups as some writers have earlier assumed. The trend toward home births must also be viewed as a criticism of rising hospital costs. While economic factors were by no means the main motivation behind the decision to deliver at home, they were an important element for some of the respondents. The criticism of the existing health care facilities and an active search for alternatives has thus reached a wide cross section of Americans. This suggests that responses to this phenomenon deal with it not as an aberration but as a serious criticism of existing obstetrical services. This study has several implications for policy and research.

POLICY RECOMMENDATIONS

Care For Women Who Choose a Home Birth

The decision to deliver at home is not a casual one. Most of the women had a consistent set of beliefs to explain the decision and persisted in their plans in the face of considerable efforts on the part of health care professionals, relatives or friends to dissuade them. Given the strength and consistency of these attitudes, and given the fact that the trend toward home births is continuing, it is important to examine the health care needs of home birth mothers and to implement health care strategies designed to meet these needs. Although a systematic assessment of the hazards of planned home births should be encouraged, an emphasis upon the risks is, by itself,

an inadequate response. As long as there are women who choose to deliver at home, it is important to assure that they do so with as much preparation, professional guidance and backup as possible.

The respondents differed in the extent to which the home birth was conducted under professional medical and health supervision. Although the majority of the women had fairly regular prenatal care, were attended by a physician, had postpartum care for themselves and follow-up for their infants, others lacked one or more aspects of such professional attention. For example, the two infants who were referred to public health nurses as a result of the interview were born to women who had essentially no prenatal care and delivered without a physician. These referrals illustrate perfectly the fact that some families are in need of health care, sometimes urgently, but do not know where or how to get it. While it may be that some women reject various dimensions of medical attention, before, during or after delivery, it is equally plausible that such care is simply unavailable to them. It is essential that prenatal care and medical attendants be readily accessible to women who choose home birth. It is also important that women who deliver at home are contacted by a public health nurse in order that appropriate medical and health services be arranged for parents who wish it. This applies equally to both planned and unplanned out-of-hospital births.

Alternative Birth Settings

It is important to provide a setting, whether within or affiliated with hospitals, where women can deliver in situations which provide not only the comforts of the home, but allow them to play a more active role in the birthing process. Successful experiments with such arrangements have been cited in the literature on birthing centers. Women are sufficiently close to the hospital to allow speedy access to all its technological facilities, but they are also sufficiently remote from it to protect the patient from its overbearing routines and procedures. Some of the women who now elect a home birth may see birthing centers as an attractive alternative to a home delivery. Such birthing centers also might respond to the needs of many other women who now deliver in hospitals but react

to their hospital experience in ways that are similar to those of the home birth parents.

Critical Evaluation of Existing Hospital Settings

In spite of the increasing trend toward home births, most women continue to deliver in a hospital. However, it is suspected that women who do so share to one degree or another the criticisms that mothers of this study expressed. A careful re-evaluation of hospital obstetrics is indicated. There certainly are ways in which patients can be provided with continuity of care from familiar health professionals. For example, hospitals are discovering that birthing rooms are a popular, viable alternative to segmented, compartmentalized care. In these comfortable, home-like settings, labor and delivery, which are traditionally separated, are brought together because the women can stay in one room for the entire birth.

Hospital administrators and personnel must express a willingness to take seriously the patient's needs for involvement in decisions regarding her care. They also must recognize that the presence of family members is an important ingredient in making the hospital delivery a satisfying experience.

It is relatively easy to make recommendations about the changes that are required if the existing health care system is to accommodate patients who have a view of health, their bodies, and birth that is almost diametrically opposed to current norms and practices. The more difficult chore is to suggest how such changes are to come about. This study of home birth illustrates a principle that has been observed for many other change efforts as well: good plans or recommendations also should indicate how they can be implemented. This latter criterion is very difficult to satisfy because the recommendations which are listed imply a dramatic change in attitude and behavior on the part of health care professionals. One can only hope that the very dramatic rejection of the existing care facilities implied in the home birth movement provides a stimulus for genuine change.

RECOMMENDATIONS FOR RESEARCH

Several methodological issues for the study of home births have been illustrated by this study; foremost among them is the importance of distinguishing between planned and un-

planned home births. Both are important topics for study, but they present distinct phenomena with very different origins and implications. This study has focused on planned home births on the assumption that planned, and not unplanned, home births account for the increase in home births. However, unplanned home births should be a critical area of concern. Why does the unplanned home birth occur? Could it have been prevented?

A second major methodological issue pertains to the difficulty of obtaining a representative sample of women who enter labor with the intention of delivery at home whether or not they do so. It is extraordinarily difficult to obtain a representative sample of this universe. If birth certificates are used as the starting point, women who plan a home birth but have to go to the hospital on an emergency basis during labor or delivery are excluded. These cases cannot be identified on the birth certificates. Contacting a sample of hospital births to discover what percentage of the women had intended to deliver at home is totally unfeasible given the small numbers of home births. On the other hand, studying the patients of health providers who are known to serve women planning home births has the limitation of being unrepresentative.

In the absence of entirely satisfactory procedures for studying the home birth phenomenon, it is necessary to be content with second best solutions and try to learn from a variety of approaches.

