

ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 86/2

1546 SHESS SB 747 (#2) - (#3)

TABLE 18
CAUSES OF PERINATAL DEATH IN PLANNED HOSPITAL GROUP*

Age At Death	Number	Delivery	Complications	Cause of Death
During labor	1	Hosp	Rapidly F Fnt	Meningoencephalitis, etiology unknown
8 days	1	Hosp	None	Aplastic left ventricle

* To compare these data with the home-birth group, see Table 10, p. 89

Shenker et al.¹³ did, however, show a significant decrease in intrapartum deaths in the monitored series versus the unmonitored series in Bellevue Hospital in New York City. Clearly, the nursing care in Bellevue Hospital is not adequate, which brings us to recent studies from the West Coast showing an equivalent success rate of nurses versus fetal monitor, but with less infections reported with the nurses. It is not hard to imagine which was the more supportive personal care.

Other important points can be made. The perineal massage technique used by the midwives to aid in preventing vaginal lacerations during delivery was effective, and, as the physicians adopted this technique, their laceration rate decreased. The higher utilization of oxytocin after delivery by the physicians may have reflected its availability to them and their training to use it frequently. The equivalence of hemorrhage and blood loss results between the physician and midwife group suggests that it was not needed as frequently as used. The lay midwives took women to the hospital more frequently than the physicians, presumably reflecting their decreased capabilities to handle specific complications at home and their lower threshold level for going to the hospital possibly related to a lower level of knowledge. The physicians were able to treat some of their cases of uterine inertia with buccal oxytocin at home, and removed several retained placentas at home, as well as carrying oxytocin and retractor to treat third stage bleeding at home. The greater number of FNT problems brought to the hospital by the midwives may reflect their greater level of anxiety in dealing with and desire for transporting abnormal situations to the hospital early.

Comparisons with the planned hospital group suggests that for women delivering at home with the philosophies and practices of this particular group of practitioners, there was no significant increase in risk with a home delivery versus a hospital delivery. In fact, by avoidance of obstetrical medication, such as was used more frequently in the hospital by equivalently prepared women (presumably because of the effect of the hospital atmosphere on the encouragement for obstetrical medication), the incidence of low Apgar scores was less at home as was the incidence of fetal hypoxia.

The greater use of analgesia in labor by the planned hospital group may have also contributed to their greater incidence of second stage dystocia and greater incidence of fetal heart-rate drops. The breech infants did not contribute to these problems. The incidence of postpartum hemorrhage was greater in the planned hospital group and may present the greater tendency to pull on the umbilical cord to aid in the delivery of the placenta. At home, the umbilical cord was rarely pulled to aid placental delivery, but rather, the natural expulsive forces of the uterus were relied upon. This is substantiated by the longer third stages seen in the home group. The contribution of other factors such as lower stress in the home environment, alternative delivery positions, and the like cannot be assessed in a study such as this, but may be significant.

Of note, as well, are the close similarity of these findings to the home delivery statistics in the Netherlands (personal communication, Jan Kloosterman, MD, University of Amsterdam) and to home delivery statistics compiled by Gregory White, MD,¹⁵ in Chicago, and by Victor Berman, MD,³ in Los Angeles.

Generally, the response of physicians to home delivery has been negative. Many view homebirth as an irresponsible risk to mother and child. They do not encourage or attend home deliveries, and many have refused to give prenatal care, advice, or instruction to couples planning homebirth. A dichotomy exists in obstetrics today between the technological trend represented by high risk obstetric units with fetal monitoring and readily available medical and surgical intervention, and the family-centered, natural childbirth trend represented in its extreme by couples planning home delivery without medical support. We feel that reducing the antagonism between these divergent poles would enhance care for women choosing hospital as well as home deliveries.

More studies of this kind are needed before any conclusions can be drawn. We are currently engaged in a study in which we are attempting to match a comparison hospital group. However, evidence from this study population already strongly suggests that home delivery is a safe alternative for medical/ screened healthy women; they deserve adequate care for the delivery of their choice. This would include prenatal care by a physician, childbirth education, and only necessary intervention by attendants. Hospitals should be encouraged to adopt those techniques of homebirth that improve pregnancy outcome, which might include perineal massage and gentle head delivery to avoid episiotomies and lacerations, choice of the use of analgesia and anesthesia, and generally provide a supportive, friendly, and comfortable environment for labor and delivery.

Finally, what these statistics have missed is the importance of the spiritual and the emotional aspects of birth. Someday, perhaps, we will be able to empirically validate what our feelings tell us is true.