APPENDIX A:

Non-Hospital† and Home Births in Michigan, 1970-1976

Year of Birth	Michigan Births				
	Total	Non-Hospital		Home	
	Number	Number	Percent	Number	Percent
1970	170,515	360	0.21	271	0.16
1971	161,142	393	0.24	311	0.19
1972	146,016	355	0.24	283	0.19
1973	140,359	376	0.27	282	0.20
1974	136,418	369	0.27	282	0.21
1975	132,777	418	0.31	313	0.24
1976	130,253	539	0.41	375	0.29

†Home births are included in non-hospital births.

APPENDIX B:

Section of the Vermont Birth Certificate Requesting Information Regarding Planned Site of Birth (Refer to Q. 30)

CONFIDENTIAL INFORMATION FOR MEDICAL AND HEALTH USE ONLY; NOT FILED AS PART OF THE PUBLIC RECORD

(Health Department personnel: detach for statistics; destroy after one year.)

CHILD — NAME: FIRST / MIDDLE / LAST — BIRTH WEIGHT — 14a / 14b

PREGNANCY HISTORY (Complete each section)

FATHER — RACE — EDUCATION—SPECIFY HIGHEST GRADE COMPLETED: Elementary or Secondary (0-12) / College (1-4 or 5+) — 15 / 16

LIVE BIRTHS (Do not include this Child): 17a Now living: Number ___ None ☐ — 17b Now dead: Number ___ None ☐

OTHER TERMINATIONS (Spontaneous and Induced): 17c Before 20 weeks: Number ___ None ☐ — 17d After 20 weeks: Number ___ None ☐

MOTHER — RACE — EDUCATION—SPECIFY HIGHEST GRADE COMPLETED: Elementary or Secondary (0-12) / College (1-4 or 5+) — 18 / 19

DATE OF LAST LIVE BIRTH (Month, Year) — 17e

DATE OF LAST OTHER TERMINATION (Miscarriage or abortion) (Month, Year) — 17f

DATE LAST NORMAL MENSES BEGAN: MONTH / DAY / YEAR — 20

WEEKS OF GESTATION — 21

MONTH OF PREGNANCY PRENATAL CARE BEGAN: FIRST, SECOND, THIRD ETC (Specify) — 22a

PRENATAL VISITS TOTAL NUMBER (If none, so state) — 22b

WAS SILVER NITRATE OR OTHER SUITABLE PROPHYLACTIC USED IN BABY'S EYES? ☐ YES ☐ NO — 23

DATE(S) OF BLOOD TESTS (STS): MONTH / DAY / YEAR — 24a

SECOND TEST: DAY / YEAR — 24b

IF NONE, GIVE REASON — 24c

WAS MOTHER MARRIED? ☐ YES ☐ NO — 25

COMPLICATIONS OF PREGNANCY (Describe or enter none) — 26

PLANNED SITE OF BIRTH: ☐ Local hospital ☐ Referral hospital ☐ Home ☐ Other (Specify) — 30

CONCURRENT ILLNESSES OR CONDITIONS AFFECTING THE PREGNANCY (Describe or enter none) — 27

COMPLICATIONS OF LABOR AND/OR DELIVERY (Describe or enter none) — 28

DELIVERY: ☐ VAGINAL ☐ CAESAREAN — 31

CONGENITAL MALFORMATIONS OR ANOMALIES OF CHILD (Describe or enter none) — 29

APGAR SCORE: 1 min / 5 min — 32

IS INFANT LIVING AT TIME OF REPORT? ☐ YES ☐ NO — 33

APPENDIX C:

Letters from Families.

The following two letters are examples of those which were received from families who were contacted for the study but had left Michigan following their 1976 home birth.

Dear Mary Conklin:

We received your letter concerning home deliveries the other day. We have moved to Kansas, so were late in receiving it.

We were glad to hear that your department is taking an interest in this. Jill is our 7th child and the only one born at home. It was a wonderful delivery — the easiest I have had and the most enjoyable. The Doc did not arrive until after delivery. My husband had never been allowed in the delivery room so had always been a stranger to the other children until they had been home a while. Jill has been his baby from the moment he first saw her. It was wonderful for me to hold her and see her lift her head and smile at me even before the cord was cut. Before I was never allowed to touch my baby until after they had been washed and dressed.

The main reason we decided to have our baby at home was because of the high cost of hospital care. Really, what do you get for $1,000?

If we ever had another baby we would have it at home even if the hospital was free, because we realize now that a home delivery is so much for the mother, father and baby and the other children in the home.

I think it would be wonderful if each county could have some one trained to assist in home deliveries. Of course I feel that good doctors care before delivery is very important. If we can be of any help please let us know.

P.S. Our next youngest is 14.

Dear Mary Conklin:

We have since moved to Idaho as you can see, but we would be willing to answer any questions you have. Technically speaking though ours wasn't a home birth, since

Naomi was born at the doctor's office with his assistance. We had planned it that way.

Hopefully our next child (if and when we have one) will be born at home. Preferably with a practiced midwife present. We would almost certainly never give birth to a child in a hospital again as we did with our first child, Joshua.

Departments such as yours could do good things for parents and their babies by educating and encouraging hospital folks to think of birth as a more natural, emotion-filled, and meaningful occasion rather than thinking of birth in terms of clinical efficiency as seems to be the case now. But more importantly I think you could do more good by encouraging midwives in their training, legalizing midwife activity if it is not legal now, and encouraging classes in prepared childbirth such as Lamaze. I do not think it wise for untrained and unprepared parents to give birth by themselves at home, but given the present state of hospital care, I think even that is preferable to enduring the assault on body and soul which is presently called medical care.