REFERENCES

1. Aaro, L.A., Saed, F.: Low-Incidence Cesarean Section: 12-year experience. *Mayo Clinic Proc.* 50:365-369, 1975
2. Behrman, R.E., Babson, G.S., and Lessel, A.: Fetal and Neonatal Mortality in White Middle Class Infants. *Am. J. Dis. Child* 121:466-489, 1971
3. Berman, V.: Comment at First Annual Meeting of the North American Society of Psychosomatic Obstetrics and Gynecology (NASPOG) Chicago, Illinois, April 10, 1976
4. Chan, V.H., Paul, R.H., and Toews, J.: Intrapartum Fetal Monitoring. *Ob Gyn* 41:7-13, 1973
5. Drago, J.S., Berendes, H.: Apgar Scores and Outcome of the Newborn. *Pediat. Clin. N. Amer.* 13:635-643, 1966
6. Esstman, H.J., Hellman, L.H.: *Williams Obstetrics*. New York, Appleton-Century-Crofts, 1966, p. 988
7. Friedman, E.A.: Patterns of Labor as Indicators of Risk. *Clin OB Gyn* 16:172-183, 1973
8. Hazell, L.D.: A Study of 300 Elective Home Births. *Birth & the Family Jour.* 2:11-18, 1975
9. Klaus, M., Fanaroff, A.: *Care of the High Risk Neonate*. Toronto, Wm Saunders Co., 1973, p. 141
10. Lang, R.: *The Birth Book*. Ben Lomond, California, Genesis Press, 1972
11. Mehl, L.E., Peterson, G.H., White, H.C., and Hayes, W.: Outcomes of Elective Home Births: A Series of 1146 Cases. Paper presented at the First Annual Meeting of the North American Society for Psychosomatic Obstetrics and Gynecology, Chicago, April 10, 1976
12. Niswander, K.A., Gordon, M.: *The Women and Their Pregnancies*. The Collaborative Perinatal Study of the National Institute of Neurological Diseases and Stroke. U.S. Dept, HEW, Philadelphia, W.B. Saunders Co., 1972, p. 49
13. Shenker, L., Post, A.G., Sellar, J.S.: Routine Electronic Monitoring of the Fetal Heart Rate and Uterine Activity During Labor. *OB Gyn* 46:185-189, 1975
14. State of California, Department of Health, Center for Health Statistics, 1975
15. White, G.: Home and Hospital Delivery, 25 Years Experience With Each. Paper presented at the First Annual Meeting of NASPOG, Chicago, April 10, 1976

child care of the American Academy of Pediatrics were observed. Midwives referred infants for newborn care after the first week to pediatricians or family physicians, and continued to follow the infants themselves for varying periods of time. All mothers had a postpartum examination from 4-6 weeks by a physician, and for the lay midwives, results of this examination were recorded in their records.

STUDY POPULATION

Hazell⁸ has described the demographic characteristics of the homebirth population in the San Francisco Bay Area in a study of 300 home deliveries from the socioanthropological standpoint. Her subjects overlapped to some extent with our sample and were derived from the same subject pool--San Francisco Bay Area couples planning homebirth.

TABLE 1
HOME DELIVERY STUDY POPULATION

Contacted Home Delivery Service:	1,345	100.0%
Screened Out, Medical Dx	55	4.1%
Decided Against	147	10.9%
Attempted Home Delivery:	1,143	85.2%
Physicians	625	55.2%
Midwives	451	40.0%
Taken to Hospital:	135	11.9%
Physicians	55	5.1%
Midwives	78	6.8%
Completed Home Delivery	1,010	74.9%

* Patients hospitalized represented 8.5% of physicians' cases, 16.9% of midwives' cases.

In Hazell's study, 50% lived in typical American fashion, with the father gainfully employed, in a single family dwelling with one or two cars, were not members of an ethnic minority, not on welfare, and without household servants. A general characteristic of the group was described as a self awareness shown in a concern for nutrition, health foods, ecology, humanistic psychology, and a strong feeling for a natural birth process. Typically, the mother and father had both attended college, but neither had graduated. The fathers' occupations were noted to vary through the range of occupations present in the Bay Area, from auto mechanic to physician to homesteader. Only one tenth were classified as "hip," in rebellion to "normal American Values," living in a variety of alternative styles.

In our study, patients of the lay midwives tended to belong more to the counter-culture than Hazell's population. In the physician groups, more professional couples were included. A detailed socio-economic study on one of the lay midwife groups (the Sonoma County sample) is currently being coordinated by one of us (LEM), and a psychological/developmental outcome study on a subsample of the Santa Cruz group is being analyzed by two of us (LEM and GHP).

3:15

UP FROM BLACK

Senator PARR'S INTRO: (2-5 min)

Fairbanks (35 min)

MSG 82-00016633 PRTY 1 03/25/82 10:46:02 ORIG: LF01 IN= 0003 OUT= 0026
FROM: DEBBIE/FBX TO: LINDA/JUNEAU
TARGET: LJH2 SUBJ: VIDEO PARTICIPANT LIST FINAL PAGE 0001

- 1. VICKI PENWELL PRO
2. LIZ GOLLOGLY CON - lay mid,
3. ENID GEIST PRO
4. DR. JEAN WILBUR CON
5. LOIS DE RAADT PRO
6. JENNIFER GLEASON CON
7. CATHY REIMHERR PRO - able to help in emergency
8. ELAINE MC KENZIE CON
9. DIANE FULLER PRO - no kids, has attended home births
10. EILEEN MONTANO CON
11. PAT FRITSCH PRO - dr may refuse pre-natal care
12. JANICE CONGER PRO
13. WENDY HOGAN PRO
14. KATHIE GETTINGER PRO - 2 kids, next one due, will be at home
15. TODD PARIS PRO
16. DOROTHY WOOL PRO
17. COLLEEN MORKAL PRO

SITKA TESTIMONY (35 min)

MSG 82-00016565 PRTY 1 03/25/82 08:47:27 ORIG: LS00 IN= 0001 OUT= 0006
FROM: ELAINE TO: LINDA
TARGET: LJH2 SUBJ: MIDWIFE T.C. SITKA LIST-CORRECTED PAGE 0001

LINDA, HERE IS MY "FINAL" LIST NOW, AS I UNDERSTAND IT. I HAVE CHANGED TWO NAMES AND CORRECTED ONE WHICH YOUR LIST YESTERDAY REFLECTED AS "CON". THE CHANGES ARE **:

- 1. DR. SUSAN CARLSON, CON - ped intrusion -
2. CAROLYN EVANS, PRO
3. **DR. EDWARD SPENCER, CON
4. BETH COX, PRO
5. JEAN FRANK, CON - RN - fiscally irresponsible. Bd not qual. Need good med
6. KATHY HENDERSON, PRO
7. **DR. RODNEY VAUGHT, CON - advocate of unborn child,
8. **MARY CLAYTON PEARCE, PRO (ADDING MIDDLE NAME PER REQUEST) RN, experienced
9. **TED PALMER, PRO (YOU HAD HIM LISTED "CON") -
10. CARLENE STOKES, PRO
11. KATHY GODDARD, PRO
12. ANN LOWE, PRO - need more work on bill
NOTE, TWO PEOPLE DROPPED YESTERDAY ARE DELETED
Put Kehoi - R.N. - pro. but need for more training

ANCHORAGE

(45 min)

MSG 82-00016630 PRTY 1 03/25/82 10:39:05 ORIG: LA08 IN= 0001 OUT= 0023
 FROM: MICKI IN ANCHORAGE TO: LINDA IN JUNEAU
 TARGET: LJH2 SUBJ: NEW PARTICIPANTS FOR VIDEO PAGE 0001

IN ANCHORAGE WE WILL HAVE

1. SUSAN PECK, PRO - child ^{or} midwife. consumer protection. midwife more than baby-catcher
2. DR. DOUG SMITH, CON - AMA legch, council against
3. CHRIS RUSHING, PRO - Drs & RN's not able to meet needs, not treated as in other illnesses
- * 4. DR. JACK JACOB CON - dir AK new born project. legitimizes obstetrics who are untrained - OK if trained. Europe experience
5. TIGER OR MARY KEOUGH PRO - family centred experience
6. DR. MARIAN WITT CON - 45 pediatrician
- * 7. DR. PATTON PETTYJOHN PRO - screen beforehand, prepare, trained birth attendants. Center Disease Control, Atlanta - mortality rate. Need more funding in bill
8. KAY LAHDENPERA CON - AK Nurses Assn - against - need distinguish nurse midwives from lay midwives - no backup. 7 nurse midwives - 3 in govt practice

MSG 82-00016630 PRTY 1 03/25/82 10:39:05 ORIG: LA08 IN= 0001 OUT= 0023
 FROM: MICKI IN ANCHORAGE TO: LINDA IN JUNEAU
 TARGET: LJH2 SUBJ: NEW PARTICIPANTS FOR VIDEO PAGE 0002

9. SHERRI HOLLEY PRO - only 1 of 2 labs will do pre-natal work. Drs charge 2-3 as much for pre-natal care for home birth couples
- ✓ 10. PAULA KORN NURSE-MIDWIFE CON
- ✓ 11. CLAY NEWMAN PRO 3 children (1 hosp, 2 home)
- ✓ 12. AL RUSHING PRO
- ✓ 13. JULIE GORHAM PRO - some kid lay midwife, couldn't find list. Drs arrogant. home births safe if properly handled.
- ✓ 14. LESLIE BRECHE PRO - home birth. No obstetrician on call at Providence
- ✓ 15. ZELDA COLLETTE-PAULE PRO lay midwife. some Drs refuse, see woman planning home birth, lab work

WE ARE HOPING TO HAVE ALL 15 SPEAK

- Karen Malone - 1 child (hosp), 1 on way (midwife)
 Michael Callaghan - 3 children at home, Carter first pres born in hosp religious + personal experience
 Karen Redford - pro, the child hosp, unsatisfactory, 2d child hosp, third will be at home.



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

March 9, 1981

MEMORANDUM

TO: Representative Mike Beirne

FROM: Betty Barton *JB*
Research Staff

RE: Alaskan Abortion Data Trends
Research Request No. 81-54

This memorandum responds to your request for data on abortions performed in Alaska within the past 3 to 5 years. To respond to this request, we have contacted staff from the State Department of Health and Social Services, the Commission on the Status of Women, and Planned Parenthood. In addition, we have contacted representatives of Bartlett Memorial Hospital, which is one of the hospitals in the state where abortions are currently performed. In the course of our research, we have learned that the data you are seeking appear to be unavailable on a statewide basis.

The Department of Health and Social Services (DHSS) compiles data regarding the incidence and nature of abortions conducted in Alaska. However, the data are submitted solely on a voluntary basis. The Department receives its information from hospital providers who submit abortion reports on a form devised by DHSS; private practitioners do not usually provide the Department with data. Because of this, the data are not regarded by DHSS staff as an accurate measure of abortion trends in Alaska. Consequently, the data have been omitted from the Department's report, Alaska Vital Statistics since 1978, and according to Department staff, some thought is being given to discontinuing the abortion reports altogether.

In the event that you have not seen them, we are enclosing a copy of the Abortion Profile 1970-1977 and excerpted materials from the 1977 issue of Alaska Vital Statistics, the most recent report that included the abortion data.

If you would like us to attempt to obtain more up-to-date information for selected regions of the state, we could undertake some additional research. The additional research could include:

Representative Michael Beirne
March 9, 1981
Page 2

- contacting Anchorage-based private physicians, who are known to perform abortions, to determine the size and nature of their caseloads. As I am sure you are aware, the majority of the abortions taking place in Alaska are performed in Anchorage, and, consequently, this data could provide a fairly significant sample of statewide patterns. However, there is some indication that these practitioners may hesitate to provide us with the information due to the sensitive nature of this topic.
- contacting all hospitals within the state where abortions are performed. It is unclear whether abortion data of hospital agencies would be accessible. In my conversation with records personnel from Bartlett Memorial Hospital, I learned that no separate records regarding abortions are maintained, which means that data retrieval would entail sorting through annual records. The Bartlett spokesperson added that they would be hesitant to provide any data beyond the total number of abortions performed due to potential privacy act inflections. The staff person added that this policy might be modified if the hospital could receive justification for the release of more detailed information.
- contacting Planned Parenthood to determine the number of abortion referrals made in the Anchorage area. Staff at Planned Parenthood, which has recently opened a medical referral clinic, informed me that they would be able to compile data regarding the nature and number of abortion referrals that have been made by staff at the clinic within the past year. This data, of course, would not reflect the number of women who actually pursued this course of action nor would it include the number of individuals who have obtained referrals from other agencies. Nonetheless, Planned Parenthood does capture a significant proportion of the population seeking information regarding abortions, which perhaps would be useful information for you.

It is unlikely that any of the above options or combination of options would provide you with comprehensive statewide information. However, if you would like us to explore any of these options, please contact us. In the meantime, we hope that you find the enclosed materials helpful.

BB/bf

Encls.



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-2251

December 28, 1981

MEMORANDUM

TO: Representative Fred Zharoff

FROM: Jonathan Sherwood *JMS*
Research Staff

RE: Cost-of-Living Differences in Alaskan Communities
Research Request No. 81-145

Richard Osterman of your office requested that we provide information regarding the differences in the cost-of-living among Alaskan communities. He indicated that the focus should be on a minimum standard of living, e.g. food and rent. Although no current estimates of comprehensive cost-of-living differences are available, we have provided recent estimates of costs of food and housing for Alaskan communities.

FOOD COSTS

A price index for food costs in Alaskan communities is published on a quarterly basis by the University of Alaska Cooperative Extension Service (CES). This index compares the cost of one week's food for a family of four with two children in elementary school. The food items and their quantities are based on the U.S. Department of Agriculture's Low Cost Food Plan, which estimates consumption levels for a diet that fulfills minimum nutritional requirements.

The CES receives no funding for this program; the information is gathered by volunteers in each community. Unfortunately, the volunteers receive no training to assure data is gathered in a consistent manner. Therefore, the data may be somewhat distorted.

The U.S.D.A. plan is not intended to reflect the consumption habits of the Alaskan consumer but is used to allow comparisons with national averages, which are based on the same list of items. Variation between communities in Alaska is probably very great, given the limited selection of goods and the significance of fish and games taken to meet subsistence needs in some communities.

According to Marguerite Stetson, who compiles the information for CES, the U.S.D.A. Low Cost Food Plan is about twenty years old and may not reflect the current buying habits of any contemporary consumer very

well. For instance, soft drinks are not included on the list of items priced.

Table I shows the cost of one week's food and the percent of Anchorage cost for selected Alaskan communities for September 1981. Sitka has the lowest food costs, and Barrow the highest, with a range of 122%.

TABLE I
Cost Of Food At Home For a Week For a
Family of 4 with Elementary School Children

	<u>September 1981</u>	<u>% of Anchorage</u>
Anchorage	\$ 86.69	100
Barrow	160.05	220
Cordova	135.39	185
Delta	111.62	129
Fairbanks	98.47	114
Juneau	93.95	108
Kotzebue	152.54	176
Nome	150.27	173
Petersburg	95.17	110
Sitka	84.63	98
Tok	114.80	132
Unalakleet	174.42	201
Valdez	106.68	123

Source: Cooperative Extension Service, University of Alaska and U.S. Department of Agriculture cooperating.

HOUSING

The U.S. Department of Housing and Urban Development provides estimates for the construction costs of low income housing for thirteen locations in Alaska. These estimates do not include property costs or site preparations; however, they do serve to show the relative construction cost differences in comparable locations. The HUD data in Table II show that construction costs are almost twice as high in remote locations as they are in Southeastern and along the Railbelt.

Al Robinson, an economist with the Anchorage HUD office, felt that the estimates, made by the Washington D.C. offices, were very low. According to Mr. Robinson, the maximum funding limit of \$92,200 per unit is required for almost all HUD projects in Alaska. Most projects are for units comparable to those assumed for the table. Mr. Robinson mentioned that the Alaska office is just beginning a survey of construction costs throughout Alaska to use as evidence to obtain approval from Washington to raise the funding limit.

TABLE II
 HUD Prototype Cost For Low Income Public Housing
 June 1981

<u>Location</u>	<u>Cost for Two Bed- room Detached House</u>	<u>% of Anchorage</u>
Anchorage	\$44,000	100%
Fairbanks	46,700	106
Juneau	42,400	96
Ketchikan	42,300	96
Sitka	42,450	96
Kenai	48,200	110
Yakutat	48,200	110
Ft. Yukon	67,500	153
Galena	72,500	165
Coastal (N. of Aleutians)	81,750	186
Tok	62,650	142
North Coast	84,100	191
Mainland (N. of Aleutians)	93,500	213

Source: Federal Register, June 29, 1981. Percentages computed by House Research Agency.

HUD also provides estimates of rents for newly built homes in six Alaska locations, as shown in Table III. Lee Huskey, an economist with the Institute of Social and Economic Research expressed some skepticism of the actual costs given, but felt that the relative differences were probably fairly accurate.

TABLE III
Fair Market Rents For New Construction
1980

<u>Location</u>	<u>Cost For Two Bedroom Detached Housing</u>	<u>% of Anchorage</u>
Anchorage	\$643	100%
Fairbanks	633	98
Juneau	670	104
Ketchikan	584	91
Western Coast	947	147

Source: Federal Register, August 29, 1980. Percentages computed by House Research Agency.

The most recent information on comprehensive cost-of-living differences among Alaskan communities is Alaska Interregional Cost Differentials, a study by the University of Alaska Center for Northern Educational Research published in 1977. The study compares the cost of food, housing, transportation, and personal care in 31 communities and 21 Regional Education Attendance Areas for 1976.

The study was made during the height of pipeline construction activity; some communities had inflated prices resulting from heightened demand. Cost-of-living differences for this period may reflect a situation untypical of more recent years. In addition, the study based its housing cost estimates on a State survey which had canvassed a disproportionate number of State employees, as the survey was to be used to adjust State salaries.