But anyway, let the questions come, and if your intentions are to be helpful to expectant parents we will answer them gladly. If on the other hand your questionnaire is designed only to find ways to prevent the present hospital care system from losing more "patients" well then we may not be so polite.

APPENDIX D:

The Questionnaire

One female interviewer conducted the entire fieldwork. She was trained by individual instruction in interviewing techniques and aspects of pregnancy and the birth process. The interviews were conducted in each family's residence with the interviewer filling in the form with verbatim comments. Both mother and father were requested to be present at the interview.

SECTION I — BACKGROUND INFORMATION

The following questions pertain to all of your pregnancies.

1. How may children do you have?

2. What are their birth dates?

3. Have you had any other pregnancies?

   Yes No

   IF YES:

4. What happened to these pregnancies?
   1. Stillbirth (fetal death after 20 weeks)
   2. Child deceased
   3. Voluntary abortion
   4. Involuntary abortion (miscarriage)
   5. Adoption

5. You told me that you have ____ children. The last one was born at home, right?

   Yes No

   Now we'll talk about the others.

6. How about the oldest child, where was he/she born? Was it at a hospital? At home? Or someplace else?
    1. Hospital
    2. Home
    3. Other (SPECIFY)

7. Who delivered this child?

8. Who else was present? (IDENTIFY PROFESSION OR RELATIONSHIP)

9. The second oldest child?
    1. Home delivery
    2. Hospital
    3. Other (SPECIFY)

10. Who delivered this child?

11. Who else was present? (IDENTIFY PROFESSION OR RELATIONSHIP)

12. The third oldest child?
    1. Home delivery
    2. Hospital
    3. Other (SPECIFY)

13. Who delivered this child?

14. Who else was present? (IDENTIFY PROFESSION OR RELATIONSHIP)

(IF ANY PREVIOUS CHILDREN WERE BORN IN A HOSPITAL, ASK:)

15. You said that ____ of your children were delivered in a hospital. How did you feel about your hospital delivery?

(IF MORE THAN ONE HOSPITAL DELIVERY, ASK ABOUT EACH ONE.)

16. Now your last baby was born at home. Thinking about your pregnancies prior to this one, did you have any problems while you were pregnant?

Yes No

IF YES:

17. What were these problems?

18. What about during your labor and delivery, did you have any complications?

Yes No

IF YES:

19. What were these problems?

SECTION II — THE DECISION TO HAVE THE BABY AT HOME

As I told you earlier, I am really interested in home deliveries and why people are having their babies at home.

20. Why did you decide to deliver at home?

    (THIS QUESTION IS INTENDED TO REFER TO THE ORIGINAL DECISION; NOT NECESSARILY TO THE LAST BABY.)

21. When did you decide to have the baby at home rather than in a hospital?

22. Was the father of the baby involved in deciding to have a home delivery?

    Yes No

    IF YES:

23. Who suggested it first, he or you?

    (REMEMBER FATHER AND RESPONDENT TOGETHER.)

24. What about other people, did anyone else encourage you in making this decision?

    Yes No

    IF YES:

25. Who?

Friend
Neighbor
Relative (SPECIFY WHO) _____
Medical person (SPECIFY WHO) _____
Other

26. What was said to encourage you to have a home delivery?

27. Did you ask for this encouragement or was it given without your asking for it?

I asked for it.
It was given without asking.
Both

28. Did anyone discourage you from having a home delivery?

Yes No

IF YES:

29. Who discouraged you?

30. What was said to discourage you from having a home delivery?

31. Did you ask for this opinion or was it given without your asking for it.

I asked for it.
It was given without asking.
Both

32. Did anyone you know ever have a home delivery?

Yes No

IF YES:

33. Who was it?

(PROBE: HOW ABOUT A RELATIVE SUCH AS A GRANDMOTHER, AUNT, ETC.)

34. Have you ever been present at a home delivery other than your own?

Yes No

35. Have you ever seen a movie or a TV program about a home delivery?

Yes No

SECTION III — PREPARATIONS FOR THE HOME DELIVERY

Now, we'll talk about the preparations you made for the home delivery.

36. Have you ever read any books about childbirth?

Yes No

IF YES:

37. Which ones did you read?

38. Have you ever attended any birth training classes?

Yes No

IF YES:

39. What type of class?

40. Did you attend classes for this last pregnancy?

Yes No

IF YES:

41. What type of class?

42. Did anyone give you any special instruction to prepare for the home delivery?

Yes No

IF YES:

43. Who taught you? (THEN SKIP TO NO. 45)

Physician
M.D.
D.O.
R.N.
L.P.N.
Lay/Granny Midwife
Other

IF NO:

44. How did you know how to get ready for having the baby delivered at home?

(THEN SKIP TO NO. 49)

45. In the classes or special instruction that you took, did the instructor talk about problems associated with pregnancy, labor and delivery?

Yes No

IF YES:

46. What problems were discussed?

47. Do you think the treatment of problems was adequate?

Yes No

IF NO:

48. What problems were left out?

49. What did you actually do to get ready for the home delivery?

(PROBE — HOW ABOUT THE HOME *OR* HOW ABOUT YOURSELF, DID YOU DO ANYTHING TO PREPARE YOURSELF?)

50. Did you need to get any special equipment?

Yes No

IF YES:

51. What type of equipment?

SECTION IV — PREGNANCY OF BABY LAST DELIVERED AT HOME

The following questions pertain to the months before your last baby was born and to the care you received during this pregnancy.

52. Did you have any health problems or conditions during that pregnancy?

Yes No

IF YES:

53. What were they?

54. How about?

—high blood pressure
—heart trouble
—asthma
—diabetes
—anemia
—other (SPECIFY)

55. Did you receive prenatal care during this pregnancy?

Yes No

IF YES:

56. By whom? (PROFESSIONAL BACKGROUND)

57. How many visits did you have with this person for prenatal care?

58. During what month of your pregnancy did you first receive prenatal care?

59. Did you have blood tests?

Yes No

IF YES:

60. When?

61. How about your blood pressure? Was it checked at each prenatal visit, occasionally or not at all?

At each visit
Occasionally
Not at all

62. How about your urine? Was it checked at each visit, occasionally or not at all?

At each visit
Occasionally
Not at all

63. Did anyone listen to your baby's heart after your 5th month?

Yes No

64. Did you have a pelvic examination (or internal) of your womb?

Yes No Don't know

IF YES:

65. At what month did you have one?

_____

Don't know

SECTION V — CARE DURING LABOR AND CONDUCT OF LABOR AND DELIVERY

Now I would like to ask some questions about the labor and delivery of this last baby that was delivered at home.

66. Did anyone monitor your (the mother's) blood pressure during labor and delivery?

Yes No Don't know

IF YES:

67. How often?

68. Did anyone test your (the mother's) urine during labor and delivery?

Yes No Don't know

69. Did anyone listen to the baby's heart beat during labor?

Yes No Don't know

70. Did anyone do a vaginal (or internal) exam during labor?

Yes No Don't know

71. Who was with you during labor and delivery?

72. In what position were you most comfortable during your labor and delivery?

73. Did you eat and/or drink during labor?

Yes No

IF YES:

74. What did you have?

75. Did you take anything during labor like tranquilizers or medicine for pain?

Yes No

76. Did you do anything to ease the pain like massages or breathing exercises?

Yes No

77. What position did you deliver in?

Lying down, propped with pillows ____
Squatting ____
Knees to chest ____
Hands and knees ____

78. How did the delivery go? (PROBE: WAS IT EASY OR DIFFICULT?)

79. Were you able to hold the baby immediately after delivery?

Yes No

IF NO:

80: Why not?

81. Did you nurse the baby immediately after delivery?

Yes No

82. Right after the baby was born, was any particular care given to you (the mother) to make sure you were all right?

Yes No

IF YES:

83. What was done?

84. Did you receive any care in the weeks following the birth of the baby?

Yes No

IF YES:

85. By whom?

86. Right after the baby was born, was any special care given to him/her?

Yes No

IF YES:

87. What kind of care? (PROBE: WHAT ABOUT EYE CARE?)

88. Where was it given?

89. What medicine was used?

90. Have you taken the baby to a doctor, clinic or hospital since birth?

Yes No

IF YES:

91. Where was he/she taken?

92. What was the reason(s) for the visit?

93. Did the public health nurse call at any time during the 1st month after delivery?

Yes No

SECTION VI — AWARENESS OF RISK

94. Some people think there are special problems or risks for the mothers who deliver at home. Others disagree and think that there are no special problems or risks. What do you think?

IF YES:

95. What are the problems or risks?

96. How about for the baby? Do you think there are any special problems or risks in delivering a baby at home?

Yes No

IF YES:

97. What are they?

98. If you or your baby had had any problems during labor and delivery, would you have gone to the hospital?

Yes No

IF YES:

99. For what kind of problems?

100. Did you have any plan as to how you would get to the hospital if you needed to go?

Yes No

IF YES:

101. How would you have gone?

IF NO:

102. Why would you not have gone to the hospital?

SECTION VII — FEELINGS ABOUT HOME DELIVERY

103. Looking back, how do you (the mother) feel about your home birth? Would you say you are:

Very positive and enthusiastic
Positive with some reservation
Neutral
Negative but with some positive feelings
Negative

(EXPLAIN RESPONSE)

104. If you were to have another baby, would you have it at home?

105. Would you recommend a home delivery to others? Would you:

Strongly recommend
Recommend
Neutral
Discourage
Strongly discourage

106. As I told you at the beginning of the interview, this study is conducted by the Public Health Department. We are interested in finding out what needs to be changed in hospitals to make delivery a better experience for women and would like to know your views on this subject. What do you think needs to be changed in hospitals to make delivery a better experience for women?

SECTION VIII — GENERAL INFORMATION

107. Have you lived most of your life in a rural or urban area?

Rural Urban

108. In what state?

109. Occupation of mother _____

110. Occupation of father _____

111. Do you have hospitalization insurance?

Yes No

IF YES:

112. Was this pregnancy covered?

Yes No

113. Total family income:

1000— 3999	13000—19999
4000— 7999	20000—29999
8000— 9999	30000—49999
10000—12999	50000 & over

114. Number supported _____

115. Religious affiliation _____

BIBLIOGRAPHY

Annas, George J. "Medicolegal Aspects of Homebirth and Alternative Birth Methods." Paper presented at the annual meeting of the American Public Health Association. (Washington, D.C.) Oct. 31, 1977.