The Division of Personnel conducted surveys of food and housing expenditures in 1972 and 1976. The former study served as the basis for regional differential in the State salary schedule. The Director of the Division of Personnel of the State of Alaska is empowered by AS 39.27.030-.040 and AS 44.31.020 to require the Department of Labor to gather data reflecting cost-of-living differences among election districts for use in their annual salary survey, but he has not done so in the ten years the law has been in effect.

We regret we are unable to provide more complete, up-to-date cost-of-living information, but to our knowledge, no State agency has compiled such information. If you have any questions, or if we can be of further assistance, please do not hesitate to contact us.

Al Rushing
PO Box 4-381
ANCH 99509

Dear Al

Today we received a letter from Ken Fanning with a copy of your letter of March 26, 1982.

I have to say that I am very distressed at your implications that the Senate Health Committee has included you from testifying on SB 747. Ginger Bain and myself have worked for months on this project, have spoken to you at length on several occasions, have provided your written information and research to our legislators, have searched your legal opinions on midwifery, have lobbied the medical community and state departments on behalf of the midwives and have carefully rewritten this bill again and again to insure its passage.

I'm sure you must remember the video teleconference we had in March in which you were a participant. You must also be aware that committee meeting schedules are developed a minimum of 5 days in advance, are published in the newspapers, and are available at all legislative information offices. In addition, I know you have had weekly contact with Ginger and I feel you have little reason to

support to other legislators that we have
undermined your rights as a citizen
to have input in the legislative process

Sincerely,

Childbirth experiment goes well

by Peter Eisner
Associated Press

Fortaleza, Brazil — A pilot project that teaches basic health care to women in Brazil's poorest region may provide a Third World cure for the disease and death that threaten childbirth among the world's impoverished millions.

"The only pediatrician a new baby usually needs is its own mother," says Dr. Galba Araujo.

The Brazilian obstetrician has organized a network of traditional rural midwives who are taught methods that blend with traditional health care. They also learn to recognize warning signals in the few births which require a doctor's attendance.

"We've never had a woman die in childbirth," Araujo said in an interview. "The statistics show that 94 percent of the births were without complications."

With more than 8,000 births in five years, the project, supported by U.S. private money and Brazilian government funding, has also slashed the rate of infant death in one of the world's highest population growth areas.

"Underdeveloped countries have been irritating the developed countries in providing health care," Araujo said in an interview. "They have been adopting technology at high cost. But nobody can afford to pay."

The pilot project here stresses inexpensive methods which require minimal training, and also provides local training in family planning and birth control — a sensitive subject in this predominantly Roman Catholic country.

U.S. population specialists, based in Brazil, praise Araujo's work. With two-third of the world's people living without adequate medical care, these specialists say, the project may have major implications in the coming decades.

Araujo cited U.N. statistics which show that, if present trends continue, there will be three billion births worldwide between now and the year 2000. The statistics also indicate that one billion of those infants will die, an additional 400 million will not reach a year of age and 100 million women will die in the birth cycle.

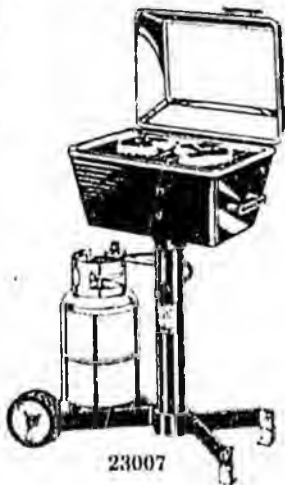
Araujo, medical director of the Maternity Hospital in Fortaleza — an Atlantic coast city of 1.3 million, 1,800 miles north of Rio de Janeiro — says the data he is gathering show at least 85 percent of pregnant women can give birth without hospital care.

"Modern medicine is using more and more sophisticated apparatus, making birth more a matter of surgery than a physiological act," said Araujo, who has sponsored international forums on health care and has lectured in the United States and elsewhere.

Sea

Sale prices effective

GREASER



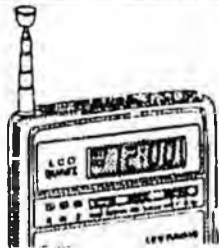
SAVER



Kenmore II with 3-s

Big 1.4 cu. ft. oven space and performs up to 1 separate cooking. Whole-meal cooking, electronic touch, probe.

SAVER



Araujo's project, which receives grant money from the Ceara State government, federal health officials and the Kellogg Foundation of the United States, has established a series of regional and local health clinics. He and other physicians enlist the help of traditional midwives and offer them group training.

The project advocates the use of "birthing stools," either at home or in a clinic, instead of giving birth lying down. The birthing stools — which can be as simple as a wooden chair with part of the seat removed — place the mother in a squatting position so that gravity aids the birth process.

Three hundred midwives have been trained in Ceara state, learning about problems of infection and about modern preventive care. They also are taught warning signals of birth problems and can refer mothers to local "satellite clinics" for better care. The satellite clinics, in turn, can refer patients to "base hospitals" for more sophisticated help.

There are now eight satellite centers and three base hospitals. Araujo says he and the state health department plan to double the number by 1983, with eventual plans to cover the entire state.

Ceara, with a population of more than five million, is in Brazil's drought-stricken northeast poverty belt. The birth rate here is higher than the national rate of 36 per 1,000 and the infant mortality rate higher than the national rate of 109 per 1,000.

The statistics at the satellite center at Aquiras, 25 miles from Fortaleza, are markedly better. Since the clinic opened on May 1, 1977, there have been 2,359 admissions and 1,806 births. An additional 329 cases were referred to the Fortaleza center and other women received pre- and post-natal care. There were 26 infant deaths among the 1,806 births, a death rate of 12 per 1,000 — one-eighth of the national average and lower than the U.S. infant mortality rate of 15 per 1,000. The overall statistics in the Ceara project are similar, Araujo said.

The coordinator of the Aquiras Center, Dona Teresinha Perelra Lins, herself a traditional midwife, said the clinic has been able to convince reluctant local residents that the free health service works.

"I began learning (to be a midwife) from my grandmother when I was 21," she said. "When I got here, everything was different. But now, everyone is used to it and we deliver 50 to 60 babies a month."

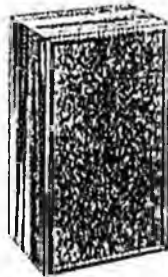
Araujo said the northeastern project has important lessons for more developed areas of Brazil, as well as for countries like the United States.

91882

Compact

Plays and records tapes. AM/FM size record cl speakers.

SA



Stereo

Stereo with cassette track. Plays and records cassettes, plays tapes. AM/FM record changer.

3B 747 March 25
Teleconference

Fairbanks

Vicki Penwell - childbirth educator, birth attendant - ~~Pro~~
need for medical backup.
freedom of choice
pro voluntary licensure

Liz Colby - ^{husband an M.D.} lay midwives from Britain (training in Louisiana)
reasonable & appropriate regulation
low risk only - adequate physician evaluation
obj.

pg 1 - for all midwives - if one fails exam, could
continue to practice
physician, PHN, nurse midwife on Board

inadequate requirements - only 20 observations

scope of practice - should limit to low risk
should insist on M.D.

Emil Geist - childbirth educator, teaches home birth
classes.

free choice - pro education
spiritual & emotional aspects of birth

Dr. Jan Wilbur - fam. prac. Tanana Clinic
doesn't favor home del. by anyone

- pg 1 line 28 - mandatory
- pg 2 line 8 - physician or nurse on Board
- line 22 - "Examination" too loose. MD should write exam - Med practical
- pg 3 line 12 - 20 births inadequate
- line 28 - 10 births not enough
- list definite course requirement
- pg 5 line 22 - presentation requires extensive training —
- define degree of suturing
- pg 7 line 10 - medical history, previous preg, and congenital anomalies in family
- routine care defined

pg 7 line 20 - Friedman curve

De Ruadt
Louis ~~De Ruadt~~ - have birth parent.
good bill, support midwife concept.

Janifer Gleason - Ch. State Board of Nursing
minimum requirements.

- more education for scope of practice
- req. ongoing backup.

pg 3 line 29 - "sponsor" should be req. to have much more training — should be mandatory

Board of Nursing does not support.

Cathy Reinker - Mother - pro.

essentials in Alaska because of rural area -
personally employed cannot afford hospital
care.

Elaine McKenzie

- need to gather data about home births
and true situation
New Mexico populations would be a good
model - scope of practice - what are limits?
better definitions needed.

Dianna Fuller - pro

support freedom of choice + safeguards on practitioners

Eileen Montana RN - con

member of Nursing Board. License says
state endorses practice.

Pat Fritsch
Pat French - pro

- rewarding, economic.
- difficult to find midwife - scarcity, secrecy.
- medical profession taken down for pre-natal
care, do not support home births. no emergency
back up for midwives

Janice Conger - mother - pro
M.D. & midwife delivery in hospital.
personal attention of midwife excellent, supportive

Wendy Hogan - pro
freedom of choice

Kathy Gittinger pro
= hospital births
has attended home births, plans on delivering
not at home (any day)

Topo Paris pro

Sitra

Caroleyn Evans - Childbirth Educator.
Parents Assoc. of free choice

free choices available in S.E.

Kathy Henderson - home birth parent.
2,500 - 3,000 lay midwives in US

Dr. Rodney Vogt - family practice - obst.
advocate of unborn child

homebirth for parents at expense of child's safety
247 unacceptable - sanction midwives who
have unacceptable training

Marcy Pierce - RN - Childbirth Ed - Pro
attended many home births - trend not
a fad. Need to open communication w/
medical community.
homebirth parent.

earlier mentioned amendments are good.

Ted Palmer - homebirth parent. - Pro
Bill needs more work, supports Dr
Wilbur's amendments. (FORS)

Carlene Stokes - mother, childbirth Ed - Pro
attending 20 births in a small community
would be hard.

Ann Howe - homebirth parent < 1 M.D.
< 1 RN
made choice of birth attendant through self-ed.
more work on Bill. Get physicians involved
in homebirth.

Pat Keho - RN - Pro midwives
need better standards & education

Arch

Susan Pick - pro - consumer - home birth parent
pref. over natal care w/ midwife
freedom of choice
good for rural Ak.
good public support.

Dr. Douglas Smith - Leg. Ch. of AMA
AMA adopted resolution -
Birth centers available close to hospital,
few M.D.'s will collaborate w/ midwife
License will increase public confidence
in midwives
against bill, will disseminate info
to parents planning home birth.

medical model has decreased mortality
and morbidity.

Chris Rushing - midwife
1940-1950 50% home births
medical community doesn't have time/skill
or inclination to do home births.
hospital harasses & discriminates
against women birthing w/ midwives.

Dr. Jack Jacobs - Newborn ICU Providence - CON.

747 legitimizes obstetrics by poorly trained.
Not opposed to home birth

Works when

1. highly developed med. services for screening high risk.
2. Emerg. med. evaluation backup

MD don't deliver at home - no guarantee of safety.

PHS had excessive newborn mortality decreased recently related to decrease in home births.

Mary Keogh - pro

Survey of Ansh homebirths 92% home / good
3.5% hosp / exper.