The author points out that while the home birth movement has made some impact on hospital practices—the attitudes and laws regarding "husband-coached" labor for example—acceptance is by no means universal. This is symbolized in a Montana court ruling that denied the constitutional right of a woman to have the father of her child with her during delivery. This and other medicolegal aspects of birth in this country are a result not only of the limited rights of women, but also of conventional medical rationale that regards childbirth as "comparable to other serious hospital procedures." These forces are powerful even in the censure of physicians who practice homebirths. The author concludes that the burden of proof necessary to create change is on the advocates of alternatives. Dr. Annas proposes a national demonstration project to prove that alternatives in and out of the hospital are reasonable, as well as safe and cheap.

Bing, Elizabeth D. "Progress in Low-Risk Normal Childbirth Care." *Birth and the Family Journal* 2(1975):109, 143.

According to the author, the philosophy of the Non-Hospital Maternity Center (opened in New York City by the Maternity Center Association in October 1975) is one in which the pregnant woman and her family make significant decisions regarding their care. This is provided for in a home-like environment that emphasizes prenatal care, education and screening for women under 35 years of age who live in three boroughs of New York. The Maternity Center Association hopes to show that the emphasis on screening will result in a small number of emergency transfers to hospitals. The intention of the Maternity Center is to "foster in expectant parents confidence in their own ability to bear and raise healthy children."

"Births at Home Create Debate on Safety." *The Nation's Health* 7(Feb. 1977):12.

This article outlines the opposing positions in the debate on home births, characterized by Dr. Lewis Mehl on one side and the American College of Obstetrics and Gynecology and other physicians on the other. Dr. Mehl has done several studies of

home births that are favorable. In contrast to Mehl, Dr. Jean Pakter of the New York City Department of Health suggests that the home trend may "be more talk than actuality." All agree that there may be negative outcomes in home births that may have been avoided in the hospital. This is summed up in a statement by the American College of Nurse Midwives that does not prohibit nurse-midwife involvement in home births but says that maternity centers and hospitals are more appropriate places.

Burnett, Claude, et al. "Home Delivery and Infant Mortality in North Carolina." Paper presented at the 105th American Public Health Association Annual Meeting. Nov. 1977.

This study compares the characteristics of the 340 home births in North Carolina in 1975 to a matched hospital population and to all births in the state. Its results illustrate that the home birth population is disproportionately black (80%), illegitimate (40%), and undereducated (21% have less than a ninth grade education). There was also an above average incidence of birth weights below 2500 grams and neonatal mortality rates were 7.5 times greater than those of the infants born in hospitals. Furthermore, the authors report that the gestational age of the home delivery population was lower than that of their hospital counterparts. The pregnant women who were to deliver at home started prenatal care later and had fewer prenatal visits. Because this population was concentrated in five socio-economically depressed counties in the state, the authors feel safe in concluding "that the study group had less access to medical care."

Carlson, Billie and Sumner, Philipe. "Hospital At Home Delivery: A Celebration." *JOGN Nursing* 5(Mar. Apr. 1976):21-27.

By providing continuity of the labor-delivery sequence in the Lamaze rooms, the obstetric staff at Manchester Memorial Hospital in Manchester, Connecticut seek to achieve a balance between the emotional and medical aspects of birth. Balance is achieved in the home-like rooms by special Lamaze trained nurses (montrices) who provide continuous uninterrupted physical and emotional support, as well as manage the labor, blood pressure checks, sterile vaginal examinations and fetal heart monitoring. They are also responsible for administering medications and keeping the physician informed.

Dingley, Erma F. "Birthplace Alternatives." *Oregon Health Bulletin* 55(Oct. 1977). Oregon State Health Division, Portland, Oregon.

In Oregon the number of out-of-hospital births increased 50% between 1975-1976. In 1976, 959 births occurred outside the hospital; 74% of these were specified as home deliveries, 18% were delivered in clinics and 8% in residences other than the mother's. A review of birth records also shows that women who delivered at home had above average levels of education, and 12% of the out-of-hospital births had no prenatal care compared to the respective figure of 1% for the total population.

Edgar, Linda. "Home Delivery Dutch Style." *Canadian Nurse* 71(Oct. 1975):36-8.

The author, a nurse, delivered her second child at home when she was living in Holland—where 70% of all births occur at home and the infant mortality rate is the lowest in the world (9.1 per 1000 births versus 19.1 in the United States). In Holland, nursing services are available to the woman and her family before, during and after the birth on a full or part-time basis. And it is common practice for doctors to attend home births and make regular house calls afterward. Despite these excellent services and her positive experience, Linda Edgar remains frightened by possible risks and suggests that a modified hospital environment might "combine the best of both worlds."

Edwards, Margot E. "Unattended Home Birth." *American Journal of Nursing* 73(Aug. 1973):1332-35.

Written from the perspective of a nurse and childbirth educator, this article discusses the attitudes of couples who opt for a home birth unattended by either a nurse or physician. The sample discussed in the article seems to be composed primarily of couples who have a "hip" lifestyle, value involvement of friends and family and personal responsibility for their decisions. These couples "express to a greater and more extreme degree the attitudes of those who seek family-centered maternity care." In addition to a discussion of important issues in childbirth education of home birth couples, this article includes results of a survey of 36 women who choose unattended home birth in two California counties.

Emrey, Margaret A. "Home Births in California." Unpublished report by the California State Department of Health.

There has been a sharp increase in the incidence of home birth in California since 1975 when there were 3,516 out-of-hospital births. They appear to be clustered in the north and central counties of the state. In Marin County, for example, 7.8% of the births were out-of-hospital as opposed to a rate of 1.1% for the entire state. Though no distinction is made between planned and unplanned births, a review of the birth records showed a correlation between out-of-hospital deliveries and late or absent prenatal care. The author, a nursing consultant for the state department of health, believes that these trends are a reflection of (a) the shortcomings of MediCal; (b) lack of knowledge on the part of consumers; (c) costs of medical care; (d) the reluctance or refusal of physicians to serve families who want a home birth; and (e) distrust of traditional medical practice and practitioners. The article also reviews the roles of physicians, nurse-midwives and lay midwives in home births.

Epstein, Janet E. and McCartney, Marion. "A Home Birth Service That Works." *Nursing Care* 9(Dec. 1976):30-1, 34.

The authors are registered nurses who assisted local obstetricians with home births before they became certified midwives and started the Maternity Center Association, Ltd. in Bethesda, Maryland in 1975. The home services they provide have the support of the physicians, any one of whom is on call during all the home births the midwives conduct. Couples who avail themselves of home delivery services must meet certain medical and non-medical qualifications. In addition to having completely normal histories and laboratory results, clients must receive prenatal care as recommended by ACOG, live a certain distance from the hospital, agree to be transferred there if necessary and make arrangements for the infant to be seen by a pediatrician within 24 hours. The philosophy of Maternity Center Associates, which stresses education and post partum follow-up, is to assist couples committed to home birth in achieving their own goals.

"Fathers in the Delivery Room." *Briefs* 40(Mar. 1976):38-9.

This is a brief outline of two court cases (in Montana and Indiana) and legislation before Congress regarding the right of fathers to attend the hospital delivery of their children. Representative James C. Corman of California has introduced legislation to permit the fathers' presence during delivery in all hos-

pitals that receive federal funding or benefit from federally guaranteed loans. This contrasts with the prevailing practice in which hospital administrators and trustees make decisions regarding fathers' attendance on an individual basis with medical advice.

Hazell, Lester. *Birth Goes Home: An Ethnographic and Attitudinal Study of 300 Couples Electing Home Birth in the San Francisco Bay Area.* Seattle, Washington, Catalyst Publishing Co., 1974.

Hosford, Elizabeth. "Alternatives in Nurse Midwifery Care: III. The Home Birth Movement." *Journal of Nurse Midwifery* 21(Fall 1976):27-30.

The author, coordinator of the Childbearing Center of the Maternity Center Association in New York, believes that trends in alternative birthing practices are positive in terms of their significance to national health, maternity care, and individual families. These trends reflect the greater responsibility individuals are taking for their own health. Furthermore, as birth centers and home services are created to respond to the needs of families, hospitals are being forced to offer a wider spectrum of services, such as family-centered care. According to the author, more studies need to be done in areas such as a woman's subjective experience of birth and its outcomes, and the effects of breast feeding on the later emotional development of the child.

Huygen, Frans J. "Home Deliveries in Holland." *Journal of the Royal College of General Practitioners* 26(1976):244-48.

This is a discussion of the philosophy and practice of obstetrics in Holland where normal deliveries are at home, attended by a midwife or general practitioner, and high risk births take place in the hospital attended by a specialist or gynecologist. Professor Huygen addresses the issues of national health insurance and the distinctive roles of midwives, general practitioners and gynecologists in a comparison of perinatal mortality rates for Great Britain and the Netherlands and on analysis of deliveries in Holland.

Lee, Cynthia. "Delivering a Baby at Home: The Rewards Vs. the Risks". *The Detroit News*, 21 Sept. 1977.

According to the author, a woman who wants a home delivery has three options: finding a cooperative physician, locating a trained midwife practicing illegally or visiting Birthcenter, a Highland Park organization of self-taught midwives. The general

discussion on home births mentions studies on the subject being done in Michigan, Minnesota and California, and it includes two accounts of home deliveries—one successful, the other unsuccessful.

Long, Phyllis and Jefferis, Clara. "Home Deliveries." *Frontier Nursing Service Quarterly Bulletin* 50(Spring 1974):33-36.

This article outlines the preparation, management and postpartum follow-up of deliveries by the Frontier Nursing Service over the past 50 years. In the last 25 years the FNS has served 2,669 women at home without a maternal death. This statistic supports others suggesting that home deliveries are as safe as hospital deliveries and that there is a relationship between nurse midwifery care and a reduction of maternal and infant mortality.

Lubic, Ruth Watson. "Alternative Patterns of Nurse-Midwifery Care: I. The Childbearing Center." *Journal of Nurse-Midwifery* 21(Fall 1976):24-5.

According to the author and director, the Maternity Center Association created the Childbearing Center as a direct alternative to "impersonalized interventionist, pathologized, technology-oriented, unresponsive and costly in-hospital care." The Center is staffed by physicians, nurse-midwives, nurse-midwife attendants and visiting nurses who provide follow-up visits to the home. The philosophy of the Childbearing Center emphasizes educational prenatal care and screening in an environment where professionals and consumers alike struggle to shed the orientation of modern obstetrics toward pathology.

Matousek, Irene. "Homebirths—Myths or Message?" *Journal of Nurse Midwifery* 19(Spring 1974):24-29.