Dr. Marian Witt - rep. 45 Pediatricians - CON

Change Board Structure

Not opposed to home birth. - no medical backups available in UK.

Dr. Pittyishan - Naturopath -

homebirth criteria - screening, adequate

training prep, qualified attendant.

Center for Disease Control, Atlanta - study
of licensed midwives - home births, screened -
mortality rate better than hospital (N.C.)

climate of medical profession - anti - home birth.
need additional training.

Kay Henderson Am Nurses Assoc. Ch. Leg. Comm.
opposes.

quality standards are inadequate

Cert. Nurse-Midwife can practice in collaboration
w/ M.D.

- not a professional board
- no relationship w/ medical profes.
- no training required.

Al Rushing Pres. of Better Ok. Birthing Experience
R.N.

no obj. scientific data against home birth.
Anch. has emerg. trans. system.

referred to Brazil study.

30% C-section rate in Anch. hospital.

Julie Gorham - Home birth parent. Ed. Admin. in H.R.
upro

Leslie Breche - home birth parent. - pro
good prenatal care can screen many complications,
Anch. Comm. Hosp. does not have OB on call
for emergencies.

Yelda Cullette-Paul - lay midwife in Anch. - pro
feels capable of handling normal pre-natal
and birthing care. M.D.'s refuse pre-natal
care to those planning home birth. More difficult
to get lab work done in Anch.
prefers to be licensed for her own protection.
has informed consent form.

Liability -
labs have been pressured by M.D.'s not to
do lab work

Karen Mulane - parent-planning home birth - pro
had experience in hospital. Midwife has
time to know family, give personal care.

Michael O'Mullaghan - home birth parent. - pro

Karen Redstone - pro

SITKA

Dr. Susan Carlson - Con.

AUDIO

Soldotna

Debbie Willington - lay Midwife / Childbirth Ed. - Pro

— active in political battle in Calif. against
AMA. Member of all Midwife Assoc. Have
high quality standards of care.

— supports recognition of midwives.

Judy Harvey - mother 3 home births - midwife. Pro
only opposition from medical community.

10 midwives in Anch, profession is
growing as is homebirth.

no M.D.'s will attend home births.

people come to Anch. for independence & free choice
5% home births in Kenai.

Dr. Anne Thorne - Stewart Study

Merilee Wilson - home birth parent.

chose H.B. because of bad hospital
experience.

Dillingham

Camila Martinez - Medical Anthropologist / ^{apprentice} midwife
involved in home birth
denial of lab work, back-up through Medical.
Parents & Midwives are encountering
unprofessional medical treatment in hospital
E.R.'s - harassment.

Midwives she has studied w/ have extensive
hands on training & book learning.
Don't make us outlaws.

Robert Clark - Health Corps.

need option with cut back in Fed dollars
expect increase in home births.

(IHS)

FBKS

~~XXXXXXXXXXXX~~

Kay Keet - Parent ^{Philosophical}

Better description of practice - too technical
drugs are practicing medicine.
Should be mandatory.

Homer

Marsha Kelsey - Midwife Nurse/Pract. - oppose
Am. College of Nurse Midwives have
carefully set standards of care.
Lay & nurse midwife should adhere to
the same requirements

Kathleen Stier - Mother / H.P. parent / Postnat Ed.
— member of N.W. Coalition of Midwives, BABE
and M.A.

— testimony is that adequate ed / testing is
necessary. More important that the knowledge
is there.

Midwifery includes emotional & spiritual.

Claudia Child - Parent pro
freedom of choice

Ray Bill - ^{oppose} Certified Fam. Prac. training in Obstet.

- Bill would foster false confidence
- need proficiency to recognize
warning signs of problems
- Board - not suff. expertise for
exams: Stats:

- 1 neonatal death
- 3 membrane mismanagement
- 2 aspirations

Paul Eulboe - Dr

doing home births in Ok. for 18 yrs. Carefully screens.
long history in favor of lay midwives.

14 yrs 1970-75 - 77 home births

11 infant deaths
problems in H.B. - emotional decision, midwives

not adequately trained, cannot recognize fetal distress.
commitment to deliver at home often delays going
to hospital.

John Child - 9 children, 2 at home - Pro
in hosp. situation, he ended up delivering his
own baby. Both doctors on vacation.

Mat - Su

Bryette Preston - 2 home births w/ midwives pro

— Midwives in gray area legally, would help
situation of lab work & prenatal screening.

Thomas Preston - pro - home birth parent.

Newsweek Cesarean 300% increase in past years.
freedom of choice.

Karen Salboye - exp. mother planning H/B pro

— Women should insure adequate knowledge/expert.
should have access to lab tests, backup emergency proced.
— midwives do screen applicants.

Yvonne Hall - 4 home births R.N./midwife in
Arkansas had physician in team.

400 births - no problems. Medical establishment

in UK. no faith in midwives.

Midwife spends more time with mother than M.D.
are there enough trained midwives to educate
others? Need more medical ed.

injection in Hosp. are problematic

Jannie Schrage - R.N. oppose

scope of prac. like nurse/midwife
nothing prohibits practice w/o license -
gray area of legality would remain.



S

B

7

4

7

3/3

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

Veronica Allmaras
Anne Bushing
Fall, 1979
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 baccalaureate 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 Inservice 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 delivered babies (obstetricians, family practitioners, or general practitioners) 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 psychologically 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 practitioners 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 hospital.

* 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 Practitioners, presumably because they would be engaged in a higher level of practice as public health nurses or as private practitioners, 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.

<u>Age</u>	<u>Percent of Nurses</u>	<u>Years of Experience</u>	<u>Percent of Nurses</u>
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 600 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 unrandomness is reflected in our statistical data.