In addressing herself to so-called myths surrounding home deliveries, the author illustrates that cultural pressures in favor of hospital deliveries and economics are making home deliveries increasingly impractical. Statistics from other countries and the examples of the Frontier Nursing Service and the Maternity Center Association in this country illustrate the importance of cultural or economic factors in responding to patients' needs for family-centered care in maternity facilities.

Maynard, Fredelle. "Home Births vs. Hospital Births." *Woman's Day*, 28 June 1977.

This article focuses on the psychological aspects of home births,

pointing out that many women believe that these benefits outweigh the risks and that hospital births pose risks also. At home the parents retain control in a peaceful, familiar environment. Without hospital interferences, the experience is enhanced because the family is together. It is true that many hospitals are introducing some of these aspects of the home experience and they deserve consideration, especially by women who for medical, psychological, or insurance reasons are not candidates for home births. It is important to have adequate preparation and a competent attendant to help insure that the out-of-hospital experience will be a successful and dignified one.

Mehl, Lewis. "Home Delivery Research Today — A Review." *Women's Health* 1(Sept./Oct. 1976):3-11.

This article divides the literature on homebirths into three categories: (1) Medical outcome studies generally report low levels of complications for home birth populations in Great Britain, California, Oklahoma and Washington, D.C.; (2) home-hospital comparison studies attempt to match home and hospital populations and conclude that the latter has a higher incidence of fetal distress, birth injuries, neonatal infections, post partum hemorrhages and depression; and (3) the conclusions about post partum depressions are further substantiated in psychological outcome studies that focus on parental attitudes and self esteem in comparing the home and hospital groups. This review of the literature is put into a political and social context by beginning and ending with a discussion of the history of modern obstetrics, its control by male physicians and their resistance to out-of-hospital alternatives. The position paper published by ACOG on the subject characterizes this resistance.

Mehl, Lewis E., et al. "Outcomes of Elective Home Birth: A Series of 1146 Cases." Unpublished Study, California Department of Health, Maternal and Child Health, 1975.

This study compares data from five home delivery services, including three physician groups and two lay midwife services. The women seeking home births appear to be a self-selected healthy group, and partly because of this, their births compare favorably in relation to the complication rates of the California population at large. Virtually all the women in this study had prenatal care, attended birth preparation classes and attempted to breast feed. Those delivered by midwives had a lesser number of episiotomies and lacerations requiring repair because the midwives practice techniques of perineal massage and gentle delivery. Further, the authors conclude that hospitals and physicians should

be encouraged to adopt some of these techniques and "generally provide a supportive, friendly and comfortable environment for labor and delivery."

Meyer, Barbara J. "Childbirth at Home — A Family Centered Affair." *JOGN Nursing* 5(Mar./Apr. 1976):20, 28-31.

This account of the author's experience and feelings surrounding the planned home delivery of her eighth child conveys the richness of her family life and the place the birth assumed in it. The birth was a happy family experience: The children had none of the fears associated with separation from the hospitalized mother and both parents marvelled at the changes in their child as they watched her continuously.

Miller, C. Arden. "What Technology Breeds: A review of recent U.S. Experience with Cesarean Section." Speech delivered at the John Sundwell Memorial Lecture. (Ann Arbor, Michigan) Mar. 20, 1978.

In 1965 the national cesarean rate was 4.5% of all live births. Today the figure is 12%, and in major medical facilities the figure is 25% Prompted by these figures and, in part, by his friendship with Ruth Lubic of the Maternity Center Association in New York, Dr. Miller questions this trend in terms of the technical-medical justifications for cesarean [illegible] terms of social economic factors. He explores the possibility [illegible] economic incentives for cesareans at a time when birth rates are declining and the number of obstetricians is increasing. Hence, there is a decline in the ratio of the number of live births to the number of physicians: from 260.7 in 1963 to 144.9 in 1975. Dr. Miller's observations of the psychoemotional experience of a cesarean birth for women and the concerns of the women's health movement in the U.S. reflect a humanist-feminist perspective.

Moawad, Atef H. "Some Problems of Professionally Attended Home Births." *The Journal of Reproductive Medicine* 19(Nov. 1977):298.

Dr. Moawad discourages home deliveries because of risk factors, unexpected problems that may occur during labor and possible post partum complications. Based on statistics regarding a higher incidence of death from neonatal pneumonia and infections among home birth infants in Great Britain, he encourages instead the development of a home-like atmosphere in hospitals rather than a total return to home births.

"New Interest in Home Deliveries." *Maternal & Child Health Information.* Health Services and Mental Health Administration Newsletter (Rockville, Maryland) 29 Jan. 1973.

According to this report excerpted from a speech by Dr. Kathleen Kendall (Chief Nursing Consultant, Maternal and Child Health Service), the interest in home deliveries seems to exist principally among "the communes or counter-cultural groups," as well as among well-educated women. The resurgence of home deliveries seems concentrated on the West coast. In contrast, the South, for example, is continuing determined efforts to decrease the number of deliveries by lay midwives. Accordingly, state health departments are gathering data on these trends.

Newton, Michael. "Woman, Wife, Mother." *Family Health* 9(Jan. 1977):19, 64.

This is an anecdotal account of the factors that went into this doctor's decision not to do home deliveries. It is the author's hope that more obstetrical units in hospitals will be transformed into a home-away-from-home where in a more personal, supportive environment a woman will have access to professional care and to an adjacent "high risk suite." He cites as examples the Family Hospital in Milwaukee and the Maternity Center Association's Childbearing Center in New York.