The parents are an educated, affluent, and younger group. Ninety-nine percent 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, 60% 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:

	<u>A.B.C. Delivery</u>	<u>Conventional Hospital Birth (Includes two-day stay)</u>
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 regarding 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

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

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 disassociate 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 confirms 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 hypothesis 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 consumers, 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.

²Women's Day, p. 12, 162.

³Journal of Reproductive Medicine, p. 291.

⁴Ms., p. 109, 113, 114.

⁵1978 Population Profile.

⁶Ibid.

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

⁸Canadian Nurse, p. 33.

BIBLIOGRAPHY

- Arms, Suzanne, "How Hospitals Complicate Childbirths,"
Ms., May, 1975, pp. 108-115.
- Cameron, J. et al., "Home Birth in Salt Lake City, Utah,"
American Journal of Public Health, July, 1979, pp. 716-717.
- Doyle, Mary C., "Approaches to Childbirth," Family and Community Health, November, 1978.
- Epstein, J. L. and McCartney, Marion, "A Home Birth Service that Works," Birth and the Family Journal, Summer, 1977, pp. 71-75.
- Estes, M. N., "A Home Obstetric Service with Expert Consultation and Back-Up," Birth and Family Journal, Fall, 1978.
- Kerney, J., and Ferris, C. B., "An Alternative Birth Center in a Community Teaching Hospital," Obstetrics and Gynecology, March, 1978, pp. 371-373.
- L'Esperance, C. M., "Home Birth -- A Manifestation of Agression?" JOGN Nursing, July-August, 1979, pp. 227-230.
- Lybic and Ernst, "The Childbearing Center: An Alternative to Conventional Care," Nursing Outlook, December, 1978.
- Lybic, Ruth, "The Maternity Center Association's Childbearing Center," Journal of Reproductive Medicine, November, 1977, pp. 293-294.
- Maynard, Fredell, "Home Births vs. Hospital Births," Woman's Day, June 28, 1977, pp. 10-12.
- Mehl, Lewis, et al., "Outcomes of Elective Home Births: A Series of 1,146 Cases," Journal of Reproductive Medicine, November, 1977, pp. 281-290.
- Rice, A. and Carty, E., "Alternative Birth Centers," The Canadian Nurse, November, 1977, pp. 31-34.
- Saltner, Alice, "Birth Without Violence: A Medical Controversy," Nursing Research, March April, 1978, pp. 84-88.
- Timberlake, Bobbi, "The New Life Center," American Journal of Nursing, September, 1975, pp. 1456-1461.

1355
White, Gregory, "A Comparison of Home and Hospital Delivery
Based on 25 Years of Experience with Both," Journal of
Reproductive Medicine, November, 1977, pp. 290-292.

1978 Population Profile, Municipality of Anchorage, Dr.
Richard Ender, JAA Urban Observatory.

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LEGISLATION AND NURSE-MIDWIFERY PRACTICE IN THE USA



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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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The American College of Nurse-Midwives
Washington, D.C.

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

Herriet 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

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ACNM Legislation Committee Members

Brenda Cosgrove, CNM (New York)

Sister Dorothy Dalton, CNM (Ohio)

Charlotte Elsberry, CNM (New York)

Ann Koontz, CNM (Maryland)

Donna LeBlanc Kern, CNM (Texas)

Sister Angela Murdaugh, CNM (Texas)

Sandra Regenié, CNM (North Carolina)

Mary Shean, CNM (Maryland)

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

Alice M. Forman, SCM
Director, ACNM-Johns Hopkins
Nurse-Midwifery Legislation Project
Elizabeth M. Cooper, CNM
Coordinator, ACNM
Legislation Information System

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 twofold: 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 ac-

cessible 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, 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 survey.

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

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

States and jurisdictions with permissive laws

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

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

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

Legislative statute only

California	Puerto Rico
Montana	Utah
Ohio	West Virginia

Rules of a statutory agency only

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

Legislative statute and rules of a statutory agency

Arizona	New York
Florida	Virgin Islands

Joint statement of state interdisciplinary professional organizations

Colorado	Maryland
District of Columbia	Mississippi
Maine	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)	Illinois	North Carolina (a)
Arkansas (b)	Iowa (b)	Oregon (a)
Connecticut (b)	Louisiana	Rhode Island
Georgia	Minnesota	Tennessee (a)
Idaho	Nebraska (b)	Washington (b)
	Nevada (a)	

Lay midwife statutes

Arkansas (b)	Indiana
Delaware	Maryland
Hawaii	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: Kansas 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	New Mexico
California	New York
Connecticut	Ohio
District of Columbia	Pennsylvania
Florida	Puerto Rico
Guam	South Carolina
Kentucky	Utah
Maine	Vermont
Maryland	Virginia
Mississippi	Virgin Islands
New Hampshire	West Virginia
New Jersey	

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

Georgia	Minnesota	Tennessee
Illinois	North Carolina	Texas
Louisiana	Oregon	Washington

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

A. Lay midwives practice fully

Alaska (a)	Hawaii
Arkansas	Oklahoma

B. Neither nurse-midwives nor lay midwives practice fully

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

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

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

(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-midwifery 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	IIEB
Alaska	IIA	Nebraska	IIEB
Arizona	IA	Nevada	IIEB
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	IIEB
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	IIEB
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	IIEB

(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 these 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

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

State Board of Medical Examiners (a)

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

State Board of Nurse Examiners (a)

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

Joint Commission of State Boards

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

Statements by interdisciplinary professional groups

Colorado	Mississippi
District of Columbia	South Carolina
Maine	Vermont
Maryland	

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

Graduation from a nurse-midwifery educational program approved by ACNM

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