Petty, Carolyn. "No More Home Deliveries!" *RN* 43(Oct. 1972): 68-73.

This is an autobiographical account of a mother of three — all born by natural childbirth — who planned a home delivery to be attended by a nurse and a doctor. During labor, complications necessitated her transfer to a hospital where an emergency cesarean was done.

Petty, Roy. "Home Birth Movement Showing Signs of Growth, Respectability." *American Medical News,* 23 June 1978, p. 13.

Though the "alternative birth movement springs from a single source—a strong disenchantment with standard hospital and obstetrician childbirth methods," a broad spectrum of alternative birth advocates attended the NAPSAC conference entitled, "Compulsory Hospitalization or Freedom of Choice in Childbirth?" Some of the hospital practices that came under fire at the Atlanta conference in May, 1978 were electronic fetal monitoring, routine episiotomies, the high rate of cesarean sections, and oxytocin-induced labor, among others.

Popins, Lillian Saltzman. "Preparation for Premature Delivery at Home." *Nursing Care* 6(Dec. 1973):29-30.

In the event that premature labor is too far advanced, transportation is poor, or the infant is almost full term, Ms. Popins states that "everything should be done to promote safe delivery at home." Her article outlines the materials and procedures necessary for the preparation and delivery and follow-up care for mother and infant.

Rising, Sharon Schindler. "Alternative Patterns of Nurse-Midwifery Care: II. The Consumer-Professional Balance," *Journal of Nurse Midwifery* 21(Fall 1976):25-27.

The Childbearing-Childrearing Center (CCC) at the University of Minnesota was created as a result of consumer and professional dissatisfaction with the orientation of health practice toward sickness care. This service provides nurse-midwifery care within a hospital setting. It is consumer oriented in areas such as husband involvement, labor room delivery, no routines, immediate and continuing contact with the baby, and early discharge. Two other unique aspects of the CCC are provision for support groups during childbearing (several which have continued for two years) and pediatric nurse associates who provide early well-child care. Data from a survey of the first 137 women who participated in the services shows that 81% of them were "highly satisfied."

Ritchie, C. Ann and Swanson, Lee Ann. "Childbirth Outside the Hospital—the Resurrgence of Home and Clinic Deliveries." *Maternal Child Nursing* 1(Nov./Dec. 1976):373-77.

Beginning with an account of a young couple's pleasant delivery in a doctor's clinic, the authors discuss the growing trend toward out-of-hospital deliveries in terms of a comparison between the obstetric practices in other countries with those of the United States, which ranks 15th in infant mortality rates. In addition to disenchantment with hospital procedures, there are more positive reasons for the home birth trends, such as the desire for harmonius, natural births.

Sauer, Mark. "Birth, 'No Big Deal': 'Just Let Your Body Do it'." *The State Journal* (Lansing, Michigan), 8 May 1977.

This article presents the attitude towards birth held by a 19 year-old woman who is pictured jogging when she is eight months pregnant. She forthrightly articulates a rejection of standard hospital delivery practices and a philosophy of birth as a natural,

healthy event. Ms. Anderson does not completely reject the health care system. She visited a prenatal clinic regularly during her pregnancy and made arrangements for hospital back-up in the event of complications.

Stoltz, Marsha Kuhn. "Home Birth Safety Study Hit as Invalid." *Nursing Care Week* (Jan. 1978):2, 30.

An American College of Obstetricians and Gynecologists news release accuses home birth studies of statistical manipulation, but it agrees with those that report a two to five times greater rate of infant and neonatal mortality for home birth populations. This article presents the positions of physicians who agree with the ACOG report and those who do not. A major criticism of both groups is that the ACOG statistics are based on a small, perhaps unrepresentative sample of home births and makes no distinctions between those that are planned and those that are not planned out-of-hospital births. An ACOG representative says the college has no plans to release the full report.

Watkin, Brian. "Back to Home Deliveries." *Nursing Mirror* 144 (Feb. 1977):42.

Since the 1950's, health policies in England have aimed for greater percentages of hospital deliveries. Presently, the proportion of hospital deliveries is over 90%. Though stillbirth rates, deaths in the first week of life and maternal mortality rates have gone down, Marjorie Tews, a medical statistician has sought to demonstrate that there is a low correlation between these rates and the number of hospital deliveries. In fact, she has found that the hospital stillbirth rate was 14.8 per 1,000, while at home it was only 4.5 per 1,000. This remains a challenge to the national health policy.

White, Gregory. "A Comparison of Home and Hospital Delivery Based on 25 Years of Experience With Both." *Journal of Reproductice Medicine* 19(Nov. 1977):291.

In his presentation of the medical statistics of 100 women, 86 of whom wished to deliver at home, the author seeks to emphasize the importance of caution and conservatism necessary in home deliveries. Dr. White believes that it is the responsibility of the medical profession to see to it that "home deliveries become more accessible to those that want them."

Work, Bruce. "Home Birth: Technology vs. Togetherness." *Michigan Medicine* 76(Nov. 1977):590.

Dr. Work believes that the interest in home births, specifically the increased acceptance, may be a reflection of both economic and societal factors of "protesting the system." Though this "desire for increased freedom from institutionalized restraints" is understandable, it is also short-sighted because it rejects some of the technological advances available in hospitals. The author suggests that togetherness of the family and modern perinatology need not be mutually exclusive.

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